Texas Healthcare Transformation and Quality Improvement Program

REGIONAL HEALTHCARE PARTNERSHIP (RHP) PLAN

December 31, 2012

Region # 3 / Southeast Texas Regional Healthcare Planning
Pass 1, 2 & 3

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Section I. RHP Organization

Section I. RHP Organization

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

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

RHP Participant Type	**Texas Provider Identifier** (TPI)	**Texas Identification Number** (TIN)	**Ownership Type** (state owned, non-state public, private)	**Organization Name**	**Lead Representative**	**Lead Representative Contact Information** (address, email, phone number)
Anchoring Entity						
Public Hospital District	133355104	741536936	Non-state public	Harris County Hospital District (Harris Health System)	Amanda Simmons	2525 Holly Hall, Houston, TX 77054 Amanda.simmons@harrishealth.org 713-566-6405
IGT Entities						
Public Hospital	020993401	760153629	Non-state public	Bayside Community Hospital	Theresa Cheaney	P.O. Box 398, Anahuac, TX 77514 tcheaney@chambershealth.org 409-267-3143
Public Hospital District	083290905	760636528	Non-state public	Bellville Hospital District	Michael Morris	44 N. Cummings Bellville TX 77418 mmorris@bellvillehospital.com 979-413-7400
Public Hospital	131045004	760488120	Non-state public	El Campo Memorial Hospital	Tisha Zalman	303 Sandy Corner Rd, El Campo, TX 77437 tzalman@ecmh.org 979-543-6251
Public Hospital District / Safety Net Hospital	133355104	741536936	Non-state public	Harris County Hospital District / Ben Taub	Nicole Lievsay	2525 Holly Hall Drive, Houston, TX 77054 Nicole.lievsay@harrishealth.org 713-566-6400

RHP Participant Type	**Texas Provider Identifier** (TPI)	**Texas Identification Number** (TIN)	**Ownership Type** (state owned, non-state public, private)	**Organization Name**	**Lead Representative**	**Lead Representative Contact Information** (address, email, phone number)
				General Hospital		
Public Hospital	130959304	746025069	Non-state public	Matagorda Regional Medical Center	Steve Smith	104 7th Street, Bay City, TX 77414 ssmith@matagordaregional.org 979-241-5520
Public Hospital	137909111	746003411	Non-state public	Memorial Medical Center	Jason Anglin	815 N. Virginia Street Port Lavaca, Texas 77979 janglin@mmcportlavaca.com 361-552-0222
Public Hospital	127303903	760339462	Non-state public	Oakbend Medical Center	Darren Coates	2801 Via Fortuna, Suite 500 Austin, 78746 coates@gl-law.com 512-899-3995
Public Hospital	212060201	12705654999	Non-state public	Rice Medical Center	Jim Janek	600 S Austin Rd, Eagle Lake, TX 77434 jjanek@ricemedicalcenter.net (979) 234-5571
Public Hospital District	n/a	n/a	Non-state public	Tomball Regional Hospital Auth	Jerald Till	13302 Wildwood Drive Tomball, Texas 77375 jerry.15260@yahoo.com (281) 351-8514
State Hospital	112672402	746001118	State Owned	The University of Texas M.D. Anderson Cancer Center	Lewis Foxhall, MD	Office of Health Policy 1515 Holcombe Boulevard, Unit 1487 Houston, TX 77030-4009 lfoxhall@mdanderson.org
County Health Dept	2967606	746001969	Non-state public	Fort Bend County Health Dept	Mary Desvignes-Kendrick	3520 Reading Road, Suite A, Rosenberg, TX 77471 md.kendrick@co.fort-bend.tx.us 281-238-3517
County Health Dept	1023163326	17604545149159	Non-state public	Harris County Public Health & Environmental Svcs	Herminia Palacio, MD	2223 West Loop South, Houston, Texas 77027 hpalacio@hcphes.org 713-439-6016

RHP Participant Type	Texas Provider Identifier (TPI)	Texas Identification Number (TIN)	Ownership Type (state owned, non-state public, private)	Organization Name	Lead Representative	Lead Representative Contact Information (address, email, phone number)
County Health Dept	0937740-08,-03,-07	27-2920745	Non-state public	Houston Dept of Health & Human Svcs	Judy Harris	8000 N. Stadium Dr. Houston, TX 77054 Judy.Harris@houstontx.gov 832-393-4345
Academic Organization	082006001	741613878	Private	Baylor College of Medicine *Higher Education Coordinating Board Agreement	John Burruss, MD	One Baylor Plaza Ste 181A, Houston, TX 77030 jburruss@bcm.edu 713-798-8750
Academic Organization	112672402	746001118	State Owned	The University of Texas M.D. Anderson Cancer Center	Lewis Foxhall, MD	Office of Health Policy 1515 Holcombe Boulevard, Unit 1487 Houston, TX 77030-4009 lfoxhall@mdanderson.org
Academic Organization	111810101	760459500	Non-state public	University of Texas Health Science Center	Andrew Casas	6410 Fannin STE 1500 Houston Texas 77030 Andrew.Casas@uth.tmc.edu 832-325-7325
Local Mental Health Authority	135254407	741659064	Non-state public	GulfBend Center	Donald L. Polzin	6502 Nursery Drive, Ste 100, Victoria, TX 77904 dpolzin@gulfbend.org 361-582-2314
Local Mental Health Authority	113180703	7416039505023	Non-state public	Mental Health – Mental Retardation Authority	Dr. Scott Strang	7011 Southwest Fwy, Houston, TX 77074 scott.strang@mhmraharris.org 713-970-7182
Local Mental Health Authority	096166602	7416841983	Non-state public	Spindletop Center	Chalonnes Hoover	P.O. Box 3846, Beaumont TX 77704-3846 chalonnes.hoover@stctr.org 409-784-5668
Local Mental Health Authority	081522701	7602532875	Non-state public	Texana	Amanda Darr	4910 Airport Avenue, Building D, Rosenberg, TX 77471 amanda.darr@texanacenter.com 281-239-1350

RHP Participant Type	Texas Provider Identifier (TPI)	Texas Identification Number (TIN)	Ownership Type (state owned, non-state public, private)	Organization Name	Lead Representative	Lead Representative Contact Information (address, email, phone number)
Performing Providers						
Academic Organization	082006001	741613878	Private	Baylor College of Medicine	John Burruss, MD	One Baylor Plaza Ste 181A, Houston, TX 77030 jburruss@bcm.edu 713-798-8750
Private Hospital	135033204	741394418	Private	Columbus Community Hospital	Rob Thomas	110 Shult Drive, Columbus, TX 78934 rthomas@columbusch.com 979-732-2371
Public Hospital	131045004	760488120 5 000	Non-state public	El Campo Memorial Hospital	Tisha Zalman	303 Sandy Corner Rd, El Campo, TX 77437 tzalman@ecmh.org 979-543-6251
County Health Dept	2967606	746001969	Non-state public	Fort Bend County Health Dept	Mary Desvignes-Kendrick	3520 Reading Road, Suite A, Rosenberg, TX 77471 md.kendrick@co.fort-bend.tx.us 281-238-3517
Private Hospital	178815001	1203745677 4 003	Private	Gulf Coast Medical Center	Randy Slack	10141 US 59 RD Wharton, Texas randy.slack@gulfcoastmedical.com 979-282-6100
Public Hospital District	133355104	741536936	Non-state public	Harris County Hospital District / Ben Taub General Hospital	Nicole Lievsay	2525 Holly Hall Drive, Houston, TX 77054 Nicole.lievsay@harrishealth.org 713-566-6400
Private Hospital	020817501	16218013593	Private	HCA Gulf Coast Division – Bayshore Hospital	Jeff Sliwinski	7400 Fannin St, Ste 650, Houston, TX 77054 Jeff.Sliwinski@HCAHealthcare.com 713-852-1534
Private Hospital	094187402	16218013593	Private	HCA Gulf Coast Division – West Houston Medical	Jeff Sliwinski	7400 Fannin St, Ste 650, Houston, TX 77054 Jeff.Sliwinski@HCAHealthcare.com 713-852-1534

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				Center		
County Health Dept	0937740-08,-03,-07	272920745	Non-state public	Houston Dept of Health & Human Svcs	Judy Harris	8000 N. Stadium Dr. Houston, TX 77054 Judy.Harris@houstontx.gov 832-393-4345
Public Hospital	130959304	746025069	Non-state public	Matagorda Regional Medical Center	Steve Smith	104 7th Street, Bay City, TX 77414 ssmith@matagordaregional.org 979-241-5520
Private Hospital / Safety Net Hospital	137805107	741152597	Private	Memorial Hermann Healthcare System	Jeff Brownawell	929 Gessner, Ste 2700, Houston, TX 77024 Jeffrey.brownawell@memorialhermann.org 713-242-2785
Private Hospital	146509801	741152597	Private	Memorial Hermann Healthcare System - Katy	Jeff Brownawell	929 Gessner, Ste 2700, Houston, TX 77024 Jeffrey.brownawell@memorialhermann.org 713-242-2785
Private Hospital / Safety Net Hospital	192751901	741152597	Private	Memorial Hermann Healthcare System – Northeast	Jeff Brownawell	929 Gessner, Ste 2700, Houston, TX 77024 Jeffrey.brownawell@memorialhermann.org 713-242-2785
Private Hospital	146021401	741152597	Private	Memorial Hermann Healthcare System - Sugarland	Jeff Brownawell	929 Gessner, Ste 2700, Houston, TX 77024 Jeffrey.brownawell@memorialhermann.org 713-242-2785
State Hospital	112672402	746001118	State Owned	The University of Texas M.D. Anderson Cancer Center	Lewis Foxhall, MD	Office of Health Policy 1515 Holcombe Boulevard, Unit 1487 Houston, TX 77030-4009 lfoxhall@mdanderson.org
Public Hospital	137909111	746003411	Non-state public	Memorial Medical Center	Jason Anglin	815 N. Virginia Street Port Lavaca, Texas 77979 janglin@mmcportlavaca.com 361-552-0222

RHP Participant Type	Texas Provider Identifier (TPI)	Texas Identification Number (TIN)	Ownership Type (state owned, non-state public, private)	Organization Name	Lead Representative	Lead Representative Contact Information (address, email, phone number)
Local Mental Health Authority	113180703	17416039505023	Non-state public	Mental Health – Mental Retardation Authority	Dr. Scott Strang	7011 Southwest Fwy, Houston, TX 77074 scott.strang@mhmraharris.org 713-970-7182
Public Hospital	127303903	760339462	Non-state public	Oakbend Medical Center	Darren Coates	2801 Via Fortuna, Suite 500 Austin, 78746 coates@gl-law.com 512-899-3995
Public Hospital	212060201	12705654999	Non-state public	Rice Medical Center	Jim Janek	600 S Austin Rd, Eagle Lake, TX 77434 jjanek@ricemedicalcenter.net (979) 234-5571
Local Mental Health Authority	096166602	17416841983	Non-state public	Spindletop Center	Chalonnes Hoover	P.O. Box 3846, Beaumont TX 77704-3846 chalonnes.hoover@stctr.org 409-784-5668
Private Hospital	181706601	204835578	Private	St. Joseph's Medical Center	Gregory Pearson	1401 St Joseph Parkway Houston, TX 77002 Greg.Pearson@sjmctx.com 713-756-5298
Local Mental Health Authority	081522701	17602532875	Non-state public	Texana	Amanda Darr	4910 Airport Avenue, Building D, Rosenberg, TX 77471 amanda.darr@texanacenter.com 281-239-1350
Children's Hospital / Safety Net	139135109	17411005550	Private	Texas Children's Hospital	Alec King	6621 Fannin, Ste A135, Houston, TX 77030 ahking@texaschildrens.org 832-824-2946
Private Hospital	140713201	760545192	Private	The Methodist Hospital	Carolyn Belk	1707 Sunset Blvd., Houston, TX, 77005 cbelk@tmhs.org

RHP Participant Type	Texas Provider Identifier (TPI)	Texas Identification Number (TIN)	Ownership Type (state owned, non-state public, private)	Organization Name	Lead Representative	Lead Representative Contact Information (address, email, phone number)
						832-667-5883
Private Hospital	288523801	32044775339	Private	Tomball Regional Medical Center	Richard Ervin	605 Holderrieth Blvd, Tomball, TX 77375 RErvin@tomballhospital.org 281-401-7897
Academic Organization	111810101	760459500	Non-state public	University of Texas Health Science Center	Andrew Casas	6410 Fannin STE 1500 Houston Texas 77030 Andrew.Casas@uth.tmc.edu 832-325-7325
Academic Organization	112672402	746001118	State Owned	The University of Texas M.D. Anderson Cancer Center	Lewis Foxhall, MD	Office of Health Policy 1515 Holcombe Boulevard, Unit 1487 Houston, TX 77030-4009 lfoxhall@mdanderson.org
UC-only Hospitals *(list hospitals that will only be participating in UC)*						
Public Hospital	020993401	760153629	Non-state public	Bayside Community Hospital	Theresa Cheaney	P.O. Box 398, Anahuac, TX 77514 tcheaney@chambershealth.org 409-267-3143
Public Hospital	083290905	274005511	Non-state public	Bellville General Hospital	Michael Morris	44 N. Cummings Bellville TX 77418 mmorris@bellvillehospital.com 979-413-7400
Private Hospital	*094225202*	N/A	Private	Christus St. Catherine Hospital	Mike Sullivan	18300 St. John Drive Nassau Bay, TX 77058 mike.sullivan@christushealth.org 281.336.3722
Private Hospital	*094198102*	N/A	Private	Christus St. John Hospital	Mike Sullivan	18300 St. John Drive Nassau Bay, TX 77058 mike.sullivan@christushealth.org

RHP Participant Type	Texas Provider Identifier (TPI)	Texas Identification Number (TIN)	Ownership Type (state owned, non-state public, private)	Organization Name	Lead Representative	Lead Representative Contact Information (address, email, phone number)
						281.336.3722
Private Hospital	152686501	760698013	Private	Palacios Community Medical Center	Don Bates	311 Green Ave, Palacios, TX 77465 dbpcmc@tisd.net 361-972-2511
Private Hospital	148698701	752922928	Private	Winnie Community Hospital	Albert B. Schwarzer	3221 Collinsworth, Ste 200 Fort Worth, TX 76107 albert@frontierhealthcare.com 817-731-1997
Other Stakeholders *(specify type)*						
County Medical Associations/Societies				Harris County Medical Society	Keith Bourgeois, MD	1515 Hermann Drive, Houston, TX 77004 713-524-4267
Other significant safety net providers within the region (specify type)				SETRAC	Darrell Pile	1111 North Loop West, Ste 160, Houston, TX 77008 Darrell.pile@setrac.org 281-822-4444
Others (specify type, e.g. advocacy groups, associations)				Gateway to Care	Ron Cookston	3611 Ennis; Houston, TX 77004 ron.cookston@gatewaytocare.org 713-783-4616
				Greater Houston Partnership	Mark Wallace	6621 Fannin Street, A135, MC 1-4460 mawallac@texaschildrens.org 832-824-1160
				Houston-Galveston Area Council	Mary E. Koch	P.O. Box 22777, Houston, TX 77227 Mary.Koch@wrksolutions.com 713-627-3200
				Partners for Community Health	John Kajander	1310 Prairie St. Suite 1080, Houston TX 77002 jkajander@hctx.net 713-368-1340

Section II. Executive Overview of RHP Plan

Section II. Executive Overview of RHP Plan

As the largest Regional Healthcare Partnership (RHP) in Texas, our RHP plan is by necessity an ambitious, comprehensive effort to improve health care services for more than five million people within the nine counties. Through a coordinated strategy that began nearly a year ago, our Plan partners and stakeholders have contributed thousands of hours to develop a community-wide strategic plan for transforming our health care delivery system. Due to our large population and the extensive health care needs of our community, the DSRIP program is a welcome opportunity to expand and transform our health care system.

As with any large area that includes both urban and rural populations, the Region's residents are an extremely diverse, heterogeneous group that varies widely in their need for health care services. According to the Census Bureau's American Community Survey (ACS), the Houston Metropolitan Statistical Area includes more than 1.3 million residents born outside the United States.

While each of our Region's nine counties has widely varying populations with diverse ethnic and cultural backgrounds, the needs of our communities and the people we serve are strikingly similar. Based on input from hundreds of stakeholders and a review of more than 75 studies of our community needs, the Region identified an extensive list of critical health care needs and challenges. The priority challenges that must be addressed to successfully transform our health care system are the focus of many of our projects and are summarized as follows:

- Inadequate primary care and specialty care capacity to meet the demands of a large and continually growing population. Every county in the region is designated a Health Professional Shortage Area for primary care, behavioral health care and dental care. Patients experience long waits for appointments and often turn to emergency rooms for primary care and non-urgent health care services that do not require emergency services.
- High prevalence of chronic disease, including diabetes, obesity, cancer, asthma and heart disease;
- High prevalence of unhealthy lifestyle behaviors, including smoking, substance abuse, lack of exercise, and poor nutritional habits;
- A diverse population that includes a large number of immigrants that speak more than a dozen different languages requiring language interpretation services and culturally-appropriate care;
- Insufficient transportation services that delay patients' access to care and encourages inappropriate utilization of emergency services;
- High utilization of emergency services for non-urgent, episodic care;
- Lack of coordination among primary and specialty care providers, and fragmentation of inpatient, outpatient and ancillary services.
- Lack of patient training and education programs that encourage and enable consumers to take charge of their health, and
- Absence of a regional plan for facilitating shared-training and learning programs among providers, with a focus on sharing best-practices and lessons learned.

The need for services and the health care challenges we face as a community are admirably addressed by the existing health care providers, but the sheer volume of need is overwhelming and often frustrating for the dedicated professionals who work in our Region. Health care services are provided by more than 12,250 physicians representing more than 200 specialties, and 85 acute care hospitals.[1] With a total of more than 13,000 inpatient beds, hospital services provided in 2010 included more than 1.6 million emergency room visits, 8.3 million outpatient visits, and more than 522,000 inpatient admissions.[2] Our health care system includes the Texas Medical Center (TMC), an organization of 52 renowned medical research and academic institutions that provide cutting edge research and services. In 2010, these facilities collectively were responsible for 7.1 million patient visits, including 16,000 visits from international patients who travel from all over the world for life-saving treatment.

But despite this impressive health care infrastructure, access to care is still a challenge for many people living in the region. Like other regions of the state, we have a high uninsured rate that varies from a low of 17.2% in Calhoun County to a high of 27.4% in Harris County.[3] The U.S. Census Bureau estimates 1.2 million people living in the Region have no insurance, many of whom rely on an extensive safety net system that struggles to keep up with the high demand for health care services. Additionally, the region includes a large population that lives in underserved areas where basic health care services are at a premium. Approximately 850,000 people live below 100% of the federal poverty level, including more than 505,000 adults and 344,600 children. The combination of low incomes, a lack of insurance, and an insufficient number of health care providers creates significant barriers for these individuals, who are a priority population in many of our regional health plan initiatives.

While the Region has many specific objectives and improvement targets based on stakeholder input and community needs assessments, the over-arching goals that have guided many of our decisions include the following:

- Develop a regional approach to health care delivery that leverages and improves on existing programs and infrastructure, is responsive to patient needs throughout the entire region, and improves health care outcomes and patient satisfaction.
- Increase access to primary and specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their condition, regardless of where they live or their ability to pay.
- Transform health care delivery from a disease-focused model of episodic care to a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary or duplicative services, and builds on the accomplishments of our existing health care system, and
- Develop a culture of ongoing transformation and innovation that maximizes the use of technology and best-practices, facilitates regional collaboration and sharing, and engages patients, providers, and other stakeholders in the planning, implementation, and evaluation processes.

[1] Texas Medical Board, Physician Demographics by County and Specialty, January 2012.
[2] 2010 Cooperative Department of State Health Services/American Hospital Association/Texas Hospital Association Annual Survey of Hospitals and Hospitals Tracking Data Base.
[3] U.S. Census Bureau, 2008-2010 American Community Survey 3 Year Estimates.

These goals provided the underlying principles that guided our discussions during the thousands of hours spent deliberating and developing our RHP projects. The inclusion of stakeholders in all stages of our work ensures that the project decisions are aimed at addressing the needs of our community and are informed by the first-hand knowledge of the providers, advocates, caregivers, and consumers who helped design our Plan. Because of their participation, we are confident that our projects will be successful in achieving our community goals. As a review of our projects and our community needs assessment will demonstrate, we have included projects specifically designed to improve access to all types of care, with a significant focus on expanding primary and behavioral health care services. Other Plan initiatives are targeted at improving the treatment of chronic disease; creation of medical homes and care coordination programs; integration of physical and behavioral health care services to treat the whole patient; consumer training and education programs that empower patients to take control of their own health; workforce recruitment and training programs that will expand the number of providers serving our region and maximize their ability to provide the most effective and cost-efficient care possible; and programs for expanding and enhancing the availability of services that meet the cultural diversity of our population. Initiatives are tailored to meet the unique needs of specific populations identified and will be specifically designed by local providers using best practices and proven strategies for improved patient outcomes. Our region will provide coordinated and ongoing training and support for all participants, with regular opportunities for stakeholder input to assess our progress.

Most importantly, our plan is a community-wide effort that includes partners who have a successful history of working together to improve the health of our population. The breadth and range of our projects will touch virtually every person accessing the health care system and will benefit patients for years to come. Improved access to care, increased patient satisfaction, reduction in costs, and better health care outcomes will affect not just the patients receiving care, but the entire community – employers who pay for health care, taxpayers who fund government health plans and purchase individual health coverage, and family members who serve as care givers are all participating beneficiaries who will work together to ensure the successful implementation of our Plan.

Summary of Categories 1-2 Projects

Project Title (include unique RHP project ID number for each project.)	Brief Project Description	Related Category 3 Outcome Measure(s) (include unique Category 3 Improvement Target (IT) Identifier specific to RHP and outcome title)	Estimated Incentive Amount (DSRIP) for DYs 2-5 (Category 1 & 2 values)
Category 1: Infrastructure Development			
082006001.1.1 1.1.1- Establish more primary care clinics: New Baylor Teen Health Clinic at the Tejano Center for Community Concerns Baylor College of Medicine 082006001	The BTHC will establish a clinic at the Tejano Center for Community Concerns (TCCC) in the southeast part of the county to serve as the medical home for adolescents and young adults. By addressing the age-specific needs of the patient population, the BTHC will provide targeted, age-appropriate family planning and STI counseling and treatment in order to lower STI and teen birth rates.	082006001.3.1 IT-1.20 Reduction of STI Rate among Adolescents and Young Adults 082006001.3.2 IT-1.20 Reduction of Pregnancy Rate among Adolescents and Young Adults	$ 2,334,000
0937740-08.1.1 1.8.9 - Expansion of school-based sealant and/or fluoride varnish Oral Health Services Expansion City of Houston Department of Health and Human Services 0937740-08	These clinics would create same day clinics that offer same day episodic primary and specialty care during extended hours to meet demand that saturated Harris Health Community Health Centers cannot meet.	0937740-08.3.2 IT-7.1 Dental Sealant 0937740-08.3.1 IT-7.2: Cavities	$10,542,601
0937740-08.1.2 1.7.7 - Implement remote patient monitoring programs for diagnosis and/or management of care for EMS services: Emergency Tele Health and Navigation (ETHAN) City of Houston Department of Health and Human Services 0937740-08	The City of Houston proposes to make use of telecommunications technologies and connectivity to triage patients with non-life threatening, mild or moderate illnesses via telemedicine with an emergency physician at the City of Houston EMS base station. The physician will then determine the most appropriate next step for the patient.	0937740-08,-03,-07.3.3 IT-9.4. ED appropriate utilization	$ 10,475,399
135033204.1.1 1.7.1 Implement Telemedicine Program to Provide or Expand Specialist Referral Services in an Area Identified as Needed Columbus Community Hospital 135033204	We will be adding an offsite pharmacist capability via telemedicine for the weekends starting with four hours per day and expanding to eight hours per day.	135033204.3.1 IT-3.1 All cause 30 day readmission rate- NQF 1789250	$ 449,950.00
2967606-01 1.1 1.13.1 Develop behavioral health crisis stabilization services as alternatives to	Fort Bend County (FBC) proposes to develop a crisis system that better identifies people with behavioral health needs, responds to those needs and links persons with their most	2967606-01 3.1 IT-9-2 ED Appropriate Utilization	$ 8,889,967

Project Title (include unique RHP project ID number for each project.)	Brief Project Description	Related Category 3 Outcome Measure(s) (include unique Category 3 Improvement Target (IT) Identifier specific to RHP and outcome title)	Estimated Incentive Amount (DSRIP) for DYs 2-5 (Category 1 & 2 values)
hospitalization: Fort Bend County Behavioral Health Crisis Response and Intervention Fort Bend County 2967606-01	appropriate level of care.		
178815001.1.1 1.9.2- Expand high impact specialty care capacity in most impacted medical specialties: Establish Adult Inpatient Psychiatric Unit Gulf Coast Medical Center 178815001	Proposes a project (1.9 Expand Specialty Care Capacity) which would allow access to inpatient level of treatment for adults with psychiatric disorders.	178815001.3.1 IT-1.18 Follow up after Hospitalization for Mental Illness 178815001.3.2 IT-1.20 Timeliness of Inpatient Admission for Mental Illness (referral/admission to Unit)	$ 3,823,217
133355104.1.2 1.1.1-Establish more primary care clinics: People's Area Same Day Access Clinic Harris Health System / 133355104	These clinics would create same day clinics that offer same day episodic primary and specialty care during extended hours to meet demand that saturated Harris Health Community Health Centers cannot meet.	133355104.3.2 IT- 6.1 Percent improvement over baseline of patient satisfaction scores	$29,164,032
133355104.1.3 1.1.2-Expand existing primary care capacity: Expand Capacity of existing Health Centers Harris Health System / 133355104	Expansion of 10 existing Health Centers: Acres, Aldine, Baytown, EFL, Gulfgate, NW, People's, Settegast, Squatty, Strawberry through additional providers at each location.	133355104.3.3 IT-6.1 Percent improvement over baseline of patient satisfaction scores	$57,930,332
133355104.1.8 1.1.2-Expand Existing Primary Care Capacity: Referrals to FQHCs Harris Health System / 133355104	Harris Health System proposes to expand the capacity of primary care by adding additional primary care providers and staff to local Federally Qualified Health Centers in order to meet the demand that saturated existing Harris Health System health centers cannot meet.	133355104.3.10 IT- 6.1 Percent improvement over baseline of patient satisfaction scores	$20,008,333
133355104.1.10 1.12.4-Enhance service availability of appropriate levels of behavioral health care- Expansion of Ambulatory Mental Health Services Harris Health System / 133355104	Harris Health System proposes to enhance service availability of appropriate levels of behavioral health care by expanding mental health services in the ambulatory care setting.	133355104.3.12 IT-1.9 Depression management: Depression Remission at Twelve Months	$21,641,667

Project Title (include unique RHP project ID number for each project.)	Brief Project Description	Related Category 3 Outcome Measure(s) (include unique Category 3 Improvement Target (IT) Identifier specific to RHP and outcome title)	Estimated Incentive Amount (DSRIP) for DYs 2-5 (Category 1 & 2 values)
133355104.1.11 1.3.1- Implement/Enhance and Use Chronic Disease Management Registry Functionalities: Implement a Chronic Disease Management Registry Harris Health System / 133355104	This would utilize electronic software to identify populations at risk and improve provider and patient management of chronic disease.	133355104.3.13 IT-3.2 Congestive Heart Failure 30-day readmission rate	$19,730,667
133355104.1.9 1.12.2-Expand the number of community based settings where behavioral health services may be delivered in underserved areas: Expansion of Pediatric Behavioral Health Services Harris Health System/ 133355104	Harris Health System will address Project Option 1.12.2 related to the shortage of pediatric and adolescent behavioral health services by implementing and expanding these services across eight facilities within the system.	133355104.3.11 IT- 6.1 (1) Percent improvement over baseline of patient satisfaction scores Improve utilization rates of clinical preventive services (testing, preventive services, treatment) in target population with identified disparity	$18,446,459
133355104.1.1 1.1.1-Establish more primary care clinics: Gulfgate Area Same Day Access Clinic Harris Health System / 133355104	These clinics would offer same day episodic primary and specialty care during extended hours to meet demand that saturated Harris Health Community Health Centers cannot meet.	133355104.3.1 IT- 6.1 Percent improvement over baseline of patient satisfaction scores	$29,164,032
133355104.1.4 1.1.1- Establish a primary care clinic: West and Northwest 1 Area Health Centers Harris Health System / 133355104	This clinic would create same day clinics that offer same day episodic primary and specialty care during extended hours to meet demand that saturated Harris Health Community Health Centers cannot meet.	133355104.3.4 IT-1.10. Diabetes care: HbA1c poor control (>9.0%)	$28,754,915
133355104.1.5 1.1.1- Establish more primary care clinics: Northwest 2 and Northwest 3 Area Health Centers Harris Health System / 133355104	Harris Health System proposes to expand the capacity of primary care by adding the Northwest 2 and Northwest 3 Area Health Centers to the compliment of existing health centers to establish Medical Homes primarily for the adult population.	133355104.3.5 IT-1.10. Diabetes care: HbA1c poor control (>9.0%)	$34,226,582
133355104.1.6 1.1.1- Establish more primary care clinics: Southwest, Medical Center, and Northeast	These clinics would expand existing primary care capacity by offering same day service at a strategically located clinic, specifically designed for the treatment of primary care treatable	133355104.3.6 IT-6. Percent improvement over baseline of patient satisfaction scores	$57,954,751

Project Title (include unique RHP project ID number for each project.)	Brief Project Description	Related Category 3 Outcome Measure(s) (include unique Category 3 Improvement Target (IT) Identifier specific to RHP and outcome title)	Estimated Incentive Amount (DSRIP) for DYs 2-5 (Category 1 & 2 values)
Same Day Access Clinics Harris Health System / 133355104	conditions with two located conveniently to LBJ and BTGH.		
133355104.1.7 1.9.3-Implement other evidence-based project to expand specialty care capacity in an innovative manner not described in the project options above: Pre-consult evaluations to facilitate efficient specialty care. Harris Health System / 133355104	Harris Health System proposes a project that will address the opportunity for increased efficiency in the referral processes to specialty clinics. This project will focus on developing algorithms to address diabetes mellitus and rheumatology clinic.	133355104.3.7 IT-1.1 Third Next Available Appointment (non-standalone) 133355104.3.8 IT-1.14 Diabetes care: Microalbumin/Nephropathy-NQF 0062(non-standalone) 133355104.3.9 IT-6.1(3) Percent improvement over baseline of patient satisfaction scores: patient's rating of doctor access to specialist (stand-alone	$ 25,383,532
133355104.1.12 1.10.4-Innovation Center for Quality Harris Health System / 133355104	Harris Health System proposes to establish a Center of Innovation 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.	133355104.3.14 IT-4.2 Central line-associated bloodstream infections (CLABSI) rates	$ 36,566,250
130959304.1.1 1.9.2 - Improve access to specialty care: Establish a Chronic Disease Clinic to Expand Access to Specialty Care Matagorda Regional Medical Center 130959304	Matagorda Regional Medical Center proposed to expand specialty care for targeted populations with chronic diseases.	130959304.3.1 IT-2.11 Ambulatory Care Sensitive Conditions Admissions Rate	$ 4,277,533
137909111.1.1 Hospital Based Clinic Improving Access to Care Memorial Medical Center 137909111	Expand access to primary and specialty care services through the establishment of a hospital-based clinic. The clinic will offer extended and non-traditional hours of care.	137909111.3.1 IT-6.1.1 Patient Satisfaction	$ 2,446,150
113180703.1.1 1.12 Enhance service availability of appropriate levels of behavioral health	The Mental Health and Mental Retardation Authority (MHMRA) of Harris County proposes to enhance service availability of appropriate levels of behavioral health care and	113180703.3.1 IT-6.1. Percent improvement over baseline of patient satisfaction scores	$ 13,168,403.42

Project Title (include unique RHP project ID number for each project.)	Brief Project Description	Related Category 3 Outcome Measure(s) (include unique Category 3 Improvement Target (IT) Identifier specific to RHP and outcome title)	Estimated Incentive Amount (DSRIP) for DYs 2-5 (Category 1 & 2 values)
care: expansion of outpatient behavioral health services for adults with severe psychiatric conditions Mental Health and Mental Retardation Authority of Harris County 113180703	expand outpatient behavioral health services for adults with severe psychiatric conditions.		
113180703.1.3 1.9 Expand specialty care capacity: IDD specialized treatment and rehabilitative services (STARS) Mental Health and Mental Retardation Authority of Harris County 113180703	The Mental Health and Mental Retardation Authority (MHMRA) proposes to expand specialty care capacity by expanding IDD specialized treatment and rehabilitative services (STARS).	113180703.3.3 IT-6.1. Percent improvement over baseline of patient satisfaction scores	$ 6,690,813.44
113180703.1.2 1.12 Enhance service availability of appropriate levels of behavioral health care: expansion of outpatient behavioral health services for adults with severe psychiatric conditions Mental Health and Mental Retardation Authority of Harris County 113180703	The Mental Health and Mental Retardation Authority (MHMRA) of Harris County proposes to enhance service availability of appropriate levels of behavioral health care and expand outpatient behavioral health services for adults with severe psychiatric conditions.	113180703.3.2 IT-6. Percent improvement over baseline of patient satisfaction scores	$ 19,471,232.85
113180703.1.4 1.12 Enhance service availability of appropriate levels of behavioral health care: expansion of outpatient services for adults with severe psychiatric conditions (Northeast) Mental Health and Mental Retardation Authority of Harris County 113180703	MHMR of Harris County proposes to enhance service availability levels of behavioral health care by expanding outpatient services for adults with severe psychiatric conditions (Northeast)	113180703.3.4 IT-6. Percent improvement over baseline of patient satisfaction scores	$ 13,168,403.42
113180703.1.5 1.12 Enhance service availability of appropriate levels of behavioral health care: expansion of outpatient	The Mental Health and Mental Retardation Authority (MHMRA) of Harris County proposes to enhance service availability of appropriate levels of behavioral health care and expand outpatient behavioral health	113180703.3.5 IT-6. Percent improvement over baseline of patient satisfaction scores	$ 13,168,403.42

Project Title (include unique RHP project ID number for each project.)	Brief Project Description	Related Category 3 Outcome Measure(s) (include unique Category 3 Improvement Target (IT) Identifier specific to RHP and outcome title)	Estimated Incentive Amount (DSRIP) for DYs 2-5 (Category 1 & 2 values)
behavioral health services for adults with severe psychiatric (Southwest) Mental Health and Mental Retardation Authority of Harris County 113180703	services for adults with severe psychiatric.		
113180703.1.6 1.12 Enhance service availability of appropriate levels of behavioral health care: expansion of outpatient behavioral health services for adults with severe psychiatric (Southeast) Mental Health and Mental Retardation Authority of Harris County 113180703	The Mental Health and Mental Retardation Authority (MHMRA) of Harris County proposes to enhance service availability of appropriate levels of behavioral health care and expand outpatient behavioral health services for adults with severe psychiatric.	113180703.3.6 IT-6. Percent improvement over baseline of patient satisfaction scores	$ 13,168,403.42
113180703.1.7 1.12 Enhance service availability of appropriate levels of behavioral health care: expansion of outpatient behavioral health services for adults with severe psychiatric (Region determined according to need) Mental Health and Mental Retardation Authority of Harris County 113180703	The Mental Health and Mental Retardation Authority (MHMRA) of Harris County proposes to enhance service availability of appropriate levels of behavioral health care and expand outpatient behavioral health services for adults with severe psychiatric.	113180703.3.7 IT-6. Percent improvement over baseline of patient satisfaction scores	$ 13,168,403.42
127303903.1.1 1.3.1 Implement and Utilize Disease Management Registry Functionality OakBend Medical Center 127303903	Receive monthly registry reports on their patients with CHF, COPD, Diabetes and ESRD. OBMC will develop and implement a registry in conjunction with FBFHC and specific home health providers.	127303903.3.1 IT-3.2 Congestive Heart Failure 30-Day Readmission Rate	$ 3,602,979
127303903.1.3 1.9.1 Expand Specialty Care Capacity OakBend Medical Center 127303903	Expand the number of Specialty Care Physicians (SCPs) on our current physician panel by the addition of Obstetrics and Gynecology, Cardiology/Interventional Cardiology, Otolaryngology and Orthopedic specialty services. In order to assist in appropriate utilization of the additional	127303903.3.3 IT-6.1 Percentage Improvement over baseline of Patient Satisfaction Scores	$ 2,119,399

Project Title (include unique RHP project ID number for each project.)	Brief Project Description	Related Category 3 Outcome Measure(s) (include unique Category 3 Improvement Target (IT) Identifier specific to RHP and outcome title)	Estimated Incentive Amount (DSRIP) for DYs 2-5 (Category 1 & 2 values)
	physician specialists, OBMC will implement an electronic specialty referral process and train its providers on its use.		
127303903.1.2 1.2.2 Increase Training of Primary Care Workforce OakBend Medical Center 127303903	OBMC will expand the number of Primary Care Physicians (PCPs) on our current physician panel by two physicians in the second (2nd) year and by a total of four (4) by year five (5). We will also plan to increase the support staff to compliment the additional physicians. In addition, OBMC will provide training to these new physicians to integrate them into the community.	127303903.3.2 IT-3.1 All Cause 30-day admission rate	$ 2,331,339
212060201.1.1 1.1.2: Expand Existing Primary Care Capacity. Rice Medical Center 212060201	Rice proposes to expand the availability of family practice obstetric services.	212060201.3.1 IT 6.1(1). Percent improvement over baseline of patient satisfaction scores	$ 275,944
081522701.1.1 1.12.2 - Expand the number of community based settings where behavioral health services may be delivered in underserved areas: Enhance service availability of appropriate levels of behavioral health care (applied behavior analysis and speech-language pathology for children diagnosed with autism spectrum disorders) Texana Center 081522701	This category 1 project, 1.12.2, will provide specialized behavioral health care services to the complex behavioral health population of children with diagnoses of autism spectrum disorders and related conditions.	081522701.3.1 IT-10.1. Quality of Life/Functional Status	$ 9,105,687

Project Title (include unique RHP project ID number for each project.)	Brief Project Description	Related Category 3 Outcome Measure(s) (include unique Category 3 Improvement Target (IT) Identifier specific to RHP and outcome title)	Estimated Incentive Amount (DSRIP) for DYs 2-5 (Category 1 & 2 values)
139135109.1.11 1.9.2 Improve access to specialty care: Expand Pediatric Allergy/Immunology Care Texas Children's Hospital 139135109	Texas Children's Hospital proposes to expand access to care in the Allergy/Immunology clinic in order to meet increased demand for care and reduce appointment wait time.	139135109.3.27 IT- 5.1. Improved cost savings 139135109.3.28 IT-5.2. Per episode of care cost 139135109.3.29 IT-5.3. Length of stay	$ 3,788,492
139135109.1.7 1.9.2 Expand Pediatric Gastroenterology Care Texas Children's Hospital 139135109	Texas Children's Hospital proposes to increase access for children to pediatric subspecialty services in the gastroenterology, hepatology and nutrition (GHN) clinic.	139135109.3.19 IT- 5.1. Improved Cost Savings 139135109.3.20 IT-5.2. Per Episode Cost of Care 139135109.3.21 IT-5.3. Length of Stay	$ 7,843,891
139135109.1.10 1.9.2 Expand Access to Specialty Care: Developmental Pediatrics Texas Children's Hospital 139135109	Texas Children's Hospital will increase capacity in the Developmental Pediatrics Clinic.	139135109.3.26 IT- 10.1 Quality of Life a. Demonstrate improvement in quality of life (QOL) scores, as measured by evidence based and validated assessment tool, for the target population.	$ 3,406,630
139135109.1.4 1.9.2 Expand Access to Specialty Care: Pediatric Cardiology Care Texas Children's Hospital 139135109	Specifically this project will increase capacity in our Cardiology Clinic. Through recruitment of additional highly-specialized Pediatric Cardiologists with focused training in sub-specialized areas such as fetal cardiology, heart failure, adult congenital cardiology, pediatric electrophysiology, and pediatric interventional cardiology along with focused attention on existing provider productivity and increased efficiencies in patient throughput, this project will	139135109.3.10 IT- 5.1. Improved Cost Savings 139135109.3.11 IT-5.2. Per Episode Cost of Care 139135109.3.12 IT-5.3. Length of Stay	$ 4,473,330

Project Title (include unique RHP project ID number for each project.)	Brief Project Description	Related Category 3 Outcome Measure(s) (include unique Category 3 Improvement Target (IT) Identifier specific to RHP and outcome title)	Estimated Incentive Amount (DSRIP) for DYs 2-5 (Category 1 & 2 values)
	enable us to open clinics and increase appointment availability.		
139135109.1.8 1.9.2 Expand Specialty Care Capacity Diabetes: Endocrinology Pediatric Care Texas Children's Hospital 139135109	Texas Children's Hospital proposes to expand access to pediatric care in diabetes and endocrinology.	139135109.3.22 IT- 5.1. Improved Cost Savings 139135109.3.23 IT-5.2. Per Episode Cost of Care 139135109.3.24 IT-5.3. Length of Stay	$ 8,786,005
139135109.1.9 1.9.2 Improve access to specialty care: Expand Child Abuse Care Texas Children's Hospital 139135109	Texas Children's Hospital proposes to establish a specialty care program for children who have experienced abuse or neglect.	139135109.3.25 IT- 10.1. Quality of Life	$2,046,964
139135109.1.15 1.9.2 Expand Access to Specialty Care: Orthopedic Pediatric Care Texas Children's Hospital 139135109	Texas Children's Hospital proposes to expand access to pediatric orthopedic care, enabling patients to receive care in a more timely manner and reduce wait times for appointments.	139135109.3.39 IT- 5.1. Improved Cost Savings 139135109.3.40 IT-5.2. Per Episode Cost of Care 139135109.3.41 IT-5.3. Length of Stay	$ 7,272,807
139135109.1.1 1.9.2 Expand Access to Specialty Care: Expand Pediatric Neurology Texas Children's Hospital 139135109	Texas Children's Hospital proposes to increase capacity for care in Pediatric Neurology Clinic.	139135109.3.1 IT- 5.1. Improved Cost Savings 139135109.3.2 IT-5.2. Per Episode Cost of Care 139135109.3.3 IT-5.3. Length of Stay	$ 8,786,001

Project Title (include unique RHP project ID number for each project.)	Brief Project Description	Related Category 3 Outcome Measure(s) (include unique Category 3 Improvement Target (IT) Identifier specific to RHP and outcome title)	Estimated Incentive Amount (DSRIP) for DYs 2-5 (Category 1 & 2 values)
139135109.1.14 1.9.2 Expand Pediatric Neurosurgery Care Texas Children's Hospital 139135109	Texas Children's Hospital will increase capacity in the Neurosurgery Clinic to improve access to care and meet the increased demand for care.	139135109.3.36 IT- 5.1. Improved Cost Savings 139135109.3.37 IT-5.2. Per Episode Cost of Care 139135109.3.38 IT-5.3. Length of Stay	$ 2,196,500
139135109.1.6 1.9.2 Expand Access to Specialty Care: Pediatric Ophthalmology Care Texas Children's Hospital 139135109	Texas Children's Hospital will increase capacity in the Ophthalmology Clinic to expand access and reduce appointment wait times.	139135109.3.16 [IT-5.1] Improved cost savings 139135109.3.17 [IT-5.2] Per episode cost of care Improvement 139135109.3.18 [IT-5.3] Length of Stay	$ 5,027,551
139135109.1.2 1.9.2 Expand Access to Specialty Care: Pediatric Hematology/Cancer Texas Children's Hospital 39135109	Increase access to care by providing comprehensive, integrated, multidisciplinary and family-centered care to children with non-malignant blood disorders.	139135109.3.4 [IT-5.1] Improved cost savings 139135109.3.5 [IT-5.2] Per episode cost of care Improvement 139135109.3.6 [IT-5.3] Length of Stay	$ 5,384,294
139135109.1.12 1.9.2 Expand Access to Specialty Care: Otolaryngology Pediatric Care Texas Children's Hospital 39135109	Texas Children's Hospital proposes to expand access to pediatric Otolaryncology care through the establishment of a Voice and Swallowing clinic to diagnose and treat complex disorders related to swallowing and vocalization.	139135109.3.32 [IT-5.1] Improved cost savings 139135109.3.33 [IT-5.2] Per episode cost of care Improvement 139135109.3.34 [IT-5.3] Length of Stay	$ 3,920,233
139135109.1.5 1.9.2 Expand Specialty Care Access: Pulmonology Pediatric Care Texas Children's Hospital 139135109	Texas Children's Hospital proposes to increase capacity in the Pulmonology Clinic, which will improve access to care and ensure reduce appointment wait time.	139135109.3.15 [IT-5.1] Improved cost savings 139135109.3.16 [IT-5.2] Per episode cost of care Improvement 139135109.3.17 [IT-5.3] Length of Stay	$ 4,415,709

Project Title (include unique RHP project ID number for each project.)	Brief Project Description	Related Category 3 Outcome Measure(s) (include unique Category 3 Improvement Target (IT) Identifier specific to RHP and outcome title)	Estimated Incentive Amount (DSRIP) for DYs 2-5 (Category 1 & 2 values)
139135109.1.16 1.9.2 Improve access to specialty care: Expand Women's Mental Health Care Texas Children's Hospital 139135109	Texas Children's Hospital will expand provider capacity, improve processes and increase availability of mental health services for women	139135109.3.42 IT—2.4: BH/MDD as the principal diagnosis	$ 2,196,500
139135109.1.3 1.9.2 Expand Specialty Access: Pediatric Rheumatology Care Texas Children's Hospital 139135109	Texas Children's Hospital proposes to increase capacity, improve care and reduce appointment wait time in our Rheumatology Clinic.	139135109.3.7 [IT-5.1] Improved cost savings 139135109.3.8 [IT-5.2] Per episode cost of care Improvement 139135109.3.9 [IT-5.3] Length of Stay	$ 4,115,596
139135109.1.13 1.9.2 Expand Access to Specialty Care: Pediatric Plastic Surgery Texas Children's Hospital 139135109	Texas Children's Hospital proposes to expand capacity for Pediatric Plastic Surgery.	139135109.3.33 [IT-5.1] Improved cost savings 139135109.3.34 [IT-5.2] Per episode cost of care Improvement 139135109.3.35 [IT-5.3] Length of Stay	$ 5,627,436
288523801.1.1 1.1.2 – Expand existing primary care capacity: Expand primary care access for uninsured populations within and around Tomball. Tomball Regional Medical Center 288523801	Tomball Regional Medical Center (TRMC), the area's full service hospital, is proposing a Category 1 DSRIP project to expand primary care access for the uninsured population within and around The City of Tomball.	288523801.3.1 IT 2.5 COPD Admission Rate 288523801.3.2 T-2.10 Flu and Pneumonia Admission rates 288523801.3.3 IT -3.1 Potentially preventable re-admission within 30 day 288523801.3.4 IT -9.2 ED appropriate Utilization	$ 897,183

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112672402.1.1 1.1.3 – Expand Mobile Clinics, specifically Project VALET of Screening Mammograms The University of Texas MD Anderson Cancer Center 112672402	The University of Texas MD Anderson Cancer Center (MD Anderson), in partnership with The Rose, a non-profit breast organization, and the Houston Department of Human and Health Services (HDHHS), will expand Project VALET (Providing Valuable Area Life-Saving Exams in Town), a breast cancer screening mammography service for uninsured women, ages 40 and older in Houston, to the RHP3's coverage area.	112672402.3.1 IT-11.1 Improvement in Clinical Indicator in identified disparity group. Clinical indicator to be improved and disparity group to be determined by provider. 112672402.3.2 IT.12.1 Breast Cancer Screening (HEDIS 2012)	$ 7,338,085.65
111810101.1.1 1.1.2 Expand Primary Care Capacity: C3 Expand Existing Primary Care Capacity at UT Physicians Clinics UTHealth, UTPhysicians 111810101	UT Physicians will expand primary care capacity at each of its 4 outlying (outside the Texas Medical Center) clinics. This project proposes to add space, providers, support staff, and extend service hours to include evenings and weekends at these locations where the demand for services is high.	111810101.3.1. IT-1.1 Third next available appointment (Non- standalone measure) 111810101.3.2. IT-12.1 Breast Cancer Screening (HEDIS 2012) (Non-standalone measure) 111810101.3.3. IT-12.3 Colorectal Cancer Screening (HEDIS 2012) (Non-standalone measure)	$ 19,914,303
111810101.1.2 1.2.1 Increase Training of Primary Care Workforce: A2 UT Health Regional Academy for Translational Medicine and UT Health Academy for Patient Quality and Safety UTHealth, UTPhysicians 111810101	An innovative residency program in translational medicine will be developed and implemented by the UT Health Regional Academy for Translational Medicine. The current residency program does not include training for residents that includes health care systems, patient-centered team-based practice, quality improvement, and cost control.	111810101.3.4 TBD. TBD	$ 7,414,901
111810101.1.3 1.2.2 Increase training of primary care workforce: SPH1 Training of Community Health Workers (CHWs) UTHealth, UTPhysicians 111810101	Partner with Gateway to Care, Harris Health System, and UT Physicians to increase the number of certified CHWs in the region (currently approximately 500) and respond to specific continuing education needs as identified by providers and CHWs. Additionally, providers and clinic staff will be trained in how to integrate CHWs as members of the health care team.	111810101.3.5. IT-11.5 (IT-2.10). Select any other Category 3 outcome (PPAs, PPRs, or ED utilization) or a combination of non-standalone measures and target a specific minority population with a demonstrated disparity in the particular measure IT-2.10 Flu and pneumonia Admission Rate)	$ 11,440,132

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111810101.1.4 1.3.1 - C12 UT Physicians Chronic Disease Registry - Implement a Chronic Disease Management Registry UTHealth, UTPhysicians 111810101	UT Physicians will implement and use chronic disease management registry functionalities.	111810101.3.6 IT-1.7 Controlling high blood pressure	$ 8,050,463
111810101.1.5 1.6.2 - C11 UT Health Nurse-line Medical Triage Call Center - Enhance Urgent Medical Advice UTHealth, UTPhysicians 111810101	UT Physicians will expand access to medical advice and direction to the appropriate level of care to reduce Emergency Department use for non-emergent conditions and increase patient access to health care by implementing a nurse-line medical triage call center that will be staffed 24/7/365.	111810101.3.7 IT-2.11. Ambulatory Care Sensitive Conditions Admissions Rate	$ 18,007,615
111810101.1.6 1.7.1 Introduce, Expand, or Enhance Telemedicine/Telehealth: A1 UT Health Telemedicine UTHealth, UTPhysicians 111810101	A telemedicine program will be established that provides access to the UT Health Regional Multispecialty Physician Group (Virtual ACO). We propose to develop a rapid e-mail and/or internet based/tecnologically driven consultation process to manage complicated diabetes and other patients who would otherwise require a referral and visit to specialists. We will recruit dedicated specialists, physician assistants and nurse practitioners to manage the process.	111810101.3.8 IT-6.1 (3). Percent improvement over baseline of patient satisfaction scores: (3) patient's rating of doctor access to specialist; (Stand-alone measure)	$ 18,219,470
111810101.1.7 1.9.2 Expand Specialty Care Capacity: C4 Expand UT Physician Specialty Services to Outlying Clinics UTHealth, UTPhysicians 111810101	UT Physicians will recruit specialists for each of its outlying clinics. Clinic service hours will be extended to provide evening and weekend appointment options. Standardized referral systems will be put in place to ensure access to these specialists. Also, quality improvement processes will be put in place to assess project impacts and opportunities for continuous improvement.	111810101.3.9. IT-1.1. Third next available appointment (Non- standalone measure) 111810101.3.10. T-1.6. Cholesterol management for patients with cardiovascular conditions (NCQA-HEDIS 2012) (Standalone measure)	$ 19,278,741

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111810101.1.8 1.10.2 Enhance Performance Improvement and Reporting Capacity: MS1 UT Health Regional Systems Engineering Center and UT Health Quality Improvement Dashboard Development Center UTHealth, UTPhysicians 111810101	Development of a UT Health regional systems engineering center that will embed proven evidence-based industrial and systems engineering improvement methods such as Lean, Six Sigma, and Care Logistics into local healthcare organizations to significantly improve care, reduce errors, reduce cost, improve safety and overall quality of healthcare delivered to our patients.	111810101.3.11. IT-4.8. Sepsis mortality (Standalone measure)	$ 8,050,463
Category 2: Program Innovation and Redesign			
133355104.2.1 Implement other evidence-based project that will impact cost efficiency in an innovative manner: Ambulatory Care Central Fill Pharmacy Harris Health System / 133355104	Harris Health proposes to create an automated ambulatory central fill pharmacy to facilitate dispensing up to 10,000 prescriptions per shift with a 24 hour turnaround time and mail order capability.	133355104.3.14 IT-5.1 Improved cost savings: Demonstrate cost savings in care delivery	$28,038,880
133355104.2.3 Reduce Inappropriate ED Use: Emergency Center Advanced Triage Care Harris Health System / 133355104	Harris Health System proposes a project to improve emergency center throughput and reduce inappropriate use of emergency centers in the system.	133355104.3.17 IT-9.4 Reduced EC Utilization for ESI Level 5 Patients	$ 10,042,121
081522701.2.1 2.13.1 - Design, implement, and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population: Provide crisis stabilization intervention for the dually diagnosed population to prevent unnecessary use of services in State Supported Living Centers, emergency rooms, state mental hospitals and county jails. Texana Center 081522701	This project will create a crisis behavioral health care team to intervene to keep individuals in crisis out of the emergency room or jail.	081522701.3.3 IT 9.4 Other Outcome Improvement Target- Mental health (IDD/SPMI or Challenging Behaviors) admissions and readmissions to state institutions (state mental hospitals and State Supported Living Centers)	$ 5,574,005

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133355104.2.2 Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care: Reduce ER Utilization for Top Frequenters Harris Health System / 133355104	Harris Health System proposes a project that will target top EC frequenters and ensure they are managed appropriately to receive the right care in the right setting.	133355104.3.16 IT-9.4 Reduce ER Visits for Frequent User Cohort	$ 12,801,250
082006001.2.1 2.1.1- Develop, implement, and evaluate action plans to enhance/eliminate gaps in the development of various aspects of PCMH standards: The Fifth Ward Model – Inter-professional Primary Care	The Fifth Ward Model Inter-Professional Primary Care Practice Demonstration Project will bring together an interdisciplinary team of healthcare professionals including physicians, mid-level providers (nurse practitioners and physicians' assistants), nurses (RNs, LVNs), nursing assistants, clinical pharmacists (PharmDs), social workers, health educators, and mental health professionals (psychologists, licensed professional counselors) to provide interdisciplinary primary healthcare to patients residing in a medically underserved community of Houston (the 5th ward).	08200601.3.3 IT-1.10: Improve HbA1c control Improvement Target 08200601.3.4 IT-1.20: Improve weight control 08200601.3.5 IT-12.2: Improve percentage of women who received a PAP within the past two years	$ 5,131,000
131045004.2.1 2.4.1 – Develop and implement a structured patient experience training program: Improving the Patient Experience – The AIDET Project. El Campo Memorial Hospital 131045004	El Campo Memorial Hospital will develop and implement a structured patient experience training program: Improving the Patient Experience – The AIDET Project.	131045004.3.1 IT-6.1 Percent improvement over baseline of patient satisfaction scores.	$ 733,677
127300503.2.1 2.12.1 – Develop, implement and evaluate standardized clinical protocols and evidence-based care delivery model to improve care transitions St. Luke's Episcopal Hospital 127300503	The purpose of this project is to build a bridge from the acute inpatient setting to a stable primary care-based medical home for patients with congestive heart failure (CHF). The targeted population is that group of patients with CHF cared for in the SLEH acute inpatient setting for an index admission. The goal is to reduce readmissions.	127300503.3.1 IT-3.2:Congestive Heart Failure 30 day readmission rate 127300503.3.2 IT-10.1:Quality of Life	$19,525,398

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096166602.2.1 2.15.2 - Integrate primary and behavioral healthcare services: Design, implement and evaluate projects that provide integrated primary and behavioral health care services Spindletop Center 096166602	This project will integrate primary care with the behavioral health care services Spindletop Center ("Spindletop") provides in order to improve care and access to needed health services for the clients we serve.	096166602.3.1 IT-6.1 (1) Percent improvement over baseline of patient satisfaction scores-Patients are getting timely care, appointments, and information	$ 1,178,561
112672402.2.2 2.7.2: Implement innovative evidence-based strategies to reduce tobacco use - Evidence-Based Smoking Cessation Program for Underserved Persons Living with HIV/AIDS The University of Texas MD Anderson Cancer Center 112672402	The goal of the current proposal is to adapt, implement, and evaluate an evidence-based, cell phone-delivered smoking cessation treatment program targeted to low-income and underinsured individuals living with HIV/AIDS. The proposed smoking cessation project will involve a partnership with Legacy Community Health Services – a large, Federally Qualified Health Center (FQHC).	112672402.3.5 IT-11.6 Other Outcome Improvement Target: (Quit Attempts) 112672402.3.6 IT-11.6 Other Outcome Improvement Target: (Staying Quit)	$ 3,529,433.25
112672402.2.1 2.7.1 – Implement innovative evidence-based strategies to increase appropriate use of technology and testing for targeted populations (e.g., mammography screens, colonoscopies, prenatal alcohol use, etc.): Colorectal cancer (CRC) screening program for low-income residents of RHP3 The University of Texas MD Anderson Cancer Center 112672402	We propose to implement a FIT-Flu program in RHP3 targeting low-income and underinsured populations with the intent of increasing adherence with this screening method.	112672402.3.3 IT-11.1 Improvement in Clinical Indicator in identified disparity group. 112672402.3.4 IT-12.3 Colorectal Cancer Screening (HEDIS 2012)	$ 8,773,921.80
112672402.2.3 2.7.2 - Implement innovative evidence-based strategies to reduce tobacco use - Multimedia Tools and Community Engagement for Youth Early Tobacco Prevention and Cessation The University of Texas MD Anderson Cancer Center 112672402	Tobacco is the number one preventable cause of death from cancer and other diseases. Nearly all tobacco use begins during the teenage years. Low-income, underserved youth are at highest risk for becoming tobacco users. For these reasons, we will target individuals aged 11 to 18 years and propose a tobacco prevention and cessation initiative utilizing multimedia resources as well as an extensive community network.	112672402.3.7 IT-11.6 Other Outcome Improvement Target (Improve utilization rates of the tobacco prevention and cessation program [ASPIRE] in adolescents aged 11 to 18 years)	$ 18,909,450.00

Project Title (include unique RHP project ID number for each project.)	Brief Project Description	Related Category 3 Outcome Measure(s) (include unique Category 3 Improvement Target (IT) Identifier specific to RHP and outcome title)	Estimated Incentive Amount (DSRIP) for DYs 2-5 (Category 1 & 2 values)
0937740-08.2.1 2.6 Engage community health workers in an evidence-based program to increase health literacy of a targeted population: Healthy Homes Fall Prevention City of Houston Department of Health and Human Services 0937740-08,-03,-07	The Healthy Homes Fall Prevention project proposes to utilize community health workers to provide essential education related to fall prevention and safety as critical components to the health and well-being of older adults (60+ years) in the community.	0937740-08,-03,-07.3.5 IT-9.2. ED appropriate utilization	$ 7,937,159
0937740-08.2.5 2.2.6- Expand Chronic Care Management Models-"Other": Diabetes Awareness and Wellness Network Center (DAWN) City of Houston Department of Health and Human Services 0937740-08	This project would establish a comprehensive, community based Diabetes Wellness Center in an underserved community with one of the highest incidence rates of diabetes.	0937740-08.3.13 IT-1.10. Diabetes care: HbA1c poor control (>9.0%)17- NQF 0059	$ 10,008,073
0937740-08.2.3 2.9.1- Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care: HIV Service Linkage Project City of Houston Department of Health and Human Services 0937740-08	This service linkage expansion will provide navigation services to targeted patients with HIV who are at high risk of disconnect from institutionalized health care.	0937740-08.3.9 IT-9.4 Milestone: ED appropriate utilization (Stand-alone measure)	$ 9,186,142
0937740-08.2.7 2.6.4 - Implement other evidence based project to implement health promotion programs: Nurse Family Partnership (NFP) City of Houston Department of Health and Human Services 0937740-08	This project would expand the Nurse Family Partnership (NFP) program, which is an evidence-based home visitation program for first-time mothers. NFP utilizes Bachelor prepared, Registered Nurses to conduct home visits.	0937740-08.3.17 0937740-08.3.18 IT-8.1. Timeliness of Prenatal/Postnatal Care (CHIPRA/NQF # 1382)46 IT-8.2. Pre-term Delivery Rate (CHIPRA/NQF # 1382)46	$ 10,081,472
0937740-08.2.6 2.13.2 - Implement other evidence-based project to provide an intervention for a targeted behavioral health	The Sobering Center will be a medically supervised facility which offers a continuum of care using a comprehensive multidisciplinary approach for intoxicated persons brought to the Emergency Department	0937740-08.3.15 IT-9.4. Other Outcome Improvement Target (Non emergent ER visits and hospitalizations in Sobering Center Participants)	$ 7,757,711

Project Title (include unique RHP project ID number for each project.)	Brief Project Description	Related Category 3 Outcome Measure(s) (include unique Category 3 Improvement Target (IT) Identifier specific to RHP and outcome title)	Estimated Incentive Amount (DSRIP) for DYs 2-5 (Category 1 & 2 values)
population to prevent unnecessary use of services in an innovative: The Houston Sobering Center City of Houston Department of Health and Human Services 0937740-08	as well as picked up by the Police Department from other public locations in the city. The Houston Sobering Center will offer in-patient or outpatient care to intoxicated individuals.		
0937740-08.2.2 2.9.1 - Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care Care Houston Links City of Houston Department of Health and Human Services 0937740-08	CareHouston Links proposes to provide care coordination that will reduce the frequency of non-urgent ambulance runs and ER visits and link 911 callers to appropriate primary and preventive care in lieu of unnecessary emergency room care.	0937740-08.3.7 IT – 9.4 Other Outcome Improvement Target (ED appropriate utilization)	$ 9,791,688
0937740-08.2.4 2.7.1 Expand Patient Care Navigation Program: TB Rapid Identification, Treatment and Recovery Project City of Houston Department of Health and Human Services 0937740-08	Project proposes to rapidly identify active tuberculosis (TB) cases, infectious cases and more accurately screen contacts for TB infection, and reduce the length of treatment through the introduction of short course therapy.	0937740-08.3.11 IT-4.10. Other Outcome Improvement Target	$ 10,007,597
212060201.2.1 2.7.1- Implement innovative evidence-based strategy to increase appropriate use of technology and testing: Expand Use of Immunization Tracking Rice Medical Center 212060201	Rice will implement across the board tracking of patients' immunization schedules and immunizations received in order to avoid duplication and tardiness, and to promote preventative health care.	212060201.3.2 IT 6.1(1) – OD-6 Patient Satisfaction, IT 6.1(1) Percent Improvement over baseline of patient satisfaction scores	$ 82,783
212060201.2.3 2.6.2 Establish self-management programs and wellness using evidence-based designs Rice Medical Center 212060201	Rice will develop and implement a program for diabetic care management support in its primary care clinics.	212060201.3.4 IT-1.10. Diabetes care: HbA1c poor control (.9.0%)-NQF 0059	$ 151,769
212060201.2.2 2.2.2 - Apply Evidence Based Care Management Model to Patients Identified as Having	Rice proposes to provide a systematic approach to chronic disease outreach, reduction, and management.	212060201.3.3 IT 10.1 Quality of Life	$ 165,567

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High Risk Health Needs: Chronic Disease Outreach Rice 212060201			
127303903.2.2 2.9.1 Establish Patient Care Navigation Program OakBend Medical Center 127303903	Implement and coordinate post-discharge support for patients with congestive heart failure (CHF), Diabetes, and Chronic Obstructive Pulmonary Disease (COPD). Education would begin upon admission for these specific diagnoses and follow throughout the acute inpatient stay and into the post-discharge phase.	127303903.3.5 IT-2.1 Congestive Heart Failure Admission Rate	$ 2,967,159
127303903.2.1 2.4.1 Implement Consumer Assessment System OakBend Medical Center 127303903	OBMC plans to establish a patient experience program where patients feel safe, have their voices heard and are empowered. This concept would involve staff education on communication skills and will be in line with the other initiatives that are designed to create an environment that promotes excellence, operational efficiency and quality patient-centered care.	127303903.3.4 IT-9.2 ED APPROPRIATE UTILIZATION	$ 2,755,219
2967606.2.1 2.9.1 - Establish/expand a Patient Care Navigation Program: Care Coordination Program Fort Bend County Clinical Health Services 2967606-01	A project where Indigent Health Care, Medicaid and uninsured patients who are frequent or inappropriate users of the County Emergency Medical Service (EMS) and hospital Emergency Departments (EDs) or who have repeat admissions to the hospital would be referred into a care management system based in the local Federally Qualified Health Center.	2967606.3.2 IT 1.10. Diabetes Care: HbA1c Poor Control (>9.0%) 2967606.3.3 IT 9.2. ED Appropriate Utilization 2967606.3.4 IT 9.4. Other Outcome Improvement Target (Reduce EMS use)	$2,611,029
111810101.2.2 2.2.1 Expand Chronic Care Management Models: C7 Redesign the Outpatient Delivery System of UT Physicians to Coordinate Care for Patients with Chronic Diseases UTHealth, UTPhysicians 111810101	The outpatient delivery system of UT Physicians will be redesigned to coordinate care for patients with chronic diseases (asthma, CHF, COPD, diabetes, and hypertension), based on Wagner's chronic care model and using evidence-based standards of care as follows: The National Asthma Education and Prevention Program Expert Panel Report 3 guidelines, The National Institute for Clinical	111810101.3.13. IT-9.2: ED Appropriate Utilization	$11,440,132

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	Excellence (NICE) COPD clinical guidelines, The Heart Failure Model of Care guidelines, The American Diabetes Association (ADA) Standards of Medical Care in Diabetes, and the JNCVII guidelines for hypertension.		
111810101.2.3 2.9.1 Establish/Expand a Patient Care Navigation Program: A4 UTHealth Regional Patient Navigation UT Health, UTPhysicians 111810101	A patient care navigation program will be designed and implemented within the UT Health system of medical homes. The program will target patients at high risk of disconnect from institutionalized health care.	111810101.3.14 IT-3.9. Chronic Obstructive Pulmonary Disease 30 day readmission rate (Standalone measure)	$12,711,258
111810101.2.4 2.10.1 Use of Palliative Care Programs: MS3 Integrating Palliative Care into Critical Care UTHealth, UTPhysicians 111810101	The project will entail identifying patients admitted to any adult ICU at Memorial Herman Hospital-TMC who are at high risk of death in or soon after hospitalization. In collaboration with the primary clinical team, these patients will receive a palliative care consultation to supplement their clinical therapy and assist in determination of goals of care which may include transitioning the patients from acute hospital care into home care, hospice or a skilled nursing facility.	111810101.3.15 IT-13.1. Pain assessment (NQF-1637) (Non-standalone measure) 111810101.3.16 IT-13.2. Treatment Preferences (NQF 1641) (Non-standalone measure) 111810101.3.17 IT-13.5. Percentage of patients receiving hospice or palliative care services with documentation in the clinical record of a discussion of spiritual/religions concerns or documentation that the patient/caregiver did not want to discuss. (NQF 1647 modified)	$6,567,483
111810101.2.5 2.11.1 - C10 Patient-Centered Medication Therapy Management Program - Conduct Medical Management UTHealth, UTPhysicians 111810101	UT Physicians will implement a patient-centered medication therapy management program.	111810101.3.18 IT-1.2. Annual monitoring for patients on persistent medications (NCQA-HEDIS 2012)– angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARBs) (Non-standalone measure) 111810101.3.19 IT-1.3. Annual monitoring for patients on persistent medications (NCQA-HEDIS 2012)– digoxin (Non-standalone)	$7,203,047

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		111810101.3.20 IT-1.4. Annual monitoring for patients on persistent medications (NCQA-HEDIS 2012)– diuretic (Non-standalone measure)	
111810101.2.1 2.1.3 Enhance/Expand Medical Homes: C1-2 UT Health Regional Specialty Care Centers UTHealth, UTPhysicians 111810101	Enhance/Expand Medical Homes	111810101.3.12 IT-6.1 (1). Percent improvement over baseline of patient satisfaction scores (1) are getting timely care, appointments, and information (stand alone measure)	$13,982,384
111810101.2.6 2.12.2 Implement/Expand Care Transitions Programs: A3 UTHealth General Care Transitions UTHealth, UTPhysicians 111810101	UT Physicians will implement a discharge planning program and post discharge support program that ensures that patients have an appointment for follow-up with an appropriate physician(s) prior to leaving the hospital, understand their discharge medications and other instructions, and are followed up post discharge, particularly those at risk of needing acute care services within 30-60 days.	111810101.3.21 IT-6.1 Percent Improvement over baseline of patient satisfaction scores	$11,863,840
111810101.2.7 2.15.1-C13 Integrated Primary and Behavioral Health Care Services - Integrate Primary and Behavioral Health Care Services UTHealth, UT Physicians 111810101	UT Health will design, implement and evaluate a project that will integrate primary and behavioral health care services within UT Physicians clinics to achieve a close collaboration in a partly integrated system of care (Level IV).	111810101.3.22 IT-1.8. Depression management: Screening and Treatment Plan for Clinical Depression (PQR 2011, #134) (Non- standalone measure) 111810101.3.23 IT-1.9. Depression management: Depression Remission at Twelve Months (NQF# 0710) (Standalone measure)	$ 13,134,966
139135109.2.1 2.1.4 Expand Medical Homes for Transition Population Texas Children’s Hospital 139135109	Texas Children’s Health will establish a patient centered medical home for medically fragile children in order to provide proactive care coordination, chronic disease management, and a multi-disciplinary approach that educates patients and providers on appropriate transition processes.	139135109.3.43 IT- 6.1. Percent improvement over baseline of patient satisfaction scores	$ 6,131,493

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137949705.2.1 2.17.1 - Design, implement, and evaluate interventions to improve care transitions from the inpatient setting for individuals with mental health and/or substance abuse disorders: Implement Care Transition Coordination The Methodist Hospital 137949705	The Methodist Hospital will create a program preventing behavioral health readmissions by Implementing care transition coordination.	137949705.3.1 (IT-1.18) Follow-Up After Hospitalization for Mental Illness- NQF 0576236	$ 14,470,830
140713201.2.1 2.17.1 - Design, implement, and evaluate interventions to improve care transitions from the inpatient setting for individuals with mental health and/or substance abuse disorders: Implement Care Transition Coordination The Methodist Willowbrook Hospital	Design, implement, and evaluate interventions to improve care transitions from the inpatient setting for individuals with mental health and/or substance abuse disorders: Implement Care Transition Coordination	140713201.3.1 IT-1.18) Follow-Up After Hospitalization for Mental Illness- NQF 0576236 (Standalone measure)	$ 3,991,970
181706601.2.2 2.15 – Integrate Primary and Behavioral Health Care Services: Medical Psychiatry Unit St Joseph Medical Center 181706601	This proposed unit will meet the needs of adults (ages 18 and above) who have a primary medical diagnosis with a co-occurring psychiatric diagnosis. The unit will be staffed to include two psychiatric social workers who will conduct the therapeutic interventions and make the discharge plans in collaboration with the attending physician.	181706601.2.2 IT 9.2: ED appropriate utilization- Reduce ED visits for behavioral health and substance abuse Improvement target: Reduce ED visits for behavioral health or substance abuse (TBD)	$ 12,623,903
181706601.2.1 2.17.1 – Design, implement and evaluate interventions to improve care transitions from the mental health and/or substance abuse disorder St Joseph Medical Center 181706601	St. Joseph Medical Center proposes to expand services to individuals that have a mental health and/or substance abuse disorder through a Partial Hospitalization Program.	181706601.3.1 IT-1.18: Follow-Up after Hospitalization for Mental Illness	$12,623,903
113180703.2.6 2.13.1- Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in	The Mental Health and Mental Retardation Authority (MHMRA) of Harris County proposes to provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a	113180703.3.13 IT-6.1. Percent improvement over baseline of patient satisfaction scores	$ 14,222,989

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a specific setting: transitional residential treatment post-Incarceration Mental Health and Mental Retardation Authority of Harris County 113180703	specific setting: transitional residential treatment post-Incarceration.		
113180703.2.5 2.13.1 Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specified setting: expansion of mobile crises unit Mental Health and Mental Retardation Authority of Harris County 113180703	The Mental Health and Mental Retardation Authority (MHMRA) of Harris County proposes to provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specified setting by expansion of a mobile crises unit.	113180703.3.12 IT-6.1. Percent improvement over baseline of patient satisfaction scores	$ 11,939,410
113180703.2.4 2.13.1- Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specified setting: expand chronic consumer stabilization initiative Mental Health and Mental Retardation Authority of Harris County 113180703	The Mental Health and Mental Retardation Authority (MHMRA) of Harris County proposes to provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specified setting by expanding a chronic consumer stabilization initiative.	113180703.3.11 IT-6.1. Percent improvement over baseline of patient satisfaction scores	$1,179,949
113180703.2.2 2.13.1- Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specified setting: integrating substance abuse treatment services into mental health services Mental Health and Mental Retardation Authority of Harris County	The Mental Health and Mental Retardation Authority proposes to provide intervention for targeted behavioral health populations to prevent unnecessary use of services by integrating substance abuse and mental health services. .	113180703.3.9 IT-6. Percent improvement over baseline of patient satisfaction scores	$18,419,173

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113180703			
113180703.2.7 2.13.1 Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specified setting: crises intervention response team (CIRT) Mental Health and Mental Retardation Authority of Harris County 113180703	The Mental Health and Mental Retardation Authority (MHMRA) of Harris County proposes to provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specified setting by expansion of a crises intervention response team.	113180703.3.14 IT-9.1. Decrease in mental health admissions and readmissions to criminal justice settings	$7,213,012
113180703.2.3 2.17.1- Establish improvements in care transition from the inpatient setting for individuals with mental health disorders: redesign of the transition from HCPC hospitalization to MHMRA outpatient aftercare Mental Health and Mental Retardation Authority of Harris County 113180703	The Mental Health and Mental Retardation Authority (MHMRA) of Harris County proposes to establish improvements in care transition from the inpatient setting for individuals with mental health disorders by redesigning the transition from HCPC hospitalization to MHMRA outpatient aftercare.	113180703.3.10 IT-6.1 Percent improvement over baseline of patient satisfaction scores	$2,212,418
113180703.2.1 2.15.1 Integrate primary and behavioral health care services: collaborative primary medical and behavioral health care Mental Health and Mental Retardation Authority of Harris County 113180703	The Mental Health and Mental Retardation Authority (MHMRA) of Harris County proposes to integrate primary and behavioral health care services.	113180703.3.8 IT-6.1 Percent improvement over baseline of patient satisfaction scores	$19,142,532
081522701.2.1 2.13.1-Behavioral Healthcare Crisis Center Texana Center 081522701	Texana Center, the local mental health authority, proposes to start a behavioral healthcare crisis center to serve a six-county area (Fort Bend, Matagorda, Wharton, Colorado, Austin, and Waller Counties).	081522701.3.3 TBD	$5,574,005
081522701.1.3 1.9.2 - Improve access to specialty care	Improve access to specialty care-Therapeutic Intervention for Infants and Toddlers at Risk	081522701.3.4 Potentially Preventable Admissions IT-2.13	$4,220,390

Project Title (include unique RHP project ID number for each project.)	Brief Project Description	Related Category 3 Outcome Measure(s) (include unique Category 3 Improvement Target (IT) Identifier specific to RHP and outcome title)	Estimated Incentive Amount (DSRIP) for DYs 2-5 (Category 1 & 2 values)
Texana Center 081522701			
0937740-08.2.8 2.7.1 - Implement innovative evidence-based strategies to increase appropriate use of technology and testing for targeted populations (e.g., mammography screens, colonoscopies, prenatal alcohol use, etc.) City of Houston 0937740-08	Implement innovative evidence-based strategies to increase appropriate use of technology and testing for targeted populations- The Colorectal Cancer Awareness and Screening (COCAS) project	0937740-08.2.8 0937740-08.2.8 IT-11.3 Improve utilization rates of clinical preventive services (testing, preventive services, treatment) in target population with identified disparity. (Non-standalone measure) IT-12.3 Colorectal Cancer Screening (HEIDIS 2012) (Non-standalone measure)	$10,911,392
0937740-08.2.9 2.19.2: (Other) Develop Care Management Function that integrates primary and behavioral health needs of individuals- Integrated Services for the Homeless City of Houston 0937740-08	HDHHS proposes a comprehensive project to integrate evidence based and best practice models such as Housing First to reduce chronic homelessness and associated health and other public system costs.	0937740-08.2.9 IT-9.4 Other outcome improvement target	$2,498,709
096166602.1.1 1.7.7: Implement other project to expand/establish telehealth services-- client health information access portal- Client Health Information Access Portal Spindletop 096166602	Spindletop will develop a web-based portal where secure client-focused health information can be accessed by users with only basic computer skills. Select clients will be provided Wi-Fi enabled tablets to for the implementation of the new client information portal.	096166602.1.1 IT-6.1 (4) Percent improvement over baseline of patient satisfaction scores	$186,649
111810101.1.10 1.1.1 – Establish more primary care clinics: New North Harris County Healthcare Clinic University of Texas Health Science Center 111810101	UT Physicians will recruit specialists for the new primary care clinic in North Harris County. This will further enable expansion of UT Health specialties in another area outside the Texas Medical Center. The new primary care clinic's service hours will be extended to provide evening and weekend appointment options, which will be covered by the UTP specialty services as well. Standardized referral systems will be put in place to ensure access to these specialists. Also, quality	111810101.1.10 OD - 1 Primary Care and Chronic Disease Management OD - 1 Primary Care and Chronic Disease Management	$11,379,766

Project Title (include unique RHP project ID number for each project.)	Brief Project Description	Related Category 3 Outcome Measure(s) (include unique Category 3 Improvement Target (IT) Identifier specific to RHP and outcome title)	Estimated Incentive Amount (DSRIP) for DYs 2-5 (Category 1 & 2 values)
	improvement processes will be put in place to assess project impacts and opportunities for continuous improvement.		
111810101.1.9 1.1.1 – Establish more primary care clinics: New North Harris County Healthcare Clinic University of Texas Health Science Center 111810101	Expand Primary Care Capacity	111810101.1.9 OD - 1 Primary Care and Chronic Disease Management OD - 12 Primary Care and Primary Prevention OD - 12 Primary Care and Primary Prevention	$18,267,521
112672402.2.4 2.7.2 Implement innovative evidence-based strategies to reduce tobacco use – Replicating Ask Advise Connect in Federally-Qualified Health Centers MD Anderson Cancer Center 112672402	The overarching goal of the proposed project, Replicating Ask Advise Connect (AAC), is to deliver evidence-based smoking cessation treatment to smokers seeking care in Federally-Qualified Health Centers (FQHC) in Harris County, Texas, and to ultimately reduce tobacco-related morbidity and mortality, particularly among individuals who are disproportionately burdened with the disease.	112672402.2.4 IT-11.1 Improvement in Clinical Indicator in identified disparity group IT-11.6 Other Outcome Improvement Target	$4,887,399
113180703.1.8 1.13.1- Develop and implement crisis stabilization services to address the identified gaps in the current community crisis system: Interim Care Clinic MHMRA 113180703	The Interim Care Clinic (ICC) is designed to provide initial evaluation and treatment to individuals presenting at the MHMRA Psychiatric Emergency Service (PES) voluntarily, who are not in acute crisis, but who are in urgent need of assessment and treatment to avoid further deterioration of their psychiatric condition. These individuals are diverted from admission to the PES and offered a same day evaluation with an interim care clinic psychiatrist. The clinic is designed to be a single visit clinic and no return or follow-up appointments are given, although patients my return if needed. The project proposes to have the clinic available seven days a week, including extended evening hours.	113180703.1.8 IT-6.1 Percent improvement over baseline of patient satisfaction scores	$12,561,090
113180703.2.8 2.13.1: Design, implement, and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population- IDD/ASD Wrap-	The proposed program seeks to develop wrap-around and in-home services for high risk consumers with Intellectual and Developmental Disabilities and Autism Spectrum Disorders (IDD and ASD) and their families to avoid utilization of intensive, costlier services. More specifically, program	113180703.2.8 IT-6.1 Percent improvement over baseline of patient satisfaction scores	$6,679,087

Project Title (include unique RHP project ID number for each project.)	Brief Project Description	Related Category 3 Outcome Measure(s) (include unique Category 3 Improvement Target (IT) Identifier specific to RHP and outcome title)	Estimated Incentive Amount (DSRIP) for DYs 2-5 (Category 1 & 2 values)
Around and In-Home Services MHMRA 113180703	staff will provide community based interventions for individuals to prevent them from cycling through multiple systems, by providing community-based, wrap-around services that help stabilize behavioral problems in the natural home, while linking the patient and family to other supports, such as a medical home, transition services to help individuals establish a stable living environment, peer support, employment, specialized therapies, respite, personal assistance, and linkage to short or long term residential options.		
113180703.2.9 2.13.2: Implement one or more pilot intervention(s) in care transitions targeting one or more patient care units or a defined patient population- IDD/ASD Inpatient Consultation and Liaison Service MHMRA 113180703	MHMRA proposes to expand and further develop the Inpatient Consultation and Liaison (C&L) team that provides consultation and services to patients suspected of Intellectual and Developmental Disabilities and Autism Spectrum Disorders (IDD and ASD) referred by attending physicians at the Harris County Psychiatric Center (HCPC); with subsequent expansion to provide similar services to other inpatient settings in Harris County. This model is intended to divert people with IDD/ASD from higher cost, inpatient placement and into local resources. Accordingly, this project meets the Delivery System Incentive Reform Payment (DSRIP) Pool 1115(a) waiver component 2.12, Implement and expands care transitions programs.	113180703.2.9 IT-6.1 Percent improvement over baseline of patient satisfaction scores	$7,093,560
127300503.2.2 2.2.2: Apply evidence based care management model to patients identified as having high-risk health care needs- Identification and Treatment of Patients with Hepatitis C St. Luke's Episcopal Hospital 127300503	The purpose of this project is to screen, identify, and provide high level care to individuals identified as having Hepatitis C using a distributed care model based on Project ECHOTM.	127300503.2.2 IT-4.1 Improvement in risk adjusted Potentially Preventable Complication rates	$3,216,809
127303903.2.3 2.6.1: Engage in population-	OBMC will educate and train patients and staff on the health benefits of breastfeeding, as well as evidence-	127303903.2.3 IT-8.1 Timeliness of Perinatal/Postnatal Care	$2,180,264

Project Title (include unique RHP project ID number for each project.)	Brief Project Description	Related Category 3 Outcome Measure(s) (include unique Category 3 Improvement Target (IT) Identifier specific to RHP and outcome title)	Estimated Incentive Amount (DSRIP) for DYs 2-5 (Category 1 & 2 values)
based campaigns or programs to promote healthy lifestyles using evidence-based methodologies including social media and text messaging in an identified population- Implement Evidence-Based Health Promotion Programs – Breastfeeding Promotion Program OakBend Medical Center 127303903	based strategies to enhance breastfeeding. In furtherance of this goal, OBMC will partner with Fort Bend Family Health Center (FBFHC) to educate their staff and the community on the importance of initiating early breastfeeding. This program will utilize a structured approach that incorporates training, motivation and specific practices for implementation.		
130959304.2.1 2.9.1: Provide navigation services to targeted patients who are at risk of disconnect from institutionalized health care: Establish a Patient Care Navigation Program Matagorda Regional Medical Center 130959304	Develop a regional approach to health care delivery that leverages and improves on existing programs and infrastructure, is responsive to patient needs throughout the entire region, and improves health care outcomes and patient satisfaction. Transform health care delivery from a disease-focused model of episodic care to a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary or duplicative services, and builds on the accomplishments of our existing health care system.	130959304.2.1 IT-9.2 ED Appropriate Utilization	$676,986
133355104.1.13 1.9.2-Improve access to specialty care: Increase access to outpatient Physical and Occupational Therapy specialty services Harris County Hospital District 133355104	This project will increase the number of outpatient physical and occupational therapy providers in order to improve access and meet unmet demand for patients who are being referred for services from NCQA medical homes and specialty clinics.	133355104.1.13 IT-10.1 Quality of Life	$14,644,436
133355104.1.14 1.1.1- Establish more primary care clinics: Casa de Amigos Same Day Access Clinic Harris County Hospital District 133355104	This project will expand the capacity of primary care by establishing an adult-focused primary care clinic near the current Casa de Amigos Health Center that offers same day visits during extended hours to meet demand that saturated existing Harris Health System health centers cannot meet.	133355104.1.14 IT-6.1 Percent improvement over baseline of patient satisfaction	$28,922,270
133355104.1.15 1.8.6 - The expansion of existing dental clinics, the establishment of additional	This project will expand adult dental services by establishing additional sites and expanding services at current sites. Services will be added or expanded at 7 health centers.	133355104.1.15 IT-7.8 Chronic Disease Patients Accessing Dental Services	$26,342,678

Project Title (include unique RHP project ID number for each project.)	Brief Project Description	Related Category 3 Outcome Measure(s) (include unique Category 3 Improvement Target (IT) Identifier specific to RHP and outcome title)	Estimated Incentive Amount (DSRIP) for DYs 2-5 (Category 1 & 2 values)
dental clinics, or the expansion of dental clinic hours: Increase, Expand, and Enhance Oral Health Services: Expansion of Adult Dental Services Harris County Hospital District 133355104			
1352544-07.2.1 2.15.1-Integrate Primary and Behavioral Health Care Services: Person-Centered Behavioral Health Medical Home Gulfbend 1352544-07	The goal of this project is to develop and implement a Person-Centered Behavioral Health Medical Home, targeting at risk populations with co-morbid diseases of mental illness and chronic disease who currently go untreated or under treated and who routinely access more intensive and costly services, such as emergency departments or jails	1352544-07.2.1 IT-2.4 Behavioral Health/Substance Abuse Decrease admissions due to behavioral health/substance abuse	$3,550,000
137909111.2.1 2.5.4- "Other" project option: Implement other evidence-based project that will impact cost efficiency in an innovative manner: Medication Dispensing Safety and Efficiency Memorial Medical Center 137909111	Currently, Memorial Medical Center has no automated prescription counting technology. Annually, 120,000 prescriptions are counted manually, using only a counting tray and spatula. According to HealthMEDX, on average, 74% of a typical nurse's workday is spent outside of the patient room on non-value added activity. Currently, our nursing staff spends 1.5 to 2 hours per patient ordering, receiving and administering medication. With a dispensing system in place, 95% of the medications administered in a care area would be stored for ready access. This method allows for "now orders" on medication which in return leads to better patient services by keeping the patient more comfortable. To avoid errors during the administration of medications, we would implement bedside bar-code scanning utilizing Computers on Wheels (COWS). Further, by using a dispensing system with COWS, nursing staff will have more time to spend with the patients assisting with their recovery process resulting in decreased length of stay and cost savings.	137909111.2.1 IT-5.1 Improved Cost Savings; demonstrate cost savings in care delivery	$387,300
2967606-01 2.2 2.13 - Provide an intervention for a targeted behavioral health population to prevent	– Design, implement and evaluate research supported and evidence based interventions tailored towards individuals in the target population:	2967606.2.2 IT-9.1 Decrease in mental health admissions and readmissions to criminal justice	$661,274

Project Title (include unique RHP project ID number for each project.)	Brief Project Description	Related Category 3 Outcome Measure(s) (include unique Category 3 Improvement Target (IT) Identifier specific to RHP and outcome title)	Estimated Incentive Amount (DSRIP) for DYs 2-5 (Category 1 & 2 values)
unnecessary use of services in a specific setting: juvenile justice system Fort Bend County 2967606	youth with complex behavioral health needs involved or at risk of involvement in the juvenile justice system	settings (Juvenile Detention)	
2967606-01.2.3 2.3.2: "Other" project option: Implement other evidence-based project to redesign primary- Community Paramedic Program Fort Bend County 2967606	Fort Bend County proposes a project which would identify Indigent Health Care, Medicaid and uninsured patients who are frequent or inappropriate users of the County Emergency Medical Service (EMS) and hospital Emergency Departments (EDs) to provide appropriate care in their home setting using Advanced Practice Paramedics / Community Paramedics	2967606.2.3 IT-9.2 ED Appropriate utilization/Reduce ED use in target population managed by the Community Paramedic Program IT-9.4 Other outcome improvement target/Reduce EMS transport use in target population managed by the Community Paramedic Program	$661,274
2967606-01 2.4 2.7.1: Implement innovative evidence-based strategies to increase appropriate use of technology and testing for targeted populations– Colonoscopy Screening Fort Bend County 2967606	Fort Bend County proposes a project where Indigent Health Care, Medicaid and uninsured patients who meet guidelines for screening or diagnostic colonoscopies are referred to a local medical provider for this procedure. Under contract with Fort Bend County Clinical Health Services, the local medical provider (negotiations underway) would provide the following: Instructions on preparation for the procedure, including prescriptions if needed Appointment scheduling for the procedure Coverage of the anesthesia, colonoscopy procedure and pathology, if required Acceptance for cancer surgery, radiation and/or chemotherapy for a patient diagnosed with colon/rectal cancer at a contracted rate.	2967606.2.4 IT-6.1 Patient experience with access to specialists, Shared decision making IT-12.3 Colorectal cancer screening	$475,276
081522701.1.4 1.12.2 - Expand the number of community based settings where behavioral health services may be delivered in underserved areas: Enhance service availability of appropriate levels of behavioral health care (applied behavior analysis and speech-	Provide specialized behavioral health care services to the complex behavioral health population of children with diagnoses of autism spectrum disorders and related conditions.	081522701.1.4 IT-10-1 Quality of Life	$4,449,821

Project Title (include unique RHP project ID number for each project.)	Brief Project Description	Related Category 3 Outcome Measure(s) (include unique Category 3 Improvement Target (IT) Identifier specific to RHP and outcome title)	Estimated Incentive Amount (DSRIP) for DYs 2-5 (Category 1 & 2 values)
language pathology for children diagnosed with autism spectrum disorders) Texana 0815522701			
0937740-08.1.3 1.8.11 The implementation of dental services for individuals in long-term care facilities, intermediate care facilities, and nursing homes, and for the elderly, and/or those with special needs by enhancing dental workforce capacity through collaborations and partnerships with dental and dental hygiene schools, LHDs, FQHCs, and/or local dental providers. City of Houston 0937740-08	The Houston Health and Human Services (HDHHS) proposes to a) provide ongoing diagnostic, preventive, restorative, and surgical oral health services for the low income at-risk elderly in the community; b) provide oral health services for previously screened elderly patients from Area Agency on Aging, Harris Health System, and area Federally Qualified Health Centers; and c) link more elderly to a dental home.	0937740-08.1.3 IT-7.8 Chronic Disease Patients Accessing Dental Services	$836,866
0937740-08.2.10 2.12.3: Implement/Expand Care Transitions Programs, “Other” project option to reduce the incidence of hospital readmissions within 30 days of discharge of Medicare Fee For Service and Dual Eligible individuals that are hospitalized resulting from the chronic disease specifically, Congestive Heart Failure (CHF). 0937740-08	The performing provider, Houston Department of Health and Human Services (HDHHS) proposes to implement a program, modeled after Coleman Transitions Intervention to improve transitions of patients from the inpatient hospital setting to other care settings, to improve quality of care, to reduce avoidable readmissions for high risk heart failure beneficiaries, and to document measurable savings to the Medicare program.	0937740-08.2.10 IT-3.2 Congestive Heart Failure 30 day readmission rate (Standalone measure)	$4,451,417
111810101.2.8 2.15.1 – Integrate Primary and Behavioral Health Care Services: Integrated Primary and Behavioral Health Care Services for Children and Adolescents University of Texas Health Science Center Houston 111810101	Integrate Primary and Behavioral Health Care Services	111810101.2.8 IT-1.1 Third next available appointment (Non-standalone measure) (Specialty Care) IT-1.19 Antidepressant Medication Management - NQF 0105 (Standalone measure)	$16,418,710

Project Title (include unique RHP project ID number for each project.)	Brief Project Description	Related Category 3 Outcome Measure(s) (include unique Category 3 Improvement Target (IT) Identifier specific to RHP and outcome title)	Estimated Incentive Amount (DSRIP) for DYs 2-5 (Category 1 & 2 values)
113180703.1.9 1.12.2- Expand the number of community based settings where behavioral health services may be delivered in underserved areas: Clubhouse Expansion MHMRA 113180703	MHMRA will be contracting with St. Joseph House to provide psychosocial rehab services. St Joseph House is an accredited Clubhouse and adheres to the standards of the International Center for Clubhouse Development (ICCD). The ICCD Clubhouse Model is a day treatment program for rehabilitating adults diagnosed with a serious and persistent mental health problem.	113180703.1.9 IT-9.1 Decrease in mental health admissions and readmissions to criminal justice settings	$6,586,745
113180703.1.10 1.9.2- Expand Specialty Care Capacity: Lighthouse MHMRA 113180703	Along with the Lighthouse, MHMRA proposes to expand behavioral healthcare capacity for persons with visual impairment to include identification of behavioral health needs, interventions, case management, patient and family education and coordination with primary care.	113180703.1.10 IT-6.1 Percent improvement over baseline of patient satisfaction scores	$2,616,615
127303903.2.4 2.14.3: “Other” project option: Implement other evidence-based project to implement person-centered wellness self-management strategies and self-directed financing models that empower consumers to take charge of their own health care– Patient-Centered Wellness Management Program OakBend Medical Center 127303903	OBMC will formalize partnerships with local community agencies to work on projects specifically dedicated to health and wellness promotion such as Fort Bend Family Health Center (FBFHC), United Way, OakBend Medical Group (OBMG), Weight Watchers and other agencies. We will form a task force of community members from each of the different agencies to do a needs assessment to determine targeted areas where a wellness management program would be beneficial	127303903.2.4 IT-3.4 Renal Disease 30-day Readmission Rate	$6,459,976
130959304.1.2 1.6.1- Expand Urgent Care Services: Expand Access to Urgent Care Services and Urgent Medical Advice Matagorda Regional Medical Center 130959304	A joint planning team with representatives of Matagorda County Hospital District/Matagorda Regional Medical Center, Matagorda Episcopal Health Outreach Program (MEHOP – FQHC), and Palacios Community Medical Center has explored potential models to transform access, cost and delivery of health care. The transformation goals described in the Waiver helped the group crystallize their plans and a new partnership was formed to move the joint planning effort forward. This new organization, Coastal Health Connection, is currently being incorporated with these three	130959304.1.2 IT-9.2 ED Appropriate Utilization	$2,192,046

Project Title (include unique RHP project ID number for each project.)	Brief Project Description	Related Category 3 Outcome Measure(s) (include unique Category 3 Improvement Target (IT) Identifier specific to RHP and outcome title)	Estimated Incentive Amount (DSRIP) for DYs 2-5 (Category 1 & 2 values)
	organizations as the founders to further the concept of shared infrastructure and shared planning to improve the health of the community.		
133355104.1.16 1.1.4 "Other": Implement other evidence-based project to expand primary care capacity: House Calls Program Harris County Hospital District 133355104	This project will expand the House Calls Program in order to improve access, maximize independence, and realize cost savings by providing comprehensive, coordinated, multidisciplinary primary care at home to a population of patients that are homebound or have difficulties getting to clinic visits.	133355104.3.21 IT-6.1(1) percent improvement over baseline of patient satisfaction scores	$11,217,312
133355104.1.17 1.8.6- The expansion of existing dental clinics, the establishment of additional dental clinics, or the expansion of dental clinic hours: Expansion of Pediatric Dental Services Harris County Hospital District 133355104	This project will address the growing need for pediatric oral health services by implementing these services across three facilities within our system.	133355104.3.22 133355104.3.23 IT-7.2 Topical Fluoride Application IT-7.4 Percent children with untreated dental caries	$20,042,476
133355104.2.4 2.9.1- Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care: OB Navigation Program Harris County Hospital District 133355104	This project will improve access to pre- and postnatal care through comprehensive, effective patient navigation through the Harris Health System and throughout a woman's pregnancy, with a focus on high-risk mothers.	133355104.3.24 IT-8.2 Percent of low birth weight births	$21,303,546
133355104.2.5 2.2.1 - Redesign the outpatient delivery system to coordinate care for patients with chronic diseases: Expansion of Point-Of-Care Services Provided by Clinical Pharmacists Harris County Hospital District 133355104	This project will expand point-of-care services provided by clinical pharmacists for the chronic management of patients receiving anticoagulation therapy and create an educational website.	133355104.3.25 133355104.3.26 IT-1.20 Other: Management of INR IT-2.13 Other Outcome Measure	$10,048,795
133355104.2.6 2.6.4 – Implement Evidence-based Health Promotion Program in an Innovative	This project will develop a program for promoting increased consumption of fruits and vegetables among primary care patients through an integrated approach that includes multi-provider	133355104.3.27 IT-6.1 Percent increase over baseline of patient satisfaction scores	$4,111,404

Project Title (include unique RHP project ID number for each project.)	Brief Project Description	Related Category 3 Outcome Measure(s) (include unique Category 3 Improvement Target (IT) Identifier specific to RHP and outcome title)	Estimated Incentive Amount (DSRIP) for DYs 2-5 (Category 1 & 2 values)
Manner: Integrated Promotion of Fruit and Vegetable Consumption in Primary Care through a Prescription for Healthy Eating Program. Harris County Hospital District 133355104	and multi-modal patient education and access to a clinic-based farmer's market.		
133355104.2.7 2.10.2 - "Other": Implement other evidence-based project to implement use of palliative care programs: Use of Palliative Care Programs Harris County Hospital District 133355104	This project will expand our comprehensive palliative care program through the creation of an integrated, interprofessional team of specially trained providers.	133355104.3.28 133355104.3.29 133355104.3.30 IT-13.1 Pain Assessment IT-13.3 Proportion with more than 1 ER visit in the last days of life IT-13.4 Proportion admitted to ICU in last 30 days of life	$11,217,312
137909111.2.2 2.4.1 – Develop and implement a structured patient experience training program: Improving the Patient Experience – The AIDET or similar Project. Memorial Medical Center 137909111	Memorial Medical Center will develop and implement a structured patient experience training program: Improving the Patient Experience – The AIDET Project.	137909111.3.3 6.1.1 Improve Patient Satisfaction	$634,817
137909111.2.3 2.4.1 – Redesign to Improved Patient Experience Memorial Medical Center 137909111	Under this project, Memorial Medical Center will research, design, and implement (if found to be effective) a hospitalist model to increase productivity and access to care for patients, involving both physicians and mid-level providers.	137909111.3.4 6.1.1 Improve Patient Satisfaction	$1,334,452
212060201.1.2 1.7.1: Implement telemedicine program to provide or expand specialist referral services in an area identified as needed to the region- Implement Telehealth & Telemedicine in Colorado County	Rice intends to develop the use of telemedicine in its Colorado County facilities and in schools to increase and improve access to specialty care services for community stakeholders.	212060201.3.5 IT 6.1(3) Percent improvement over baseline of patient satisfaction scores - patient's rating of doctor access to specialist	$1,640,149
212060201.1.3 1.1.1: Establish more primary care clinics- Expand primary care clinics	Rice Medical Center proposes to expand primary care access in the greater Colorado County area by establishing a clinic in Wallis, Texas.	212060201.3.6 IT 6.1(5) Percent improvement over baseline of patient satisfaction scores - patient's overall health status/functional status	$2,296,209
212060201.1.4 1.6.1 – Expand urgent care	Rice Medical Center proposes to enhance urgent medical advice in Colorado County by establishing an	212060201.3.7 IT 9.2 ED appropriate utilization	$2,132,194

Project Title (include unique RHP project ID number for each project.)	Brief Project Description	Related Category 3 Outcome Measure(s) (include unique Category 3 Improvement Target (IT) Identifier specific to RHP and outcome title)	Estimated Incentive Amount (DSRIP) for DYs 2-5 (Category 1 & 2 values)
services- Enhance urgent medical advice.	outpatient urgent care clinic in its hospital facility.		
212060201.1.5 1.9.2: Improve access to specialty care - Improve access to specialty care in Colorado County	In an effort to improve access to specialty care in Colorado County, Rice will recruit an otolaryngologist (ENT physician) to provide services at least once a week in its specialty clinic.	212060201.3.8 IT 6.1(3) Percent improvement over baseline of patient satisfaction scores - patient's rating of doctor access to specialist	$2,624,239
212060201.1.6 1.1.2: Expand existing primary care capacity- Expand the East Bernard Clinic	Rice intends to relocate and improve the existing Rural Health Clinic ("RHC") in East Bernard in order to expand access to primary care services in this community and a surrounding radius of at least 10 miles outside the city limits.	212060201.3.9 IT 6.1(1) Percent improvement over baseline of patient satisfaction scores - patients are getting timely care, appointments, and information	$2,296,209
2967606-01 1.2 1.1.1 – Expand Existing Primary Care Capacity – Expand Hours of Service	Fort Bend County proposes a project to expand the hours of operation of the local Federally Qualified Health Center (FQHC) to accommodate the expected increase in use by Indigent Health Care, Medicaid and uninsured patients who are referred into the clinic from the other projects proposed by Fort Bend County.	2967606.3.10 2967606.3.11 IT-1.1 Third next available appointment IT-9.2 ED appropriate utilization/Reduce ED use in target population referred to Care Coordination Program	$1,850,899

Section III. Community Needs Assessment

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REGION OVERVIEW

The Southeast Texas Regional Healthcare Partnership is the largest Regional Health Partnership (RHP) in Texas and includes more than 4.8 million people who receive healthcare through one of the most comprehensive healthcare systems in the world. While each county has a distinctive population and health care infrastructure designed to serve the local community, patterns of health care utilization and physician referrals commonly cross county lines, providing access to an extended network of providers and organizations positioned to serve the diverse population of this region.

Following is a brief overview of the nine counties participating in RHP Region 3.

Austin County: Austin County is located in the Northwest area of Region 3 and includes a population of approximately 28,417 residents. The county is 663 square miles in size and is primarily a rural population. It includes six incorporated (Bellville, Brazos Country, Industry, San Felipe, Sealy and Wallis) and 18 unincorporated communities, and three school districts. The community's median household income is $51,418 with 25 percent of households earning less than $25,000 annually and 20.5 percent earning $100,000 or more.[4] The county's only hospital is the Bellville General Hospital, a 32-bed full-service acute care facility. In 2010, the hospital reported more than 5,000 emergency room visits, nearly 64,000 outpatient visits, and 620 inpatient admissions. Behavioral health care services are available through Texana Mental Health and Mental Retardation Center, Youth and Family Services, and Austin County Outreach. Texana is the largest facility, but serve multiple counties and provides limited services to eligible populations. The County has no psychiatrists, so patients needing psychiatric services must often travel significant distances to obtain care. The county is a federally-designated Health Professional Shortage Area (HPSA) for primary care, dental and mental health services.[5] Health-related challenges facing the community include: inadequate safety net services for low income/uninsured population; behavioral healthcare services; insufficient long-term care services for mentally ill; lack of transportation for residents needing medical and social services.[6] The county's overall health ranking is number 104 out of 221 Texas counties with contributing factors including; a high teen birth rate (47 per 1,000 female teens); a high reported rate of poor mental health days (4.7 days per 30 day period); high adult obesity rate (30%); high rate of sexually transmitted infections; a shortage of primary care physicians; and a high rate of premature death.[7]

Calhoun County: Calhoun County is the southernmost county within the region and includes more than 1,000 square miles almost evenly divided between land and water. With a population of 21,381, that is primarily White (46%) and Hispanic (46%), the county includes the cities of Port Lavaca, Point Comfort, Seadrift, and the unincorporated Community of Port O'Connor.

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[4] U.S. Census, American Community Survey 2008-2010

[5] U.S. Department of Health and Human Services, Health Resources and Services Administration. Data accessed August 2012.

[6] Austin County Community Plan.

[7] County Health Rankings and Roadmaps, County Health Rankings 2012.

The community is served by a single acute care hospital, Memorial Medical Center located in Port Lavaca. This public hospital provided more than 10,000 emergency room visits and 26,000 outpatient visits in 2010, and more than 1,300 inpatient admissions.[8] The county is a designated MUA and has applied to be a HPSA for primary care, dental and mental health services, and has no practicing psychiatrists.[9] Behavioral health services are provided primarily by Gulf Bend MHMR Center, which serves residents from seven counties, the majority of which (62%) live in Victoria county and have an annual income of $11,000[10]. With a median household income of $42,745, Calhoun County has the highest percentage of children living in poverty (30.7%) of all counties in the Region. Due to its proximity about halfway between Houston and Corpus Christi, Calhoun County residents often must travel between 80 and 150 miles to these larger communities for specialty care. The county's overall health ranking is number 49 out of 221 Texas counties[11] with contributing factors of high adult obesity rate (30%); high teen birth rate (81 per 1,000 female teens); a high number rate of sexually transmitted infections; and a high uninsured population (28%).[12]

Chambers County: Nearly 36,000 residents live in Chambers County, a coastal county that includes 872 square miles, of which approximately one third is water. The county includes the cities of Anahuac, Baytown (part of which lies in Harris County), Beach City, Cove, Monbelvieu, Old River-Winfree, and parts of Shoreacres, Seabrook, and Texas City, as well as numerous unincorporated areas. The median income is $69,491. Two acute care hospitals are located in the county. Bayside Community Hospital is a public hospital located in Anahuac, with 2,769 emergency room visits, more than 30,000 outpatient visits, and nearly 250 admissions in 2010. Winnie Community Hospital is a private, for-profit facility that reported more than 2,500 emergency room visits, 14,854 outpatient visits, and 556 inpatient admissions in 2010.[13] Behavioral health services are available through the Spindletop Mental Health and Mental Retardation Center, which serves four counties with no clinic presence in Chambers County. The county is a federally designated Primary Care Health Professional Shortage Area and has no practicing psychiatrists.[14] The county received a health care ranking of number 74 out of 221 counties with contributing factors of insufficient access to care; a high teen birth rate (40 per 1,000 female teens); a high number of poor mental health days (3.7 per 30 days); a high adult obesity rate (29%); a high rate of preventable hospital stays for Medicare patients;[15] and a low rate of prenatal care within the first trimester.[16]

Colorado County: Colorado County is a rural community with slightly more than 20,000 residents, the smallest population in Region 3. The county is 949 square miles in size and

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[8] Texas Department of State Health Services, 2010 Cooperative DSHS/AHA/THA Annual Survey of Hospitals and Hospital Tracking Database.
[9] Health Resources and Services Administration, August 2012, and Texas Medical Board, Physician Demographics by County and Specialty, January 2012.
[10] Gulf Bend MHMR, http://www.gulfbend.org/poc/view_doc.php?type=doc&id=11325
[11] County Health Rankings 2012.
[12] Ibid
[13] 2010 Cooperative DSHS/AHA/THA Annual Survey of Hospitals and Hospital Tracking Database.
[14] Health Resources and Services Administration, August 2012, and Texas Medical Board, Physician Demographics by County and Specialty, January 2012.
[15] County Health Rankings
[16] Texas Department of State Health Services, Health Facts Profile 2009

includes three small incorporated communities (Columbus, Eagle Lake, and Weimar) with approximately 9,588 residents, and 18 rural, unincorporated communities with a total of approximately 11,213 residents.[17] The county has a median household income of $40,930. An estimated 22% of the population has no health insurance. The area is served by three acute care hospitals, Colorado-Fayette Medical Center, Columbus Community Hospital and Rice Medical Center. Together these facilities accounted for 10,241 emergency room visits, 101,821 outpatient visits, and 9,012 inpatient admissions, and provided more than $5 million in uncompensated care in 2010. [18] Behavioral health and intellectual disability services are available to eligible residents through Texana Center. The county is a designated HPSA for primary care, dental and mental health services. The county's health care ranking is 132 of 221 counties[19] with contributing factors of insufficient access to care; high adult obesity rates (29%); a high number of poor physical (5.6 per 30 days) and mental (4.6 per 30 days) health days reported by residents; a high rate of sexually transmitted infections; and a high uninsured rate.

Fort Bend County: Fort Bend County is the second largest county in RHP Region 3 and the 10th largest county in the state with a population of nearly 600,000. The county is 875 square miles in size and includes 17 towns ranging in size from 200 to 75,000 and a rural population of 83,000 (14%). At $76,758, the county has the highest median household income in the region as well as the lowest percentage of children living in poverty (12.5%), and the highest high school and college graduation rates in the region (88.6% and 40.5%, respectively).[20] The county is served by 10 acute care hospitals. Behavioral health services are provided by Texana Center, the local mental health authority for Fort Bend and five other counties. The county received the highest health ranking of all counties within Region 3, rated at number 9 of 221 Texas counties. However, despite these positive indicators of financial stability and health status, nearly 100,000 residents (17.4%) are uninsured and face the same health care challenges as residents throughout the region. The county is a designated HPSA for primary care, dental and mental health care and struggles to provide sufficient access to care.[21] The county's 10 hospitals provided more than $116 million in uncompensated care in 2010. [22] An estimated 16% of the county's population is considered to be in poor or fair health; 8.3% of babies are born with a low birth weight and nearly 40% of pregnant mothers receive no prenatal care in the first trimester.[23]

Harris County: Harris County is the third largest county in the United States and includes the country's fourth largest city, Houston, as well as 30 other municipalities. The county is home to more than 4 million people, including a rural population of approximately 62,000 residents and more than 8,000 homeless individuals.[24] In 2010, 41 percent of residents were Hispanic, followed by 34 percent who reported themselves as Anglo/white. [25] Approximately 25% of Harris County residents are foreign-born with 71% reporting Latin America as their birthplace

[17] Colorado County, Colorado County Community Plan 2011-2012.
[18] 2010 Cooperative DSHS/AHA/THA Annual Survey of Hospitals and Hospital Tracking Database
[19] County Health Rankings
[20] U.S. Census Bureau, 2010 U.S. Census.
[21] U.S. Department of Health and Human Services, Healthcare Resources and Services Administration.
[22] 2010 Cooperative DSHS/AHA/THA Annual Survey of Hospitals and Hospital Tracking Database
[23] County Health Rankings, 2012 and Texas Department of State Health Services, Health Facts Profile 2009.
[24] U.S. Census Bureau, 2010 U.S. Census and Coalition for the Homeless of Houston/Harris County, *Houston/Harris County 2010 Homeless County & Survey and 2011 Homeless Enumeration Count.*
[25] U.S. Census Bureau and Texas State Data Center, 2010 U.S. Census.

and 21% born in Asia.[26] Median household income is the third highest in the region at $50,437. County residents are served by 67 acute care hospitals which collectively provided more than $3.3 billion in uncompensated care in 2010 and reported more than 7.6 million outpatient visits, 476,000 inpatient stays, and 1.44 million emergency room visits.[27] Behavioral health care services are available through the county's community mental health center, the Mental Health and Mental Retardation Authority of Harris County as well as other healthcare providers. Harris County is also the location of The Texas Medical Center, the largest medical complex in the world with a total annual budget of $14 billion for the 52 not-for-profit member institutions. But despite its large health care infrastructure, the county is a designated HPSA for primary, dental and mental health care and struggles to meet the complex needs of a diverse population that is constantly growing. Based on health factors, the county is ranked 160 of 221 counties, due in part to insufficient access to care; high rates of adult obesity (29%), sexually transmitted infections, tuberculosis, and excessive drinking (17%). The county also has a high rate of teen births and low birth weight babies, and low rate of prenatal care in the first trimester (51%).[28] Other health care challenges include a high prevalence of behavioral health issues and needs, an inadequate number of primary care and specialty service providers to meet significant demands, and development of a comprehensive region-wide care coordination system that manages patient needs in the most appropriate setting.

Matagorda County: Located on the Gulf Coast, Matagorda County includes the towns of Bay City and Palacios, as well as 15 smaller communities spread throughout the county of more than 1,000 square miles. More than 36,000 people live within the county which has a median household income of $39,874. Nearly 20% of the population lives below the poverty level, and the county has the second highest rate of children living in poverty at 28.4%. While the median age is 38, more than 20 percent of the county residents are over the age of 60.[29] More than 26 percent of the population is uninsured. The county is served by two acute care hospitals, Matagorda Regional Medical Center and Palacios Community Medical Center. In 2010, the facilities reported 40,480 outpatient visits, 19,368 emergency visits, and 3,156 inpatient admissions. The hospitals provided more than $16 million in uncompensated care, which accounted for 14.9% of total patient revenue, the second highest percentage in the region.[30] The county is ranked 130 of 221 Texas counties; 25% of residents reported they are in poor or fair health, significantly higher than the Texas average of 19%.[31] Specific health care challenges include: high rates of smoking and excessive drinking among adults; high rate of adult obesity; high rate of teen births; poor access to primary care; and a high rate of sexually transmitted infections. The county is also a designated HPSA for primary, dental and mental health care providers.

Waller County: With just over 518 square miles, Waller County is home to slightly more than 47,000 residents. The county includes 6 towns, including Brookshire, Hempstead, Katy, Pine Island, Prairie View and Waller as well as several small unincorporated communities. The

[26] U.S. Census Bureau, Statistical Abstract of the United States: 2011.
[27] 2010 Cooperative DSHA/AHA/THA Annual Survey of Hospitals and Hospital Tracking Database; eight hospitals in Harris County were not included in the survey data, but are included in the total count.
[28] County Health Rankings 2012, and Health Facts Profile 2009
[29] U.S. Census Bureau, 2010 Census.
[30] 2010 Cooperative DSHS/AHA/THA Annual Survey of Hospitals and Hospitals Tracking Database
[31] County Health Rankings 2012.

county has a median household income of $46,313 and the highest percentage of residents living in poverty (20.4%) among all counties in within the region. The county also reflects a younger population, with a median age of 31.7 years, Residents needing hospital services obtains care in surrounding counties; there are no acute care hospitals within the county.[32] Behavioral health and intellectual disability services are available to qualified residents through the Texana Center. The county is a designated HPSA for primary, dental and mental health care. In the County Health Rankings, Waller County is number 112 of 221 counties with contributing factors of a high proportion of poor mental health days (5.5 per 30 day period); a high level of adult obesity (32%), high rate of sexually transmitted infections; high teen birth rate; poor access to primary care; high rate of uninsured.[33]

Wharton County: Wharton County is a rural agriculture area of slightly less than 1100 square miles. More than half of the population of 44,780 resides in the towns of East Bernard, El Campo, and Wharton, with the remaining 18,600 spread across 14 unincorporated communities. With a median household income of $36,097, a fact that is reflected in the high rate of poverty for both adults (19.1%) and children (26.6% live in poverty). The counties two hospitals, El Campo Memorial Hospital and Gulf Coast Medical Center, provided more than $17 million in uncompensated care in 2010, and reported 15,530 emergency room visits, 73,438 outpatient visits, and 2,695 inpatient admissions.[34] Behavioral health and intellectual disability services are available to eligible residents through Texana Center. Wharton is a designated HPSA for primary care, dental and mental health services.[35] While it has a total of 49 practicing physicians, no psychiatrists are located within the county.[36] The county is ranked number 61 of 221 Texas counties, in part due to the following: high rate of poor physical health days (4.3 per 30 day period); high rate of low birth weight babies (8.5%); high rate of adult obesity (31%); excessive drinking (17%); high rate of sexually transmitted infections; high uninsured rate, poor access to primary care, and a rate of preventable hospital stays among Medicare enrollees.[37]

Region Demographics and Insurance Coverage

The population of Region 3 includes nearly 5 million individuals that reflect a diverse race and ethnic distribution.

Table 1: 2010 Population - Race/Ethnicity Distribution

County	White	%	Hispanic	%	Black	%	Other	%	Total
Austin	18,759	66	6,641	23	2,726	10	291	1	28,417
Calhoun	9,901	46	9,922	46	557	3	1,001	5	21,381
Chambers	24,998	71	6,635	19	2,056	9	507	1	35,906
Colorado	12,544	60	5,452	26	2,739	13	139	1	20,874
Ft Bend	216,371	37	138,967	24	126,298	21	103,739	18	585,375
Harris	1,372,792	34	1,671,540	41	722,691	18	275,436	7	4,042,459

[32] 2010 Cooperative DSHS/AHA/THA Annual Survey of Hospitals and Hospitals Tracking Database.
[33] County Health Rankings 2012 and Health Facts Profile 2009.
[34] 2010 Cooperative DSHS/AHA/THA Annual Survey of Hospitals and Hospitals Tracking Database.
[35] Health Resources and Services Administration, August 2012.
[36] Texas Medical Board, 2012.
[37] County Health Rankings 2012 and Health Facts Profile 2009.

Matagorda	17,530	48	14,074	38	4,187	12	911	2	36,702
Waller	19,409	45	12,536	29	10,811	25	449	1	43,205
Wharton	19,761	48	15,445	37	5,830	14	244	1	41,280
Total:	**1,712,065**	**35**	**1,881,212**	**39**	**878,795**	**18**	**382,717**	**8**	**4,854,789**

Source: Texas State Data Center, Texas Population 2010.

Over the next three years, the region is expected to grow by more than 10 percent, adding an additional 633,126 individuals for a growth rate of 13.04 percent.

Table 2: 2015 Population Predictions[38]

County	White	%	Hispanic	%	Black	%	Other	%	Total	Growth Rate 2010-2015
Austin	19,655	62	7,298	23	4,334	14	201	1	31,488	10.8%
Calhoun	11,310	47	11,398	47	599	2	599	2	24,259	13.5%
Chambers	28,451	69	7,973	19	4,348	11	406	1	41,178	14.7%
Colorado	12,201	53	6,677	28	4,123	18	127	1	23,128	10.8%
Ft Bend	252,376	35	183,263	25	167,481	23	120,384	17	723,504	23.6%
Harris	1,114,466	25	2,246,282	50	773,679	17	379,061	8	4,513,488	11.7%
Matagorda	17,344	44	15,246	39	4,978	13	1,378	4	38,946	6.1%
Waller	19,579	41	13,736	29	13,522	29	304	1	47,141	9.1%
Wharton	19,941	44	17,859	40	6,700	15	283	1	44,783	8.5%
TOTAL	**1,495,323**	**27**	**2,509,732**	**46**	**979,764**	**18**	**503,096**	**9**	**5,487,915**	**13.04%**

Income

The average Median Household Income varies significantly within the region and Census data shows that 16.8% of county residents had incomes below the federal poverty level; among children under 18, the rate was even higher at 24.5 percent.

Table 3: Income and Poverty Status by County – 2010

County	Median Household Income	Number of People in Poverty	%	Number of Children Under 18 in Poverty	%
Austin	$50,154	3,525	12.5	1,281	18.3
Calhoun	$42,745	4,092	19.4	1,712	30.7
Chambers	$69,491	3,717	10.6	1,418	14.2
Colorado	$41,395	3,544	17.3	1,349	27.6
Fort Bend	$76,758	52,716	9.0	21,654	12.5
Harris	$50,437	758,916	18.7	308,583	27.1
Matagorda	$39,874	7,211	19.9	2,720	28.4
Waller	$46,313	8,104	20.4	2,975	28.1
Wharton	$36,097	7,823	19.1	2,913	26.6
Statewide	$49,646	4,411,217	17.9	1,746,564	25.7

Sources: U.S. Census Bureau, Small Area Income and Poverty Estimates- 2010 State and County Level Estimations

[38] Source: Texas State Data Center, Texas Population 2010.

Education

For residents age 18-24, the high school graduation rate varies from 73.8 percent in Colorado County to 91.7 in Waller County. As expected, college graduation rates were significantly higher for ages 25 and over, with the highest percentage in Fort Bend at 40.5 percent, followed by Harris County with a graduation rate of 27.5 percent.

Table 4: Educational Attainment by Age
2008-2010 Average

	Age 18-24 Years			Age 25 and Over		
County	**Less than High School**	**High School Graduate**	**College Graduate**	**Less than High School**	**High School Graduate**	**College Graduate**
Austin	12.3%	87.7%	5.4%	18.6%	81.4%	19.1%
Calhoun	22.4%	77.6%	0.0%	23.5%	76.8%	12.1%
Chambers	24.1%	75.5%	0.0%	14.2%	85.7%	15.9%
Colorado	26.2%	73.8%	4.3%	20.8%	78.1%	15.7%
Fort Bend	17.0%	83.0%	9.2%	11.3%	88.6%	40.5%
Harris	24.2%	75.8%	8.1%	22.2%	77.8%	27.5%
Matagorda	33.9%	66.1%	4.6%	21.6%	78.4%	14.0%
Waller	8.3%	91.7%	6.1%	18.7%	81.3%	20.6%
Wharton	24.5%	75.5%	1.9%	27.5%	72.5%	16.5%

Source: U.S. Census Bureau, 2008-2010 American Community Survey, 3-Year Estimates

Employment

As the largest urban area in the state and the fifth largest Metropolitan Statistical Area (MSA) in the country, the Houston MSA provides a diverse choice of employment opportunities and ranks third among areas serving as Fortune 500 headquarters.[39] The 10 county MSA has reported steady job growth for more than two years, and added more than 207,400 jobs since January 2010.[40] Table 5 confirms that employment across the region has historically been generally high, with unemployment rates for most counties falling between 6 and 7.5 %. Two counties, Calhoun and Matagorda, reported significantly higher unemployment rates of 11.3% and 13.2%.

As of November 2010, the Houston MSA recorded more than 2.54 million jobs, more than the total count of 31 states. The region offers a diverse mix of employment opportunities that include major manufacturing companies, oil and gas industries, research and technology firms, aerospace engineering companies, agriculture, an extensive retail and service industry, and numerous healthcare professions. Over the next thirty years, the region is predicted to lead the state in job growth, growing from 2.7 million jobs in 2011 to 4.3 million jobs in 2040 and accounting for almost one-fourth of the state's job growth.

Approximately 850,000 residents of Region 7 live below the federal poverty level, many of whom work at low paying jobs that often do not provide insurance benefits. These people are part of the 1.2 million uninsured who rely on the safety net for critical health care services

[39] Greater Houston Partnership, Economic Development Facts and Figures.
[40] Greater Houston Partnership, The Economy at a Glance. October 2012.

provided throughout the Region, and who often obtain care through emergency departments due to shortages of primary care services.

Table 5: Workforce Status of People Aged 16 and Over 2008-2010				
County	**Total Population**	**Percentage In Labor Force**	**Percentage Employed**	**Percentage Unemployed**
Austin	21,873	62.9%	58.8%	6.4%
Calhoun	16,357	60.0%	54.0%	11.3%
Chambers	25,061	66.2%	62.0%	6.1%
Colorado	16,424	59.7%	56.7%	4.9%
Fort Bend	418,152	68.6%	64.9%	5.3%
Harris	3,019,173	69.1%	63.8%	7.5%
Matagorda	28,202	61.7%	53.5%	13.2%
Waller	32,986	64.4%	59.6%	7.3%
Wharton	31,087	65.0%	60.2%	7.4%

Source: U.S. Census Bureau, 2008-2010 American Community Survey

Health Insurance Status

For more than 15 years, the state of Texas has experienced the highest uninsured rate in the country. The most recent census data available estimates 1,091,525 citizens have no insurance, which is larger than the statewide uninsured population in 38 states and represents 27.6 percent of the region's total population. Of those with insurance, 77 percent were insured under private plans and 33 percent received coverage through a public program.

Insurance status also varies significantly among the various racial and ethnic groups residing in the region. The Behavioral Risk Factor Surveillance System (BRFSS) survey found that of the uninsured residing in the Houston-Baytown-Sugar Land MSA in 2010, White residents reported an uninsured rate of 11.0% compared to 54.8% of Hispanics and 26.7% of Blacks. Individuals without insurance report problems obtaining needed medical care, including not having a usual source of care, postponing care or going without care or necessary prescriptions drugs due to cost.[41] In 2009, a study of emergency department utilization in 29 Houston hospitals found that 41% of Emergency department visits by Harris County residents were Primary Care Related visits that were for non-emergency services that could have been treated in a primary care setting. [42] One-third of the visits were attributed to the uninsured and 26.8% were attributed to individuals covered by Medicaid. These data are significant to the Region's Plan to expand access to services that provide the most appropriate care in the most cost effective setting, improve patient care and satisfaction, and lead to a healthier population.

[41] Kaiser Family Foundation. *The Uninsured: A Primer, October 2011.*
[42] University School of Public Health, *Houston Hospitals Emergency Department Use Study, January 1, 2009 through December 31, 2009.* University of Texas Health Science Center at Houston, May, 2011.

Table 6: Health Insurance Status – 3 Year Estimate, 2008-2010								
County	**Total Population**	**Total Insured**	**%**	**Insured with Private Coverage**	**Insured with Public Coverage**	**Medicaid, CHIP Enrollees, Dec. 2009**	**Total Uninsured**	**%**
Austin	28,199	23,228	82.4	20,231	6,038	2,977	4,971	17.6
Calhoun	21,126	17,496	82.8	12,926	7,070	3,119	3,630	17.2
Chambers	33,693	27,694	82.2	24,158	6,107	2,842	5,999	17.8
Colorado	20,587	16,065	78.0	12,538	6,402	2,729	4,522	22.0
Fort Bend	561,578	463,943	82.6	412,695	79,542	47,117	97,635	17.4
Harris	4,004,455	2,908,456	72.6	2,191,685	952,770	550,837	1,095,999	27.4
Matagorda	36,238	26,637	73.5	19,234	11,414	6,126	9,601	26.5
Waller	41,710	30,358	72.8	23,709	9,685	4,745	11,352	27.2
Wharton	40,599	31,066	76.5	23,134	12,497	6,117	9,533	23.5
Total	**4,788,185**	**3,544,943**	**74.0**	**2,740,310**	**1,091,525**	**626,609**	**1,243,242**	**26.0**

Source: U.S. Census Bureau, 2008-2010 American Community Survey 3 Year Estimates; Texas Health and Human Services Commission Monthly Medicaid Enrollment Report, December, 2009

Federal Initiatives

Performing providers of DSRIP initiatives strategically aligned all programs with the community needs but were mindful of existing or similar federally funded or aligned initiatives or grants. Table seven references the disclosed federal or DHHS initiatives.

Table 7: Federal Initiatives	
Performing Provider(s)	**DSHS / Federal Funding**
Local Mental Health Authorities	Texas Department for Assistive & Rehabilitative Services (DARS) Texas Department of State Health Services (DSHS) mental health grants USDHHS to South East Texas Regional Planning Commission HITECH payments for HER incentives
Harris County Hospital District	Healthcare for the Homeless (Health Resources & Services Admin Breast & Cervical Cancer Control Program (DHHS) Retention after Hospitalization (National Institute of Mental Health Ryan White Funds (DHHS) Title IV Women's Program (DHHS) Expanded Testing (DHHS) SPNS (DHHS) MCH Title V (DHHS) TX/OKLA AIDS Education (DHHS) Ryan White Early Intervention (DSHS) HIV Perinatal Prevention (DHHS) CDC Prevention Grant (DHHS) Healthy Texas Babies (TXDHHS) BTGH Epilepsy Program (TXDHHS) Children w/Special Healthcare Needs (TXDHHS)

Description of Regional Health System and Challenges

As evidenced by the diverse population and economic dynamics of the communities participating in Region 3, by necessity the healthcare system serving this region is significant in size and complexity. The city of Houston is home to the world-renowned Texas Medical Center, which includes 49 of the most advanced medical research and academic institutions in the world, including three medical schools, six nursing schools, two schools of pharmacy, and schools of dentistry, public health, and virtually all health-related careers. [43] The region includes a total of 86 acute care hospitals with more than 13,000 inpatient beds (Table 7), providing a wide range of specialty services. In 2010, these facilities provided services for more than 1.6 million emergency room visits, 8.3 million outpatient visits, and more than 522,000 inpatient admissions.[44] The hospitals collected a total of nearly $41.8 billion in patient revenue and provided $3.48 billion in uncompensated care (8.3% of patient revenue).

Table 7: Hospital Utilization and Financial Experience – 2010

County	# of Hospitals	# of Beds	ER Visits	Outpatient Visits	Inpatient Admissions	Total Uncompensated Care	Total Patient Revenue	Uncomp. Care as % of Total Patient Revenue
Austin	1	23	5,021	63,846	620	$2,234,848	$21,722,744	10.3%
Calhoun	1	25	10,325	26,427	1,321	$6,274,008	$42,694,891	14.7%
Chambers	2	39	5,299	45,164	799	$3,452,446	$20,911,428	16.5%
Colorado	3	73	10,241	101,821	9,012	$5,198,957	$63,496,889	8.2%
Fort Bend	8	771	119,979	294,483	28,743	$116,670,008	$1,995,333,877	5.8%
Harris	59	12,098	1,441,087	7,684,098	476,500	$3,317,319,516	$39,395,686,451	8.4%
Matagorda	2	69	19,368	40,480	3,156	$16,185,582	$108,463,293	14.9%
Waller	0	0	0	0	0	0	0	0
Wharton	2	99	15,530	73,437	2,695	$17,740,547	$149,056,953	11.9%
TOTAL	**78**	**13,197**	**1,626,850**	**8,329,756**	**522,846**	**$3,485,075,912**	**$41,797,366,526**	**8.3%**

Source: Texas Department of State Health Services, 2010 Cooperative DSHS/AHA/THA Annual Survey of Hospitals and Hospitals Tracking Database

Serving the patients of Region 3 are more than 12,280 physicians from more than 200 specialties (Table 8).[45] These physicians are highly concentrated in Harris County, with 92.9% of physicians, followed by Fort Bend County with 5.7% of physicians. The remaining 7 counties in Region 3 account for only 2.4% of the region's physicians. It is important to note that six of the nine counties have no practicing psychiatrists, underscoring the challenges faced by the region in meeting the behavioral health needs of the population.

[43] Greater Houston Partnership, Partnership Research, 2011.
[44] 2010 Cooperative DSHS/AHA/THA Annual Survey of Hospitals and Hospitals Tracking Database
[45] Texas Medical Board, Physician Demographics by County and Specialty, January 2012.

Table 8: Physicians by County and Specialty – January 2012							
County	**General Practice, Family Medicine**	**Pediatrics**	**Internal Medicine**	**OB/GYN**	**General & Specialty Surgery**	**Psychiatry**	**Total Physicians - All Specialties**
Austin	5	1	3	0	0	0	10
Calhoun	7	1	5	2	0	0	18
Chambers	4	1	0	0	1	0	6
Colorado	13	1	2	1	3	2	29
Fort Bend	148	82	89	47	73	26	707
Harris	1150	1,187	1,549	484	1,037	461	11,425
Matagorda	7	4	8	5	3	0	38
Waller	2	1	1	0	0	0	4
Wharton	14	5	3	5	6	0	49
Total:	1,350	1,2823	1,660	544	1,123	489	12,286

Providers and community partners throughout the region have worked strategically to develop an extensive safety net system that includes more than 100 public and private organizations, most of which operate private non-profit, federally funded or public clinics that provide services for the uninsured. These organizations annually provide more than $1 billion in uncompensated care and are funded by a variety of sources, including patient fees, state and federal grants, state and local taxes, Medicaid and CHIP, and philanthropic donations. For the most part, these organizations are operated by clinical and administrative staff who works on a voluntary or low-cost basis.[46] Behavioral health services for the safety net population are provided by multiple organizations including the Mental Health and Mental Retardation Authority of Harris County (MHMRA), Texana Center, Gulf Bend Center, Spindletop Center, the University of Texas Harris County Psychiatric Center, the Harris County Hospital District, the Michael E. DeBakey Veteran's Affairs Medical Center of Houston, and a variety of mental health services delivered through public school programs. Inpatient psychiatric care is provided primarily by seven private, free-standing psychiatric hospitals.[47] Despite the range of services available, these options fail to meet the demand for care by more than 665,300 Houstonians with mental illness, including more than 181,500 who have a serious mental illness.[48] With only 23 total inpatient beds including 7 public beds per 100,000 people, the Harris county region falls well below the recommended standard of a total of 70 inpatient beds and a minimum of 50 public beds per 100,000.[49]

Serving as the focal point of the safety net is the publicly-funded Harris County Hospital District (HCHD) which operates three public hospitals, twelve community health clinics, eight school-

[46] Houston Health Services Research Collaborative for the Health of Houston Initiative, "Harris County Health Care Safety Net: Where We Stand 2010."
[47] Ibid.
[48] Mental Health Policy Analysis Collaborative, *The Consequences of Untreated Mental Illness in Houston.* Mental Health Policy Analysis Collaborative of the The Health of Houston Initiative of the University of Texas School of Public Health. September 2009.
[49] Ibid.

based clinics, one dental center, a health care program for the homeless, a specialty center for people with HIV/AIDS, and five mobile health facilities. Staff for the District hospitals and clinics is provided through a contractual arrangement with the Baylor College of Medicine and the University of Texas at Houston School of Medicine.

To meet the unique challenges of serving the population of more than 10,000 homeless people, the region created Healthcare for the Homeless-Houston. Designated a Federally Qualified Health Center (FQHC) in 2002, the program operates three integrated health clinics that provide comprehensive health services, with a specific focus on integrated primary and mental health care.[50] In 2010, health and support services were provided to more than 10,000 adults and children, including medical visits, medical case management, and a transportation services. Among nearly 900 homeless persons surveyed in 2010, 39% reported mental health disorders; 12% reported problems with alcoholism; and 55% reported they had a chronic health condition.[51]

However, despite the significant health care infrastructure, due to the volume of need, growing population and limited resources, the region continually struggles to keep up with the increasing demands for care. Access to care is clearly a critical issue for the Region that presents multiple challenges. With more than 1.2 million uninsured residents in the region, many people struggle to obtain even basic health care services. As reported by the Texas Primary Care Coalition, these patients rarely receive preventive, primary or continuous care and commonly have chronic conditions such as hypertension and diabetes that go unmanaged and untreated until the individual had an emergency condition that sends them to the emergency room. They often receive no care management and see multiple physicians and health care providers, resulting in duplicative and unnecessary diagnostic tests, lab work and screenings, contributing to unnecessary health care costs.[52]

According to the U.S. Department of Health and Human Services, every county in the region has been designated in part or in full a Medically Underserved Area/Population (MUA) and a Health Professional Shortage Area (HPSA).[53] Resolving this issue is not simple and requires long-term planning and infrastructure development necessary for the education and training of new physicians. This shortage of providers is particularly critical due to the growing population of Region 3 and the increased demand for services that is anticipated beginning in 2014 with implementation of health insurance tax credits for low income families. Preparing for these changes will require a comprehensive strategy and significant financial investment to ensure patients have timely access to the appropriate health care provider in the most cost-effective setting possible. Individuals without access to a medical home or primary care provider are more likely to seek care in an emergency room setting, resulting in significant increases in health care costs. A study of 2009 hospital emergency department visits in Houston found that primary-care

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[50] Held, Mary Lehman, Brown, Carlie Ann, Frost, Lynda E., Hickey, J. Scott Hickey, and Buck, David S., *Integrated Primary and Behavioral Health Care in Patient –Centered Medical Homes for Jail Releases with Mental Illness.*
[51] Coalition for the Homeless of Houston/Harris County. *Houston/Harris County 2010 Homeless Count & Survey and 2011 Homeless Enumeration Count.*
[52] The Primary Care Coalition, Texas Academy Family Physicians. The Primary Solution: Mending Texas' Fractured Health Care System, 2008.
[53] U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Primary Care. August, 2012.

related emergency department visits that could have been treated in a primary care setting resulted in costs of more than $214 million, up from $187 million in 2007.[54] Accessing inappropriate care through the emergency room not only is inefficient and costly, but it delays services for more critical patients who need services immediately, and potentially contributes to poorer health outcomes for these patients. Many of these costs and delays could have been avoided if patients had access to the services they needed through lower cost clinics and physician offices with extended hours that enable them to obtain non-urgent services at non-traditional times, and at facilities that are accessible. Improving access to these critically needed services is an important component of our Regional Plan and long-term strategy for ensuring patients have access to the most appropriate care at the right time and in the right place.

Key Challenges

As with any large urban community, our Region faces significant challenges in meeting the health care needs of our population. With nearly five million residents living within the Region and thousands more traveling to the region for health care services, our health care providers continually strive to provide the best patient care possible. However, to continue our efforts to become more efficient and more effective in the services we provide, we face significant challenges that will require a concerted effort to overcome. Following is a very brief summary of some of the key challenges we have identified and addressed in our plans for transforming the local health care system.

- **Inadequate number of primary and specialty care providers.** As discussed throughout this background overview, the region faces a significant shortage of primary and specialty care providers. Patients are unable to obtain to locate a provider willing to serve them, face extended waits for appointments, or are unable to locate a provider with extended hours in order to accommodate work schedules. Addressing this problem requires a long-term solution that includes development of the educational infrastructure as well as programs for attracting and retaining qualified providers.
- **High prevalence of chronic disease, including diabetes, heart disease, asthma, cardiovascular disease and cancer.** The region has high rates of chronic disease, which account for a significant portion of health care spending, are a leading cause of disabilities, and are factors in a majority of deaths. Many of these problems may be alleviated through a coordinated care system that includes improved access to care, patient education, and care management to ensure patients receive the right care at the right time in the right setting.
- **Diverse patient population speaking multiple languages, and with varying cultural backgrounds.** Improving the health care services for a diverse population requires a variety of approaches that are uniquely suited for each population. Without effective patient education and communication programs that address language and cultural barriers, patients will not receive the services they need for the best possible health outcomes and may delay seeking appropriate and preventive care.
- **High number of uninsured patients.** With more than one million uninsured patients, the region struggles to keep up with the demand for services. Patients do not receive basic health

[54] Houston Hospitals Emergency Department Use Study.

care services, delay treatment, and often seek primary care services through the emergency rooms, resulting in hundreds of millions of dollars in unnecessary spending.

- **High prevalence of behavioral health conditions and lack of an integrated care solution.** The region lacks both the providers and facilities to adequately meet the demand for behavioral health care, and is often unable to provide an integrated approach that meets both the physical and mental health care needs of the patient. Many individuals may receive either physical treatment or behavioral health care, but not both, or they receive no care at all. The current system is fragmented and difficult to navigate, and challenging for both patients and providers. These problems can be addressed by creating a health service system that is fully coordinated and integrated with behavioral health and primary health care, as well as services provided through school programs, criminal justice systems, and social service providers.
- **Fragmentation of patient services throughout a large, uncoordinated health care system.** Regardless of insurance status, many patients receive fragmented health care that is both inefficient and ineffective. Patients may receive duplicative and unnecessary services, which could be avoided through a regional integrated care system that maximizes the use of electronic health records and health information exchange. While implementation of coordinated care systems involves planning, training and communication strategies that maximize the use of technology and is both challenging and costly, the long-term benefits will be significant in terms of reductions in unnecessary services and costs, and improved patient care and outcomes.
- **Limited access to public transportation and emergency medical services.** Many patients live in areas that provide little or no options for public transportation to obtain medical care, and have very limited options for emergency transportation. Services vary greatly throughout the region, and are especially limited for those living in rural communities that have limited resources and large territories to cover. The absence of these services results in patients delaying necessary care until it becomes a critical health care condition, and relying on emergency transportation for services could have been provided in a primary care setting, or avoided entirely.
- **An aging population and increased need for high-cost services, including behavioral health care.** Although this problem is certainly not unique to Region 3, the large number of individuals that will require increased services (many of whom are already in poor health) poses significant problems. Dealing with these problems will require a coordinated delivery system approach that takes into account the unique physical and behavioral health needs and limitations of the elderly population and a community-wide effort to develop cost effective, long term solutions. Increasing the number of specialty providers, and providing additional training for primary care providers treating older patients are critical challenges that must be met to ensure these patients receive appropriate care and services to ensure the best healthcare outcome possible.
- **Inadequate IT infrastructure necessary for improved care coordination.** Though the region has made progress on the implementation of EHR, extensive expansion and implementation is necessary to meet the future needs of this community. Improvements in health care delivery as well as the monitoring and tracking of progress and outcomes are dependent on an effective program through which providers can track and share patient information and services.

Summary of Community Needs

ID #	Brief Description of Community Needs Addressed through RHP Plan	Data Source for Identified Need
CN.1	Inadequate access to primary care	1,2,5,8,12,13,15,16,17,19,20,21,30,32, 33,34,35,36,39,42,48
CN.2	Inadequate access to specialty care	1,2,12,13,15,16,17,19,25,30,32,33,34, 35,36,42, 48
CN.3	Inadequate access to behavioral health care	1,2,7,11,12,13,15, 16,17,20,21,27,28,48 29,30,33,34,35,36, 42
CN.4	Inadequate access to dental care	1,2,12,35
CN.5	Inadequate access to care for veterans and active military, particularly mental health and substance abuse services	1,7,29
CN.6	Inadequate access to treatment and services designed for special needs populations, including disabled, homeless, children, elderly	1,2,5,11,12,14,15, 16,17,31,32,34,37
CN.7	Insufficient access to care coordination practice management and integrated care treatment programs	1,2,6,8
CN.8	High rates of inappropriate emergency department utilization	1,2,38
CN.9	High rates of preventable hospital readmissions	1,2,4,18,38
CN.10	High rates of preventable hospital admissions	1,2,4,38
CN.11	High rates of chronic disease and inadequate access to treatment programs and services for illnesses associated with chronic disease, including • Cancer • Diabetes • Obesity • Cardiovascular disease • Asthma • AIDS/HIV	1,2,4,13,15,16,17, 24,25,26,32,34,40
CN.12	High rates of tobacco use and excessive alcohol use	1,2,3,9,34
CN.13	High teen birth rates	1,2,3
CN.14	High rates of poor birth outcomes and low birth-weight babies	1,2,3,41
CN.15	Insufficient access to services for pregnant women, particularly low income women	1,2,16,17,22,30,34,41
CN.16	Shortage of primary and specialty care physicians	1,8,34,35,36,39,42
CN.17	High rate of sexually transmitted diseases	1,2,3,9,25,26
CN.18	Insufficient access to integrated care programs for behavioral health and physical health conditions	1,6,7

CN.19	Lack of immunization compliance, resulting in rising incidence of preventable illnesses such as • Mumps • Measles • Pertussis • Tuberculosis	1,2,32
CN.20	Lack of access to programs providing health promotion education, training and support, including screenings, nutrition counseling, patient education programs	1,2,10,13,25
CN.21	Inadequate transportation options for individuals in rural areas and for indigent/low income populations	1,2,12,13,42
CN.22	Insufficient access to services that are specifically designed to address racial, ethnic and cultural health care disparities	1,2,8,13,23,34
CN.23	Lack of patient navigation, patient and family education and information programs.	1,2,13
CN. 24	Lack of care coordination and unnecessary duplication of services due to insufficient implementation and use of electronic health records	1,2,8
CN.25	Graduate medical education (residency training) in health care systems, team-based practice, quality improvement, and cost control	43, 44, 45, 46, 47

Community Need Assessment Reports and Resources:

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30. Greater Houston Partnership Health Care Policy Advisory Committee. *A Region in Crisis – A Call to Reduce the Uninsured and Expand Access to Health Care in the Ten County Houston Region.* February 2010.
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32. Cook Children's System Planning and Community Health Outreach. Cook Children's Community-Wide Children's Health Assessment and Planning Survey Report. 2010.
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34. Houston, Texas Institute for Health Policy. Health of Houston Survey 2010 – A First Look. The University of Texas School of Public Health.

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Section IV. Stakeholder Engagement

Section IV. Stakeholder Engagement

Development of a comprehensive and inclusive process for ensuring stakeholder participation has been a high priority since the beginning of RHP 3 planning efforts. As the anchor entity, the Harris Health System (HHS, previously known as the Harris County Hospital District, or HCHD) identified initial strategies for reaching out to the community to provide information on the waiver opportunity and invite public participation in the planning process. To begin the outreach activities, HHS publicized and hosted an initial planning meeting that was widely attended and served as the "kick-off" forum for the RHP activities. Local media were invited to attend, and several published news stories reached a circulation of readers that exceeds more than one million area residents.

As described at the initial meeting, a key goal of the RHP is to ensure active stakeholder participation from a broad cross section of community members representing every aspect of the health care delivery system. The Region includes a diverse mix of stakeholders from very different backgrounds and with varying levels of interest and expertise. Participation of representatives from a broad cross section of providers, consumers, health care advocates and community officials is critical to the success of this initiative and a key goal of the outreach and communication activities. To achieve this, several fundamental principles have informed and influenced our outreach plan:

- Provide participants with comprehensive and detailed information at all times;
- Communicate frequently and effectively, with an emphasis on transparency and the sharing of information;
- Provide an open, inclusive environment that welcomes and encourages participation at all levels; and
- Ensure stakeholders actively participate in all RHP activities and remain engaged at all times.

A. RHP Participants Engagement

Soon after the Harris Health System was identified as the anchor for Region 3, officials identified a comprehensive list of potential Performing Providers that included hospitals, Academic Health Science Centers, Community Mental Health Centers, local county governments and public health agencies throughout the Region. Within each organization, initial contacts were identified and were invited to begin working with HHS to participate in the process of developing a regional plan.

All of these entities, as well as other stakeholders, were invited to participate in the initial kick-off meeting held February 8, 2012. Among the well-attended meeting were hospital representatives from all facilities that were eligible for Medicaid Uncompensated Care (UC) payments. The meeting included an overview of the waiver activities and requirements, and a summary of the tentative timeline. Speakers included Texas State Representative Garnet Coleman, a local Member of the Texas House of Representatives who was instrumental in developing the legislation that authorized the waiver activities.

In March, key stakeholders were invited to attend the first meeting of the Regional Advisory Committee (RAC). The RAC was created to serve as an oversight entity that provides leadership and guidance for the Region. The RAC includes more than 40 members, including representatives of the hospital and non-hospital performing providers. All meetings are open to the public, but are primarily attended by RAC members.

In addition to providing another opportunity for communication and updates, the RAC meetings facilitate more technical discussions among the Performing Providers. Four RAC meetings have been held during the past 8 months. Throughout the duration of the waiver, meetings will be held on a quarterly basis, or more frequently if necessary. These meetings will provide an opportunity to discuss progress, share experiences and challenges, review reporting requirements, and discuss other issues relevant to the waiver.

As described in Section B. below, Performing Providers also participated in large numbers in stakeholder meetings and in the activities of nine workgroups created to discuss specific community needs and care transformation options. Performing Providers also participated in a Public Summit to discuss project options and identify potential partnerships among providers within the Region, and to encourage all hospitals to participate in DSRIP projects. Providers also attended Public Hearings held throughout the region to present the RHP plan and solicit comments from the general public. In addition to the RAC meetings, more than 40 additional meetings have been held throughout the region to discuss regional health care needs, ideas for improvement, and specific projects for consideration by the Performing Providers. Performing Providers were involved at all levels of these discussions and provided significant input into the identification and development of specific project initiatives. Performing Providers will continue to participate in stakeholder meetings held on a regular basis throughout the life of the waiver.

B. Public Engagement

One of the first steps towards engaging stakeholder participation was creation of a website devoted entirely to providing information on activities related to the Southeast Texas Regional Healthcare Plan (see http://www.setexasrhp.com/go/doc/4807/1326403/). The website is an effective tool for communicating information and updates, and for inviting stakeholders to participate in the planning process. The anchor administrators developed an extensive distribution list and encouraged recipients to forward information to others who would be interested in participating in the planning process. A link to the RHP 3 website was also provided on the Harris Health System website. Individuals who visited the website were invited to provide contact information so they could receive regular updates.

Information on the website was widely distributed through the hospital district's communication channels. Other partners, including Performing Providers, were enlisted to also distribute DSRIP planning information and inform individuals of the Region 3 website link. Throughout the planning activities, the Region used the website to post updates from the Health and Human Services Commission; announce meeting dates and locations; provide draft planning documents and project initiatives; and invite comments and feedback from stakeholders. More than 675 people enrolled to receive regular updates through the email distribution list, and that number continues to grow as new people become engaged in this ongoing process.

Prior to the first stakeholder meeting, Performing Providers and other stakeholders were encouraged to submit community needs assessments to HHS. More than 75 documents were submitted covering the entire region and virtually every aspect of the health care system. A detailed review of those documents resulted in the identification of nine general categories of primary needs. Based on this analysis, the following nine workgroups were created:

- Access to Care
- Disease Management
- Health Promotion
- Hospital Utilization
- Information Technology
- Behavioral Health/Substance Abuse
- Pediatrics
- Women's Health/Birth Outcomes
- Workforce

Stakeholders and Performing Providers from throughout the Region were invited to attend meetings of each of the nine workgroups. Over five months, each workgroup met four times for a total of 36 meetings. Where facilities could accommodate it, stakeholders were able to participate via phone conference. Hundreds of individuals attended the meetings, during which participants identified specific community needs and health care improvements related to each of the topics. In subsequent meetings, stakeholders drafted specific projects and identified key priorities. This information was distributed to all Performing Providers, who used the recommendations in selecting the project initiatives included in the Regional Plan.

Numerous meetings were also held throughout the counties participating in the Region. Meetings were open to the public and were attended by varying numbers of stakeholders. Below is a summary of the schedule of meetings held to date:

March:
• 9 Stakeholder Meetings over a 3 day period
• Regional Advisory Committee
April:
• 9 Stakeholder Meetings over a 3 day period
• Regional Advisory Committee
• Commissioner's Court presentations
• County Judge and Commissioners meeting
May:
• 9 Stakeholder Meetings over a 3 day period
• Regional Advisory Committee
• Behavioral Health Collaborative
• 3 County Judge and Commissioners meetings
• 2 Fort Bend County Workgroup meetings
• 2 Chambers County Workgroup meetings
• Calhoun County Workgroup meeting
• Matagorda County Workgroup meeting

June:
• 2 Calhoun County meetings
• 2 Chamber County meetings
• 1 Fort Bend County meeting
• 2 Matagorda County meetings
• 1 Waller County workgroup meeting
• 1 Waller County Commissioner's Court meeting
• 1 Wharton County meeting
July:
• 9 Stakeholder Meetings over a 2 day period
• Regional Advisory Committee
• 2 IGT Performing Providers Collaboration meetings
• Austin County Workgroup meeting
• 2 Colorado County meetings
• 2 Fort Bend County meetings
• 2 Matagorda County meetings
• 2 Wharton County meetings
August:
• Behavioral Health Collaboration meeting
• 1 Chambers County meeting
• 2 Pre and Post Summit Reviews
• 3 IGT Collaboration meetings
September:
• Regional Planning Summit
• 3 IGT Collaboration meetings
• Public Meeting to Present Plan
October:
• 3 IGT Collaborations
• Regional Advisory Committee meeting
November:
• Public Hearing # 2 – November 20, 2012

Organizations and individuals that participated during the planning and development of our Plan included:

- Consumers
- Patient advocacy representatives
- Public and private hospitals
- Academic Health Centers
- Primary care providers, behavioral health providers, and specialty care providers representing an extensive list of health care practice areas
- Local medical and hospital societies
- Ancillary providers
- Local government officials
- Community planners and administrators
- FQHC administrators and service providers
- Community care clinics
- MHMR Community Centers

- Safety net providers;
- Representatives of religious organizations

Representatives of the local county medical society were also heavily involved in all meetings, and have provided significant input into the planning process. They have been instrumental in communicating information to providers in the Region, and have been a supportive partner in our activities. A letter indicating their participation and support is included in the Addendum, as well as letters of support from other stakeholders.

As the waiver planning and implementation process continues during the coming months and years, we are committed to continuing and improving our communication and outreach strategy, and will ensure stakeholders remain engaged and informed about the implementation, evaluation and review process. Regular community updates will be provided through the website, public meetings, and other communications. We will work with our Performing Providers to provide periodic project updates through various venues, including websites, newsletters and other communication media used by the providers. At least annually, a summary report will be published on the RHP website.

Section V. DSRIP Projects

A. Category I

Baylor College of Medicine

Pass 1

Project Option 1.1.1- Establish more primary care clinics: New Baylor Teen Health Clinic at the Tejano Center for Community Concerns

Unique RHP Project ID: 082006001.1.1
Performing Provider Name/TPI: Baylor College of Medicine/082006001

Summary:
Provider: The Baylor Teen Health Clinic (BTHC) operates seven clinic sites in medically underserved areas throughout Houston and sees all patients who seek care, regardless of ability to pay.
Intervention: This project will expand the BTHC service area by opening a new clinic at the Tejano Center for Community Concerns, which provides transitional housing services for the Houston community.
Need for Project: The TCCC is located in a medically underserved area. The population is predominantly non-white, and there are few clinics specifically targeting at-risk youth.
Target Population: The target population includes females ages 13-23 and males ages 13-25. Approximately 50% of patients qualify for the Women's Health Program, 15% qualify for Medicaid, and 45% do not have health insurance.
Category 1 Expected Benefits: The clinic will provide access to age-appropriate, comprehensive primary care services for 4,000 patients by DY5.
Category 3 Expected Benefits:

- Reduce STI rates by 5% compared to baseline by DY5.
- Reduce teen pregnancy rates by 2% compared to baseline by DY5.

Project Option 1.1.1- Establish more primary care clinics: New Baylor Teen Health Clinic at the Tejano Center for Community Concerns

Unique RHP Project ID: 082006001.1.1

Performing Provider Name/TPI: Baylor College of Medicine/082006001

Project Description:

Texas has the nation's 4th highest teen pregnancy rate (88 per 1000 Texas girls vs. 70 per 1000 US girls)[55], is third in the nation for teen birth rates (60.7 per 1000 Texas girls vs. 39.1 per 1000 US girls)[56], and is number one in the nation for repeat teen births (23% in Texas vs. 19% in the US)[1]. Harris County birth rates nearly mirror Texas rates at 63 births per 1000 females aged 15-19[57]. Unintended pregnancy is particularly prevalent among African-Americans and Hispanics. Rates of sexually transmitted infections (STI) in Harris County are also much higher than those seen in the nation. For example, Harris County rates of gonorrhea are 916.2 per 100,000 population ages 15-19 vs. 520.9 in the United States.

The Baylor Teen Health Clinic (BTHC) at seven sites in inner city Houston offers accessible, age-appropriate, comprehensive primary care services to adolescents and young adults living in inner-city Houston, where the economic and health disparities are the greatest. Its services include family planning, screening and treatment for STI and HIV, mental health screening, immunization administration, health risk reduction education, prenatal care, sports physicals, wellness exams, nutrition services, counseling and case management. In addition to providing primary care services, the BTHC works with community partners to connect patients to medical specialists as well as dental, mental health and adoption services. The clinic sites currently serve the Greater Third Ward, Greater Fifth Ward, Kashmere Gardens and Acres Home neighborhoods. In 2011, the BTHC had a total of 9,895 unduplicated client visits at the seven sites. During 2011, there were 2,165 chlamydia cases, 671 gonorrhea cases, 22 syphilis cases and 22 HIV cases. A total of 876 teens between the ages 13-22 tested positive for a pregnancy.

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

The BTHC will establish a clinic at the Tejano Center for Community Concerns (TCCC) in the southeast part of the county to serve as the medical home for adolescents and young adults. By addressing the age-specific needs of the patient population, the BTHC will provide targeted, age-appropriate family planning and STI counseling and treatment in order to lower STI and teen birth rates. These goals are aligned with the regional goals of expanding access to primary care in order to deliver the right care at the right time, reducing teen birth and STI rates. The BTHC increases access to primary care in medically underserved areas and treats all patients who request care, regardless of ability to pay.

[55] University of Wisconsin Population Health Institute, Robert Wood Johnson Foundation. County Health Rankings and Roadmaps, Harris County. (2012). County Health Rankings. http://www.countyhealthrankings.org/#app/texas/2012/harris/county/1/overall.

[56] Texas Department of State Health Services. Birth Data To Texas Residents 2005-2009, Customized Queries. http://soupfin.tdh.state.tx.us/birth05.htm. (accessed August 1, 2012).

[57] County Health Rankings & Roadmaps. 2012 Harris, Texas, Teen Birth Rate. http://www.countyhealthrankings.org/node/2758/14. Accessed October 1, 2012.

Challenges:
As indicated previously, Harris County teen birth and STI rates are much higher than the national rates. The BTHC will provide access to family planning services and contraception to reduce the number of unplanned teen births. It will also provide sexual health counseling and STI treatment to decrease the STI rate in the adolescent and young adult populations.

5-Year Expected Outcome for Provider and Patients:
Access to primary care will be increased for 1,500 unique patients by DY 5, with at least 10,000 cumulative patient visits anticipated in the first three years. STI rates will be reduced by 5% compared to the patient population's baseline through counseling and treatment. Teen birth rates will be decreased by 2% compared to the baseline.

Baseline:
Baseline data (teen birth and STI rates) for the specific patient population will be established during the first year of the clinic's opening.

Rationale:
The purpose of BTHC is to provide an affordable medical home for underserved adolescents and young adults. Established in 1971, the BTHC has a track record of engaging and empowering teens and young adults. Its care team, which includes physicians, nurse practitioners, social workers and pharmacists, provides both comprehensive and holistic care to its patients.

The clinic at the TCCC is proximal to several medically underserved areas in Houston[58,59,6] and will provide access to care for the predominantly Hispanic and Latino population[60]. The metrics selected reflect salient health needs of the adolescent and young adult population, including access to education, counseling and care for STIs and teen pregnancy. Reproductive and sexual health is one of the seven priorities identified in the National Prevention Strategy published by the National Prevention Counsel and the Office of the Surgeon General[61]. The BTHC provides services that address each of the four specific recommendations put forth in the strategy: access to preconception and prenatal care; reproductive and supportive services for sexually active teens, pregnant and parenting women; sexual health education, particularly for adolescents; and early detection and treatment of STIs.

Project Components:
Not Applicable / The project option 1.1.1 does not have components

Milestones & (Metrics):
Process Milestones and Metrics: P-2 (P-2.1); P-5 (P-5.1)

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[58] Census Tracts 3115, 3116 and 3117 are immediately adjacent to Census Tract 3201 in which the TCCC is located.
[59] U.S. Department of Health and Human Services, Health Resources and Services Administration. Find Shortage Areas: MUA/P by State and County. http://muafind.hrsa.gov/index.aspx. Accessed October 1, 2012.
[60] United States Census 2010. 2010 Census Interactive Population Search. http://2010.census.gov/2010census/popmap/. Accessed October 1, 2012. Census Tracts 3115, 3116, 3117, 3201, 3202, 3329, 3330.
[61] National Prevention Council, *National prevention Strategy,* Washington, DC: U.S. Department of Health and Human Services, Office of the Surgeon General, 2011.

Improvement Milestones and Metrics: I-12 (I-12.1); I-X (I-X.1, I-X.2, I-X.3)

The BTHC proposes increases in STI counseling, STI treatment and family planning services as improvement measures for the target population, which lacks access to these and is at particular risk. Nearly 50% of newly diagnosed STIs occur among young adults aged 15-24 years[62]. According to the CDC, 40% of sexually active teens did not use a condom the last time they had sex[63]. The counseling services at the BTHC focus on reduction of risk behaviors, and success will be measured through the proposed Category 3 measures below.

Increased access to family planning and contraception services is another proposed improvement measure. High rates of teen birth in the county (63 per 1,000 females aged 15 to 19) and high rates of repeat teen births (23%) [64] make preventing teen pregnancy a cost effective and healthy strategy.

The mission of the BTHC is to provide access to affordable care for at-risk, underserved teens in the community. By reducing health-risk behaviors through counseling and preventive care, the BTHC will help provide tools for its young patients to make responsible decisions and become contributing members of society.

Unique community needs identification number:

This project addresses the following community needs according to the community needs assessment:

- CN1 – Access to primary care
- CN13 – Reduction in teen birth rates
- CN17 – Reduction of high rates of sexually transmitted infections

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

This project significantly enhances the existing delivery system as the expansion to the TCCC will improve primary care access for adolescents and young adults in an area that is medically underserved.

Related Category 3 Outcome Measures:

OD- 1 Primary Care and Chronic Disease Management

- IT-1.20 Other Outcome Improvement Target: Reduction of STI Rate among Adolescents and Young Adults
- IT-1.20 Other Outcome Improvement Target: Reduction of Pregnancy Rate among Adolescents and Young Adults

Reasons/Rationale:

Because the BTHC focuses on prevention, the proposed Category 3 milestones and metrics are reduced STI and teen pregnancy rates. The chronic illness milestones identified on the Category 3 do not address the salient health issues faced by adolescents and young adults.

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[62] Weinstock H, Berman S, Cates W. Sexually transmitted diseases among American youth: incidence and prevalence estimates, 2000. *Perspectives on Sexual and Reproductive Health* 2004;36(1):6-10.

[63] http://www.cdc.gov/healthyyouth/sexualbehaviors/index.htm. Accessed September 27, 2012.

[64] Child Trends. Percentage of All Teen Births That Are Repeat Births, and Number of Births to Mothers Under 20, in Large Cities, 2008. http://www.childtrends.org/Files/Child_Trends_2011_04_14_FG_RepeatBirths2011.pdf. Accessed October 1, 2012.

Because STIs disproportionately affect this population, it is a more appropriate metric that clearly measures the success of the STI counseling proposed in the Category 1 improvement measures.

Similarly, teen pregnancy reduction is an appropriate measure for this population. The milestones identified in Category 3 pertain to improvements in low birth weight, infant mortality, etc., which do not apply if pregnancy is avoided altogether. Decreasing teen pregnancies and births will indicate that the BTHC succeeds in providing access to family planning and contraception services.

Relationship to Other Projects:

Like the Fifth Ward Clinic (project 082006001.2.1), the BTHC will provide primary care services in a medically underserved area. However, the BTHC is situated in a different geographic area and targets a specific age cohort.

Relationship to Other Performing Providers' Projects in the RHP:

Primary Care/Ambulatory Care clinics are a top priority to Region 3 due to the acuity of the regional patient mix, population concentration, and lack of primary care access points for our patient base. The regional approach of collaboration as well as existing patient referral pattern relationships allowed our team to properly identify the community needs based on the necessity of population, uninsured, and medically underserved patient bases. This program is consistent with our region and similar to numerous initiatives in our RHP plan sharing both concepts as well as outcome measures focused to percent improvement over baseline of patient satisfaction scores, reduction of inappropriate ED utilization, and third next available appointment status. The Region 3 Initiative Grid attached as a RHP Plan addendum reflects a grid of relationship for all initiatives.

Plan for Learning Collaborative:

We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system.

Project Valuation:

The value of this project was determined by an econometrics assessment of access to primary care; STI counseling, screening and treatment; and teen pregnancy prevention. The value assigned to primary care is based on cost avoidance of emergency room visits. The difference between the cost of an emergency room visit and the cost of a primary care visit for primary-care-treatable conditions per visit was calculated for the age groups in question[65]. Historical data were reviewed to determine the percentage of preventive and acute care visits. Rather than assume that all acute care visits could result in an emergency room visit, the project value conservatively estimates that a fraction of acute care visits results in an avoided emergency room visit.

[65] School of Public Health, *Houston Hospitals Emergency Department Use Study: January 1, 2010 through December 31, 2010,* Houston, Texas: University of Texas Health Science Center at Houston, 2012.

Researchers at the CDC have evaluated the cost effectiveness of STI treatment[66] and developed formulae to assess the direct and indirect cost savings of education, screening and treatment. The formula developed for HIV costs averted by HIV counseling and testing was used to calculate the estimated bundle amount for STI counseling, as HIV counseling is included in all STI education, and screening is available to all patients. The estimated bundle amount for STI treatment was based on the pro rata sequelae costs averted for the treatment of gonorrhea, which is a more conservative estimate than that for treatment of chlamydia or syphilis. Historical data were reviewed to determine the percentage of men vs. women treated. The value for decreases in STI rates is based on treatment and pro rata sequelae costs averted because of reductions in the infections in the population, assuming the reductions occur in a patient population of 1,000 patients.

The National Campaign (to Prevent Teen and Unplanned Pregnancy) determined that the cost to Texas taxpayers for teen births in the state between 1991 and 2004 was $15.1 billion[67]. This cost includes medical expenses, welfare services and productivity loss. The costs averted were broken further into episodic costs that include the cost of delivery and healthcare for mother and child the first year after birth. The remainder was prorated for the life of the Waiver. The expected success of family planning was based on the average teen birth rate for Harris County and the weighted average effectiveness for different types of contraception[68] based on the historical administration rates. Teen pregnancy rates in the neighborhoods currently serviced by the Teen Clinic are higher than the Harris County average. By reducing the pregnancy rate, we will achieve additional savings in healthcare costs and taxpayer burden that are not duplicated in the estimated bundle for the rendering of contraception management services.

The total value for the project was combined and distributed across measures to ensure category 3 outcome measurements comprised 5%, 10%, 15% and 20% of the project value in DY2-5. Distribution among the components was based on the weighted value of the measure.

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[66] Chesson HW, Collins D, Koski K. Formulas for estimating the costs averted by sexually transmitted infection (STI) prevention programs in the United States. *Cost Effectiveness and Resource Allocation.* 2008; 6:10.

[67] The National Campaign. By the Numbers: The Public Costs of Teen Childbearing in Texas, November 2006. http://www.thenationalcampaign.org/costs/pdf/states/texas/fact-sheet.pdf. Accessed October 1, 2012.

[68] CDC, Reproductive Health, Contraception. http://www.cdc.gov/reproductivehealth/unintendedpregnancy/contraception.htm Accessed October 4, 2012.

082006001.1.1	*1.1.1*	*N/A*	*NEW BAYLOR TEEN HEALTH CLINIC AT THE TEJANO CENTER FOR COMMUNITY CONCERNS*	
Baylor College of Medicine				*082006001*
Related Category 3 Outcome Measure(s):	*IT-1.20* *IT-1.20*	*082006001.3.1* *082006001.3.2*	*Reduction of STI Rate among Adolescents and Young Adults* *Reduction of Pregnancy Rate among Adolescents and Young Adults*	

Year 2 (10/1/2012 – 9/30/2013)	**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]: Implement a community-based clinic at the TCCC. <u>Metric 1</u> [P-2.1]: Open one additional clinic at the TCCC. Goal: Documentation of expansion plan. Data Source: New primary care schedule. Milestone 1 Estimated Incentive Payment: $ 300,000 **Milestone 2** [P-5]: Hire one mid-level provider for the TCCC. <u>Metric 1</u> [P-5.1]: Documentation of hiring. Goal: Hire one additional mid-level provider. Data Source: Documentation from Human Resources. Milestone 2 Estimated Incentive Payment: $ 283,000	**Milestone 3** [I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. <u>Metric 1</u> [I-12.1]: Increase number of visits. Baseline: 2,500 patient visits. Data Source: Patient registry / scheduling system. Milestone 3 Estimated Incentive Payment: $ 156,000 **Milestone 4** [I-X]: Provide STI counseling and screening to prevent STI transmission. <u>Metric 1</u> [I-X.1]: Implement counseling service. Goal: 1,000 visits that include STI counseling. Data Source: Patient registry / medical record. Milestone 4 Estimated Incentive Payment: $ 28,000 **Milestone 5** [I-X]: Treat patients for STIs to reduce transmission and prevent sequelae.	**Milestone 7** [I-12]: Increase primary care clinic volume. <u>Metric 1</u> [I-12.1]: Increase number of visits by 50% over baseline. Goal: 3,500 patient visits. Data Source: Patient registry / scheduling system. Milestone 7 Estimated Incentive Payment: $ 160,000 **Milestone 8** [I-X]: Increase STI counseling and screening. <u>Metric 1</u> [I-X.1]: Increase number of visits by 50% over baseline. Goal: 1,500 visits that include STI counseling. Data Source: Patient registry /medical record. Milestone 8 Estimated Incentive Payment: $ 29,000 **Milestone 9** [I-X]: Increase STI treatments. <u>Metric 1</u> [I-X.2]: Increase STI treatment services by 50% over	**Milestone 11** [I-12]: Increase primary care clinic volume. <u>Metric 1</u> [I-12.1]: Increase number of visits by 100% over baseline. Goal: 4,000 patient visits. Data Source: Patient registry / scheduling system. Milestone 11 Estimated Incentive Payment: $ 162,000 **Milestone 12** [I-X]: Increase STI counseling and screening. <u>Metric 1</u> [I-X.1]: Increase number of visits by 100% over baseline. Goal: 2,000 visits that include STI counseling. Data Source: Patient registry / medical record. Milestone 12 Estimated Incentive Payment: $ 30,000 **Milestone 13** [I-X]: Increase STI treatments. <u>Metric 1</u> [I-X.2]: Increase STI treatment services by 100% over

DRAFT

082006001.1.1	*1.1.1*	*N/A*	*NEW BAYLOR TEEN HEALTH CLINIC AT THE TEJANO CENTER FOR COMMUNITY CONCERNS*
Baylor College of Medicine			*082006001*
Related Category 3 Outcome Measure(s):	*IT-1.20* *IT-1.20*	*082006001.3.1* *082006001.3.2*	*Reduction of STI Rate among Adolescents and Young Adults* *Reduction of Pregnancy Rate among Adolescents and Young Adults*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	Metric 1 [I-X.2]: Implement treatment services. Baseline: 800 visits for STI treatment. Data Source: Patient registry / medical record. Milestone 5 Estimated Incentive Payment: $ 91,000 **Milestone 6** [I-X]: Provide birth control services to prevent unplanned teen pregnancy. Metric 1 [I-X.3]: Implement contraception services. Baseline: 500 patients who accept contraception. Data Source: Patient registry / medical record. Milestone 6 Estimated Incentive Payment: $ 297,000	baseline. Goal: 1,200 visits for STI treatment. Data Source: Patient registry / medical record. Milestone 9 Estimated Incentive Payment: $ 93,000 **Milestone 10** [I-X]: Increase birth control services. Metric 1 [I-X.3]: Increase contraception services by 50% over baseline. Goal: 750 patients who accept contraception. Data Source: Patient registry / medical record. Milestone 10 Estimated Incentive Payment: $ 304,000	baseline. Goal: 1,600 visits for STI treatment. Data Source: Patient registry / medical record. Milestone 13 Estimated Incentive Payment: $ 94,000 **Milestone 14** [I-X]: Increase birth control services. Metric 1 [I-X.3]: Increase contraception services by 100% over baseline. Goal: 1,000 patients who accept contraception. Data Source: Patient registry / medical record. Milestone 14 Estimated Incentive Payment: $ 307,000
Year 2 Estimated Milestone Bundle Amount: $ 583,000	Year 3 Estimated Milestone Bundle Amount: $ 572,000	Year 4 Estimated Milestone Bundle Amount: $ 586,000	Year 5 Estimated Milestone Bundle Amount: $ 593,000
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:** $ 2,334,000			

Bayshore Medical Center

Pass 1

Project Option: 1.1.2 Expand Primary Care Capacity: Expand Obstetrical and Gynecological Care Capacity in East Houston
Performing Provider: HCA Bayshore Medical Center/020817501
Unique Project ID: 020817501.1.1

- Provider: Bayshore Medical Center is a 476-bed facility with its main campus situated in Pasadena, Texas, with an additional campus called East Houston Regional Medical Center located in Houston, Texas. The facility is located in the Houston-Sugarland-Baytown MSA, which serves a population of approximately 6,000,000 people.
- Intervention(s): HCA intends to expand OB/Gyn care capacity in the existing community clinics by recruiting two (2) new OB/Gyns to the area and by hiring additional support staff. HCA also intends to expand the service hours and days in existing clinics. Finally, HCA will relocate a Pasadena clinic in order to allow for better care coordination and access.
- Need for the project: HCA chose this project because Harris County has a higher rate of low-birth weight than the statewide rate, a lower rate of mammography screening than the statewide rate, and a rate of sexually transmitted infections equal to the statewide rate. These specific problems, along with myriad of others particular to women of a reproductive age, can be treated and often prevented when women have regular access to an OB/Gyn, thus making it imperative for Harris County to increase the availability of these providers in the community.
- Target population: The target population of this project is women of reproductive age seeking OB/Gyn services through HCA's OB clinics in East Houston. The three clinics currently provide 3500-4500 patient encounters. Of these patients, 93-100 % are Medicaid-eligible or uninsured. The project is intended to improve access for the clinics' existing patients and to allow the clinics to treat a greater volume of Medicaid and uninsured patients in the future.
- Category 1 or 2 expected patient benefits: HCA expects that, by recruiting additional OB/GYNs to the East Houston community to maintain and expand obstetrical and gynecological care access for the East Houston patient population, patient satisfaction and health outcomes will improve. HCA expects a 5% increase in volume of clinic patients from DY3 to DY4, and a 5% increase in volume of clinic patients from DY4 to DY5. In DY3, HCA will recruit and retain two additional OB/Gyns, and will expand its hours at the main clinic to include one additional weekday per week and one weekend per month. Finally, in DY4, HCA will relocate its Pasadena clinic into a larger site that is more convenient to access via public transportation.
- Category 3 outcomes: IT 8.2 – Bayshore intends to reduce the number of low-weight births to its clinic clients by reducing the number of unhealthy pregnancies and early deliveries through regular access to OB/Gyn care. Those reductions should increase the infants' short- and long-term health outcomes, and reduces the cost of providing care to the mothers and infants. The percentage reduction will be determined in DY3.

Project Option 1.1.2 Expand Primary Care Capacity: Expand Obstetrical and Gynecological Care Capacity in East Houston

Unique RHP Project ID: 020817501.1.1
Performing Provider Name/TPI: HCA Bayshore Medical Center/020817501

Project Description:
HCA will expand the availability of obstetrical services through existing OB Clinics located in the service areas of Bayshore Medical Center and East Houston Regional Medical Center. HCA will do this by recruiting new OB/GYNs to the East Houston area to help with a growing community need. East Houston is an area projected to grow by 8.6% over the next five years and has a current deficit of 20.6 OB/GYNs according to a needs assessment completed in October of 2011.

Goal(s) and Relationship to Regional Goal(s):
Project Goals:
HCA intends to expand OB/Gyn care capacity in the existing community clinics by recruiting two (2) new OB/Gyns to the area, by hiring additional support staff, and by expanding the hours of the existing clinics. Additional goals include:

- Expansion of services hours in existing clinics by one day per week and one weekend per month
- Relocating the Pasadena clinic location to a larger space that is closer to the local FQHC (in order to allow for care coordination) and closer to a bus stop
- Increase staffing in the existing OB/Gyn clinics with additional medical assistants (2) , one Office Coordinator, and one Medicaid Enrollment Coordinator

This project addresses the following Region 3 goals:
While the Region has many specific objectives and improvement targets based on stakeholder input and community needs assessments, the over-arching goals that have guided many of our decisions include the following:

- Develop a regional approach to health care delivery that leverages and improves on existing programs and infrastructure, is responsive to patient needs throughout the entire region, and improves health care outcomes and patient satisfaction.
- Increase access to primary and specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their condition, regardless of where they live or their ability to pay.
- Transform health care delivery from a disease-focused model of episodic care to a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary or duplicative services, and builds on the accomplishments of our existing health care system, and

- Develop a culture of ongoing transformation and innovation that maximizes the use of technology and best-practices, facilitates regional collaboration and sharing, and engages patients, providers, and other stakeholders in the planning, implementation, and evaluation processes.

Challenges:
HCA expects the biggest challenge for this project to be identifying and securing quality OB/GYNs that are willing to practice in Houston, where there is currently a shortage of these providers, and treat a growing population of indigent patients. HCA will address this challenge by offering competitive benefits and seeking candidates with a calling to treat traditionally underserved populations.

5-Year Expected Outcome for Provider and Patients:
HCA expects that, by recruiting additional OB/GYNs to the East Houston community to maintain and expand obstetrical and gynecological care access for the East Houston patient population, patient satisfaction and health outcomes will improve. OB/Gyns are able to provide primary care in the form of annual checkups for women of reproductive age in the community, and also to provide specialty services for women with specific gynecological and obstetric needs. Improving patient access to these services in a preventative and ongoing capacity is expected to result in improved health outcomes for pregnant women and women at risk for gynecological conditions, and to result in reduced long-term costs for treating women in need of regular gynecological and obstetric services.

Starting Point/Baseline: HCA's 3 current OB/Gyn clinic locations include: Midwives of East Houston – Main Office; Midwives of East Houston – Wayside; and Midwives Care Clinic – Pasadena. These locations see patients on Tuesdays and Wednesdays. The clinics are currently served by a total of nine (9) OB/Gyns. . With a total of three clinics, they average 387 patients/month (East Houston: 252 patients/month; and Pasadena: 97patients/month; Wayside: 38 patients/month). The targeted population is indigent woman of child-bearing age and indigent woman with gynecologic needs.

Rationale:
HCA chose this project because Harris County has a higher rate of low-birth weight than the statewide rate, a lower rate of mammography screening than the statewide rate, and a rate of sexually transmitted infections equal to the statewide rate. These specific problems, along with myriad of others particular to women of a reproductive age, can be treated and often prevented when women have regular access to an OB/Gyn, thus making it imperative for Harris County to increase the availability of these providers in the community. To compound the issue, Harris County has a higher rate of uninsured residents than the statewide rate (almost 1 in 3 residents),

meaning that access to OB/Gyns willing to treat indigent patients is also imperative for the health of women in Harris County.

Project Components:
HCA will meet the core requirements of this project in the following manner:

a. Expand primary care clinic hours: HCA will increase the hours at the Main Office by at least one day per week and offer weekend hours at least once per month, enabling working and school-age girls to access OB/Gyn primary care.
b. Expand primary clinic space: HCA will relocate its Pasadena clinic location into a larger space that is closer to an FQHC and public transportation.
c. Expand primary care clinic staffing: HCA will recruit two (2) additional OB/Gyns into its community clinics, and will hire additional staff to support the increased patient load, which will include two (2) new MAs, an Office Coordinator, and a Medicaid Enrollment Coordinator.

Unique Community Needs Identification Numbers:

- CN.1- Inadequate access to primary care
- CN.2- Inadequate access to specialty care
- CN.13- High teen birth rates
- CN.14- High rates of poor birth outcomes and low birth-weight babies
- CN.15- Insufficient access to services for pregnant women, particularly low income women
- CN.16- Shortage of primary and specialty care physicians
- CN.17- High rate of sexually transmitted diseases

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

This project represents an expansion of an existing initiative, which is to provide OB/Gyn services through local clinics to patients who might otherwise have difficulty accessing primary and preventative OB/Gyn care.

Related Category 3 Outcome Measures:
OD 8: Perinatal Outcomes; IT 8.2: Percentage of Low birth weight births

Bayshore chose this outcome because one intended consequence of increasing community access to OB/Gyns is to reduce the number of unhealthy pregnancies and reduce the number of early deliveries. Those reductions should result in fewer infants being born with low birth weight, which increases their short- and long-term health outcomes, and reduce the cost of providing care to the mothers and infants.

Relationship to Other Projects: The increased access to primary care visits will naturally generate additional need of specialty care visits based on the condition and acuity of the patients served. Understanding that the patient base targeted through this initiative will generate significant specialty care visits due to chronic conditions and lack of previous treatments, this initiative and similar initiatives will focus to 30-day readmission rate reductions, improvement for patient satisfaction scores, and admission rates specific to chronic conditions. Numerous initiatives have been included in the RHP plan and the addendum of the Initiative Grid can directly tie all specialty care projects together by category.

Plan for Learning Collaborative: We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system.

Project Valuation: The valuation of each HCA project takes into account the degree to which the project accomplishes the triple aim of the Waiver: community needs, the population served by the project (both number of people and complexity of patient needs), and investment required to implement the project. Specifically, this project valuation incorporates the difficulty of recruiting and retaining OB/GYN providers, and need for increasing the number of local providers in the local clinics to meet patient demand. The valuation also takes into account the emphasis that the Region 3 DSRIP work groups have placed on the expansion of specialist services such as OB/GYN care.

020817501.1.1	***1.1.2***	***A-C***	***EXPAND PRIMARY CARE CAPACITY: EXPAND OBSTETRICAL AND GYNECOLOGICAL CARE CAPACITY IN EAST HOUSTON***
HCA – Bayshore Medical Center			*020817501*
Related Category 3 Outcome Measure(s): OD-6	*020817501.3.1*	***IT-8.2***	***Percentage of Low birth weight births***

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-5]: Train/hire additional primary care providers and staff. Metric 1[P-5.1]: Documentation of increased number of providers and staff Baseline/goal: Recruit and retain two (2) additional OB/Gyns to serve in HCA's three local clinic spaces. Data Source: Documentation of physician's recruitment and retention Milestone 1 Estimated Incentive Payment *(maximum amount):* $3,610,752	**Milestone 2** [P-5]: Train/hire additional primary care providers and staff. Metric 1[P-5.1]: Documentation of increased number of providers and staff Baseline: 2 OB/Gyns hired in DY2 Goal: Recruit and retain two (2) Medical Assistants, one (1) Office Coordinator, and one (1) Medicaid Enrollment Coordinator to serve in HCA's three local clinic spaces. Data Source: Documentation of support staff recruitment and retention Milestone 2 Estimated Incentive Payment: $1,969,568 **Milestone 3** [P-4]: Expand the hours of a primary care clinic, including evening and/or weekend hours. Metric 1[P-4.1]: Increased number of hours at primary care clinic over baseline Baseline: The three clinic sites currently provide services two (2) days per week (Tuesdays and Wednesdays).	**Milestone 4** [P-1]: Relocate primary care clinic. Metric1 [P-1.1]: Expanded space Baseline/goal: Bayshore relocate its Pasadena clinic location to a larger space that it identifies as more convenient to public transportation and closer to the local FQHC Data source: floor plan and location information of new space, and documents evidencing the relocation Milestone 4 Estimated Incentive Payment: $1,975,293 **Milestone 5** [I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 [I-12.1]: Documentation of increased number of visits. Demonstrate improvement over prior reporting period. Goal: HCA will measure the clinic	**Milestone 6** [I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 [I-12.1]: Documentation of increased number of visits. Demonstrate improvement over prior reporting period. Goal: HCA will measure the clinic volume of patients during DY4, and demonstrate a 5% improvement during DY5. Data Source: Clinic registry and/or electronic health records Milestone 6 Estimated Incentive Payment: $ $3,263,529

020817501.1.1	***1.1.2***	***A-C***	***EXPAND PRIMARY CARE CAPACITY: EXPAND OBSTETRICAL AND GYNECOLOGICAL CARE CAPACITY IN EAST HOUSTON***
HCA – Bayshore Medical Center			*020817501*
Related Category 3 Outcome Measure(s): OD-6	*020817501.3.1*	***IT-8.2***	***Percentage of Low birth weight births***

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	Goal: the OB/Gyn Main Office will provide clinic care for at least one additional day per week (totaling three days per week) and for one weekend day per month. Data Source: Clinic documentation from DY2 and DY3 showing increase in hours Milestone 3 Estimated Incentive Payment: $1,969,568	volume of patients during DY3, and demonstrate a 5% improvement during DY4. Data Source: Clinic registry and/or electronic health records Milestone 5 Estimated Incentive Payment: $1,975,293	
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $$3,610,752	Year 3 Estimated Milestone Bundle Amount: $$3,939,136	Year 4 Estimated Milestone Bundle Amount: $ $3,950,587	Year 5 Estimated Milestone Bundle Amount: $ $3,263,529
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)**:*** $ $14,764,004			

Project Option: 1.7.1 Implement Telemedicine program to provide or expand specialist referral services in an area identified as needed to the region: Behavioral Health Telemedicine Services
Performing Provider: HCA Bayshore Medical Center/020817501
Unique Project ID: 020817501.1.2

- Provider: Bayshore Medical Center is a 476-bed facility with its main campus situated in Pasadena, Texas, with an additional campus called East Houston Regional Medical Center located in Houston, Texas. The facility is located in the Houston-Sugarland-Baytown MSA, which serves a population of approximately 6,000,000 people.
- Intervention(s): HCA intends to expand its existing telemedicine program to include a 24/7 tele-psychiatry program in its Bayshore Emergency Department (ED), as well as implementing telemedicine capabilities in the EDs at its other local hospitals. Specifically, HCA will identify the necessary technology to establish the program, reach out to behavioral health providers to participate, train the ED staff at each hospital to effectively use the new capabilities, and will implement protocols for obtaining tele-psychiatry consults and referrals to and from Bayshore.
- Need for the project: Currently, the time from "Initial Contact to Assessment Completion" at the other HCA hospital EDs includes four hours (on average) for the QMHP to arrive, another two hours to complete the assessment, and additional time to obtain a transfer for treatment (which can take days). As a result, the BH/SA patients often languish in area EDs for days awaiting a transfer. This project is intended to more efficiently use the limited staff resources when dealing with overcrowding in the Bayshore ED to provide consults to its own patients and the patients in its sister EDs in a timelier manner.
- Target population: The target population of this project is the residents of the community with behavioral health and substance abuse issues who are likely to seek care in area EDs. HCA's Houston EDs experience 8000-9500 BH/SA related visits per year, with 2800-3500 requiring in-depth psychiatric assessments for appropriate placement. Of these patients, approximately 57-67% are Medicaid-eligible or uninsured. The average time from decision to transfer for these patients is 4-8 hours. Bayshore's ED receives 500-650 BH/SA patient requiring in-depth psychiatric assessments per year, which leads to overcrowding when coupled with the fact that many patients are put in a hold pattern for hours, or even days.
- Category 1 or 2 expected patient benefits: The 24/7 telemedicine capability system should improve the quality, timeliness, and efficiency of consultations and referrals provided to BH/SA patients at hospitals in the area. After implementing the telemedicine program in DY3, HCA expects a 10% increase in the number of telemedicine consults in DY4, and a 20% increase in the number of telemedicine consults in DY5.
- Category 3 outcomes: IT 11.1 – Bayshore will reduce the average ED wait time for BH/SA patients in DYs 3-5, addressing the disparity in access to care that BH/SA patients often experience in all domains, including primary care and up through acute care services. BH/SA patients' health outcomes will improve as they spend less time in EDs and more time receiving the treatment they need. The target annual reductions will be determined in DY3.

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Project Option - 1.7.1 Implement Telemedicine program to provide or expand specialist referral services in an area identified as needed to the region: Behavioral Health Telemedicine Services

Performing Provider/TPI: Bayshore Medical Center/020817501
Unique project ID number: 020817501.1.2

Project Description:

HCA intends to expand its existing telemedicine program to include a 24/7 tele-psychiatry program in its Bayshore Emergency Department (ED), as well as implementing telemedicine capabilities in the EDs at West Houston Medical Center, East Houston Regional Medical Center (a campus of Bayshore), Clear Lake Regional Medical Center and Woman's Hospital. The service areas will include the primary and secondary zip codes at these three hospitals which are located in Harris County (Bayshore: 77501, 77502, 77503, 77504, 77506, 77012, 77017, 77034, 77505, 77508, 77536, 77571, 77587, East: 77015, 77530, 77013, 77029, 77044, 77049, 77547 West: 77072, 77082, 77083, 77036, 77042, 77077, 77094, 77099, 77450, Clear Lake: 77058, 77059, 77062, 77586, 77598, Woman's: Harris County) This initiative will result in BH/SA patients from those area EDs, who often have to wait several days for a consult or referral, being rerouted to Bayshore after an initial assessment by a Bayshore (or other) psychiatrist via telemedicine (because Bayshore has psychiatric inpatient beds).

Specifically, HCA will identify the necessary technology to establish the program, reach out to behavioral health providers to participate in the tele-psychiatry program, train the ED staff at each hospital to effectively use the new capabilities, and will implement protocols for obtaining tele-psychiatry consults and referrals to and from Bayshore.

Goals and Relationship to Regional Goals:

Project Goals:

The goal of this project is to reduce the time it takes for BH/SA patients presenting in Bayshore's ED and other HCA EDs in the area to obtain a consultation and/or referral for care. In order to accomplish that goal, Bayshore hopes to increase the number of patients who are able to access telemedicine consultations after the program's inception, and are either transferred to Bayshore from other area EDs, or from Bayshore to non-hospital appropriate care settings.

This project meets the following Region 3 Goals:

While the Region has many specific objectives and improvement targets based on stakeholder input and community needs assessments, the over-arching goals that have guided many of our decisions include the following:

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- Develop a regional approach to health care delivery that leverages and improves on existing programs and infrastructure, is responsive to patient needs throughout the entire region, and improves health care outcomes and patient satisfaction.
- Increase access to primary and specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their condition, regardless of where they live or their ability to pay.
- Transform health care delivery from a disease-focused model of episodic care to a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary or duplicative services, and builds on the accomplishments of our existing health care system, and
- Develop a culture of ongoing transformation and innovation that maximizes the use of technology and best-practices, facilitates regional collaboration and sharing, and engages patients, providers, and other stakeholders in the planning, implementation, and evaluation processes.

Challenges:

- Identifying and recruiting willing telepsychiatry providers to furnish consultations and/or referrals to Bayshore and other area hospitals' ED patients – in order to address this challenge, the hospital will offer competitive compensation to participating providers, and will seek out providers with a calling to treat traditionally underserved patients.
- Identifying and implementing the most effective technology for operating the program – Bayshore will address this challenge by researching the available options and making a reasoned decision, focused on value, cost, and feasibility.
- Training providers to use the new technology – Bayshore will address this challenge by taking time with the ED staff at Bayshore and other area HCA hospitals to orient them to using the technology, and by creating protocols to guide ED providers.
- Coordinating with the other participating hospitals to ensure smooth patient transitions: Patients will need to be transferred from the other area hospitals to Bayshore when the assessment from their consults is that they require inpatient psychiatric care. Coordinating this transition will require protocols and process, which Bayshore will work with the participating providers to develop and implement.

5-year Expected Outcome for Provider and Patients:

Bayshore expects that its own ED patients and those at its sister facilities will benefit from the program because the 24/7 telemedicine capability will mean no longer having to wait in the Bayshore ED until a psychiatrist is on-site and/or available for a consult and/or referral. This system is intended to improve the quality, timeliness, and efficiency of consultations and referrals provided to patients presenting at Bayshore's ED and other HCA hospitals in the area. Bayshore expects to experience a reduced cost in treating these patients, as they will spend less time waiting in the ED and will experience improved health outcomes. Additionally, Bayshore expects its provision of care to other patients in the ED to improve, as there will be more efficient triaging/transferring/discharge of BH/SA patients into the appropriate setting of care, allowing increased resources to be dedicated to emergent patients.

Starting Point/Baseline:

Currently, the time from “Initial Contact to Assessment Completion” at the other HCA hospital EDs includes four hours (on average) for the QMHP to arrive, and another two hours to complete the assessment. These assessments and/or eventual referrals are done entirely face-to-face, and are usually outsourced to providers not employed by Bayshore. After the initial assessment, it can take up to several days to obtain a transfer to Bayshore for treatment; meanwhile, the BH/SA patient is languishing in the ED. At Bayshore, the ED is overcrowded with patients needing ED consults, which Bayshore cannot provide in a timely manner due to limited staff. The volume for these ED patients is currently averaging 150 assessments per month.

Rationale:

Bayshore chose this project because most of Houston is comprised of federally-designated Health Provider Shortage Areas (including Harris County Hospital District, and many geographical areas within and around Houston) in the domain of mental health. The shortage of providers must be addressed through innovative solutions, such as telemedicine, because the ratio of BH/SA providers to residents with need is only shrinking as the population grows and the amount of money available to pay for health care decreases. Harris County suffers from a higher rate of violent crime, lack of adequate social support, unemployment, and children living in poverty than the statewide average, each of which are conditions that can lead to increased need and utilization of behavioral healthcare/substance abuse services. When patients’ conditions reach an acute level, they often end up in the ED and spend an extended amount of time there (while their conditions worsen and other patients experience longer waits than would otherwise be necessary). Providers must be equipped to quickly assess their conditions and where to best treat them. The telepsychiatry program will make this a quicker and less expensive process for Bayshore and area hospitals, while improving patient outcomes and satisfaction.

Project Components:

Bayshore will address the core components in the following manner:

a) Provide patient consultations by medical and surgical specialists as well as other types of health professional using telecommunications – Bayshore will create relationships with psychiatric service providers who are available to provide consults and referrals (where appropriate) 24 hours a day, seven days a week through technology implemented to allow meaningful assessments. Additionally, Bayshore psychiatrists will provide consults at the local HCA hospital EDs via mobile telehealth units, allowing for expedient transfer of patients to Bayshore when necessary.

b) Conduct quality improvement for project using methods such as rapid cycle improvement – Bayshore will participate in a bi-annual face-to-face meeting with other providers in the RHP performing similar projects to share lessons learned, best practices, and identify key challenges and areas for improvement.

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Unique community need identification number the project addresses:

- CN.3- Inadequate access to behavioral health care
- CN.10- High rates of preventable hospital admissions

Related Category 3 Outcome Measures:

OD-11; IT 11.1: Improvement in Clinical Indicator in Identified Disparity Group

Bayshore chose this outcome because one goal behind providing more timely access to consultations and referrals for BH/SA patients in the ED is to address the disparity in access to care that BH/SA patients often experience, starting the primary care domain and extending through access to acute care services. BH/SA patients' health outcomes will improve as they spend less time in EDs and more time receiving the treatment they need. Thus, the clinical indicator that Bayshore will measure is ED wait time to treatment and/or referral and transfer to the appropriate care setting, and the population identified will be BH/SA patients.

Relationship to Other Projects: This behavioral health telemedicine project is one of two projects aimed at improving delivery of behavioral health services. It is part of HCA's larger plan of expanding and developing specialty services along with delivery improvements targeted to particular populations (e.g., geriatric patients and behavioral health patients).

Relationship to Other Performing Providers' Projects in the RHP: An innovative approach to increasing access to primary care and specialty care has been created by the miracles of the internet and computer systems. Telemedicine is leading edge for those communities who cannot easily access behavioral health or specialty care due to remote locations, lack of physicians, or urgency of encounter needs. Numerous telemedicine projects have been proposed, as seen in the Region 3 Initiative grid in the addendum, and all focus to outcomes such as appropriate emergency department utilization, 30-day readmission rates, and patient satisfaction scores.

Plan for Learning Collaborative: We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system.

Project Valuation: The valuation of each HCA project takes into account the degree to which the project accomplishes the triple aim of the Waiver: community needs, the population served by the project (both number of people and complexity of patient needs), and investment required to implement the project.

Project valuation rationale: Specifically, this project valuation considers the difficulty of implementing tele-psychiatry capabilities and integrating those capabilities into the emergency departments at these hospitals, as well as the expected benefits to behavioral health patients presenting at the emergency departments. The valuation also takes into account the emphasis that the Region 3 DSRIP work groups have placed on the expansion of specialist services and improved access to behavioral health services.

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020817501.1.2	1.7.1	A-B	IMPLEMENT TELEMEDICINE PROGRAM TO PROVIDE OR EXPAND SPECIALIST REFERRAL SERVICES IN AN AREA IDENTIFIED AS NEEDED TO THE REGION: BEHAVIORAL HEALTH TELEMEDICINE SERVICES
HCA – Bayshore Medical Center			020817501
Related Category 3 Outcome Measure(s): OD-6	020817501.3.2	IT-11.1	Improvement in Clinical Indicator in identified disparity group

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1 [P-3]: Create or expand a telemedicine program for selected medical specialties, based upon community and regional need. Metric 1[P-3.1]: Documentation of program materials including implementation plan, vendor agreements/contracts, staff training and HR documents. Baseline/goal: Establish a tele-psychiatry program at Bayshore and other area at least three other HCA hospitals in the community, allowing for more timely consultations and referrals of BH/SA patients by specialist providers, resulting in transfers to and from Bayshore (where appropriate); implementation will include identifying provider partners, implementing the technology, training the staff, and creating protocols and process for transfers and referrals Data Source: Program materials Milestone 1 Estimated Incentive	**Milestone 2** [P-11]: Participate in face to face learning at least twice per year with other providers and the RHP to promote collaborative learning around similar projects. Metric 1 [I-11.1]: Participate in semi-annual face to face meetings or seminars Baseline/Goal: Bayshore hopes to share ideas with other providers using telemedicine in order to identify best practices and address key challenges going forward. Data Source: Documentation of semiannual meetings, including agendas, slides, and/or notes Milestone 2 Estimated Incentive Payment: $2,132,567 **Milestone 3 [P-X1]:** Establish a baseline. Metric [P-X.1]: the number of telemedicine visits for specialty identified as high need	**Milestone 4** [I-12]: Increase the number of telemedicine visits for each specialty identified as high need. Metric 1[1-12.1]: Number of telemedicine visits Goal: Increase the number of ED patients at Bayshore, East Houston, West Houston, and Woman's Hospital presenting with BH/SA needs utilizing tele-psychiatry by 10% over baseline established in DY 3 Data source: ED health records for BH/SA patients treated Milestone 4 Estimated Incentive Payment: $4,277,532	**Milestone 5** [I-12]: Increase the number of telemedicine visits for each specialty identified as high need Metric 1[1-12.1]: Number of telemedicine visits Goal: Increase the number of ED patients at Bayshore, East Houston, West Houston, and Woman's Hospital presenting with BH/SA needs utilizing tele-psychiatry by 20% over baseline established in DY 3. Data Source: ED health records for BH/SA patients treated Milestone 5 Estimated Incentive Payment: $3,533,614

020817501.1.2	1.7.1	A-B	IMPLEMENT TELEMEDICINE PROGRAM TO PROVIDE OR EXPAND SPECIALIST REFERRAL SERVICES IN AN AREA IDENTIFIED AS NEEDED TO THE REGION: BEHAVIORAL HEALTH TELEMEDICINE SERVICES
HCA – Bayshore Medical Center			020817501
Related Category 3 Outcome Measure(s): OD-6	020817501.3.2	IT-11.1	Improvement in Clinical Indicator in identified disparity group

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Payment: $3,909,573	Goal: determine the percentage of ED patients at Bayshore, East Houston, West Houston, and Woman's Hospital presenting with BH/SA needs who utilize the new tele-psychiatry program. Data source: ED health records for BH/SA patients treated at the aforementioned facilities Milestone 3 Estimated Incentive Payment: $2,132,567		
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $3,909,573	Year 3 Estimated Milestone Bundle Amount: $4,265,134	Year 4 Estimated Milestone Bundle Amount: $4,277,532	Year 5 Estimated Milestone Bundle Amount: $3,533,614
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $15,985,853			

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City of Houston Department of Health and Human Services

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Project Option - Project Option 1.8.9 - Expansion of school-based sealant and/or fluoride varnish programs that provide sealant placement and/or fluoride varnish applications to otherwise un-served school-aged children by enhancing dental workforce capacity.

Unique Project ID: 0937740-08.1.1

Performing Provider Name/TPI: Houston Department of Health and Human Services/0937740-08

Project Summary: Provider: The performing provider, Houston Department of Health and Human Services (HDHHS) is the public health authority for Houston, Texas with a population of 2.1 million in 2010. HDHHS has 1,100 employees and a budget of $100,245,403. HDHHS serves the City of Houston through 44 distinct programs. HDHHS provides core public health services to all Houston residents such as air and water quality monitoring and restaurant inspections; birth and death certificates; leadership in emergencies such as hurricanes; operates a comprehensive regional reference laboratory, provides communicable disease prevention and control and surveillance and a variety of health and human services such as the Women, Infants and Children (WIC) nutrition program, senior nutrition services, family planning, oral health services and immunizations via a network of 4 health centers, 14 WIC sites and the Harris County Area Agency on Aging.
Intervention(s): This new project will improve dental health in Medicaid/CHIP or indigent populations by: 1) expanding oral health services for children 6 mos to age 18 in HDHHS dental clinics 2) expanding an evidence-based dental sealant program for elementary school children in low income areas 3) initiating new oral health services for eligible perinatal women through three months post-partum.
During HDHHS' last fiscal year, 10,000 visits were provided via the HDHHS dental clinics. Of this #, 19% were Medicaid clients, 4% on CHIP and 77% uninsured. The project will expand to provide 900 more visits per year. The dental sealant program served 4063 children of which 49% were Medicaid clients, 28% CHIP and 27% uninsured. The project will expand to serve 4000 more children per year. The new perinatal oral health services program will provide 1200 visits per year.
Need for the Project: Early Childhood Caries (ECC) is the most common chronic condition found in young children. Disproportionately affecting low income children, ECC results in infection, pain, and early tooth loss. The project will utilize prevention models and services (screening, oral health education, sealants, and fluoride varnish) that drive down unnecessary caries and costs.
Target Population: The primary target population for the three program components are low income children ages 1-18, at risk 2nd graders that are in schools with a high proportion of minority and low income families and low income eligible perinatal women through post-partum.
Category 1 or 2 expected patient benefits: Increase by 5% over baseline the number of special population members that access services in past 12 months in DY4 and increase by 10% over baseline the number of special population members that access services in past 12 months.
Category 3 outcomes: IT-7.1 Dental Sealant: Increase percentage of children age 6-9 with a dental sealant on a permanent first molar tooth by 5% over baseline in DY4 and by 10% over baseline in DY5 IT-7.2 Cavities: Increase percentage of children with untreated dental caries by 2% over baseline in DY4 and by 5% over baseline in DY5.

Project Option 1.8.9 - Expansion of school-based sealant and/or fluoride varnish programs that provide sealant placement and/or fluoride varnish applications to otherwise un-served school-aged children by enhancing dental workforce capacity through collaborations and partnerships with dental and dental hygiene schools, local health departments, federally qualified health centers, and/or local dental providers: Oral Health Services for At-Risk Populations

Unique Project ID: 0937740-08.1.1
Performing Provider: City of Houston Department of Health and Human Services/ 0937740-08

Project Description:
The City of Houston Health and Human Services (HDHHS) proposes to a) initiate new diagnostic and preventive oral health services for perinatal and safety net eligible persons b) expand Project Saving Smiles (dental sealant program for 2nd graders) and c) link more patients to a dental home.

This project seeks to enhance dental health in underserved populations by: 1) expanding diagnostic, preventive, restorative, and surgical oral health services for safety net eligible persons, 2) expanding an evidence based dental sealant program for elementary school children, Project Saving Smiles and 3) initiating diagnostic, preventive, restorative, and surgical oral health services for eligible perinatal women through three months post-partum

Safety Net Oral Health Services
Houston Department of Health and Human Services (HDHHS) currently provides comprehensive dental care for children ages six (6) months of age through 21 years of age. Title V funding is used to fund these services in addition to the general fund dollars that are allocated by the City of Houston. This project will expand existing services to provide access to safety net oral health services for additional children.

Dental Sealants Program, Project Saving Smiles
Project Saving Smile, which was established more than 5 years ago by HDHHS, provides screening, oral health education, sealants, and fluoride varnish for at-risk 2nd graders. At-risk 2nd graders are identified through partnerships with individual schools, school principals and through Houston Independent School District (HISD), which is the third largest school district in the US. HISD has a very high percentage of minority populations and a large number of schools have a large proportion of low income students receiving free or reduced cost breakfast and lunch program. Currently, Project Saving Smile has a limited capacity, and only able to serve a few schools. Second graders from at-risk, low income schools will be targeted for the expansion of Project Saving Smile. The project will link these 2nd graders to a dental home.

Perinatal Oral Health
The project will also add oral health services for pregnant women to the mix of oral health services offered by HDHHS. By providing perinatal diagnostic, preventive, restorative, and surgical oral health services (during pregnancy and through the third month post-partum), the

performing provider will improve the health and quality of life for at-risk Houston area mothers and their children.

By the end of the three months post-partum the project would1) link the perinatal patients to a dental home, 2) provide anticipatory guidance for perinatal women and their children, 3) promote and support breastfeeding practices with anticipatory guidance, e.g., wiping the baby's gums after breast or bottle feeding and 4) provide a coordinated effort between the prenatal and oral health provider to promote utilization of dental services during pregnancy.

Plaque causing oral diseases, dental caries, gingivitis, and periodontitis can be prevented with optimal oral hygiene. Good oral health during pregnancy and throughout life is imperative to promote health and quality of life for the mother. It also prevents vertical pathogenic bacteria transmission from mother to child, as well as horizontal pathogenic bacteria transmission among all. Yet, many prenatal patients do not receive oral health care services during pregnancy despite evidence that poor oral health can have adverse pregnancy outcomes. There are barriers to care for pregnant women stemming from the patient herself and from the health care system. Due to a lack of understanding about oral health services during pregnancy, oral health and prenatal providers limit their patients' oral health care during pregnancy. Research supports the benefits of providing dental care during pregnancy clearly outweigh any potential risks. Routine access to oral health services is imperative throughout life. With young children, there is an opportunity to begin prevention and for them to enjoy optimal oral health for life.

HDHHS will address and reduce the vertical transmission, mother to child movement, of pathogenic bacteria by treating common oral conditions found in pregnancy, e.g., gingivitis, dental caries, infections due to cariogenic bacteria. In so doing, HDHHS anticipates treating fewer cases of Early Childhood Caries (ECC) among the child patients it serves. The ECC is defined as tooth decay in children under six years of age. The timely provision of oral health services during pregnancy serves to address oral problems thus avoiding systemic infections and the risk of transmission of cavity causing bacteria from the mother to her children. While there is ongoing research, the evidence to date suggests that periodontal treatment during pregnancy does not affect the frequency of low birth weight babies or preterm births, and is safe for the fetus and the mother. The American College of Obstetricians and Gynecologists note: "Caries, poor dentition, and periodontal disease may be associated with an increased risk for preterm delivery. It is very important that pregnant women continue usual dental care in pregnancy. The dental care includes routine brushing and flossing, scheduled cleanings, and any medically needed dental work."

Goals and Relationship to Regional Goals:

The goal of this project is to partner with Dental providers, Dental Schools, School Districts, School principals and other stakeholders and provide services to underserved population who are at risk for poor oral health. The primary goal is to close gaps in access to dental care in certain sub-population groups. The target population addressed for this project will be perinatal women and elementary school children (aged 6-9 years). This is directly related to the regional goal of alleviating dental health disparities by provision of access to dental care. By enhancing access to Preventive Care in high risk populations, a long term investment in dental health ensues.

<u>Project Goals:</u>

The overall goal of this program is to improve oral health in underserved or under-served populations, specifically perinatal women and children.

- Close gaps/disparities in access to dental care services

This project meets the following regional goals:

- Increase access to primary and specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their condition, regardless of where they live or their ability to pay.
- Transform health care delivery from a disease-focused model of episodic care to a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary or duplicative services, and builds on the accomplishments of our existing health care system.

Challenges:
Some of the challenges that the provider anticipates are 1) Developing an efficient and effective referral process: a) For Safety Net Dental Operations - For dental procedures beyond the HDHHS' scope of services, continue referring to Harris Health System for oral surgery, University of Texas School of Dentistry for Endodontics, Pediatric Dentistry, Orthodontics, and for Oral Surgery 2) Ensuring a dental home for all – disposition of patients after application of dental sealant: For patients with restorative or surgical dental needs and for those with just preventive needs, refer them to their dental home. If they do not have a dental home and do not have private dental insurance, refer them to HDHHS dental clinics to be their dental home. 3) Disposition of patient post-perinatal period – finding a dental home post-perinatal period (three months post-partum): a) If the patient is age-eligible for the HDHHS dental program, retain the patient within the program to complete her restorative and/or surgical care, as well as, to meet their preventive needs b) If the patient is not age-eligible, refer the patient to Harris Health System, Federally Qualified Health Center Dental Clinic, and/or University of Texas School of Dentistry to complete her restorative and/or surgical care, as well as, to meet their preventive needs. Additionally, the challenges mentioned will be addressed by instituting an efficient follow-up process. This follow up procedures will be in place for 60-90 days after the patient completes the program.

5 Year Expected Outcome for Providers and Patients:
The Houston Department of Health and Human Services (HDHHS) as the primary provider expects to see a reduction in early childhood caries in low-income zip codes that have been identified by the Houston Independent School District as those with greater than 70% of students on free/reduced lunch program. The provider also expects to see better dental health in perinatal women and the newborn children in the underserved areas of Houston. Due to the comprehensive nature of the program, dental health in underserved areas is likely to improve among high-risk populations.

Starting Point/Baseline:
Currently, no comprehensive program exists that targets improvement in dental health of perinatal women, young infants, and young elementary school children in high risk populations living in underserved areas. Baseline will be established by the end of in DY 2 of the project for proportion of children with dental sealant and for proportion of children with dental caries.

Rationale:
Oral disease is common in the underserved population. Oral disease can lead to poor nutrition; serious systemic illnesses and conditions such as poor birth outcomes, diabetes, and

cardiovascular disease; and a diminished quality of life and life expectancy. Inadequate access to oral health services compounds other health issues. It can result in untreated dental disease that not only affects the mouth, but can also have physical, mental, economic, and social consequences. Fortunately, many of the adverse effects associated with poor oral health can be prevented with quality regular dental care, both at home and professionally. Increasing, expanding, and enhancing oral health services will improve health outcomes.

Children who have regular access to a dental provider are more likely to have received preventive dental services such as sealant placement. Children who have regular access to a dental provider are less likely to suffer from untreated dental caries. The Centers for Disease Control and Prevention rate the application of sealants within a school-based setting as one of two strongly recommended evidence-based dental public health prevention methods. There is clearly a return on investment associated with dental sealants when applied within a school sealant program: for every $28 spent on placing one dental sealant and preventing decay, at least $70 will be saved by not filling a one-surface cavity.

This program will reach the underserved target population on Medicaid or CHIP as well as many indigent in previously identified zip codes. This program has the potential to improve dental health among at risk population and help close dental health disparity gaps in our population. Cost incurred to the health care system from those that do not have a dental home, or those that do not have access or availability due to other barriers is significant. These are avoidable costs and this program will help offset a portion of this cost by providing care before there is a dental health emergency. The prevention of early childhood caries (ECC) through the provision of oral health services and education for the mother serves to address the documented morbidity and mortality associated with ECC. Among US children, ECC is the most common chronic condition found in young children and yet it is the most prevalent untreated condition in children. Disproportionately affecting low income children, ECC results in infection, pain, and early tooth loss. The ECC is prevalent, costly, and preventable. There are prevention models in place that can affect these statistics while driving down unnecessary caries and costs.

Additionally, dental sealants are cost effective thin coatings applied to the chewing surface of the molar/back teeth to prevent cavities. The painless application of sealants fill-in the deep pits and grooves where food and plaque (bacteria) accumulate. Some 90% of dental caries occur on the occlusal surface of the molars, the targeted surface for sealants. The Centers for Disease Control and Prevention rate the application of sealants within a school-based setting as one of two strongly recommended evidence-based dental public health prevention methods. There is clearly a return on investment associated with dental sealants when applied within a school sealant program: for every $28 spent on placing one dental sealant and preventing decay, at least $70 will be saved by not filling a one-surface cavity.

Project Components:

This project has no required core components. Major features of the project include:

a) Increase services to young elementary school children in low income area schools in partnership with the school district and the individual schools, by providing a sealant placement program off-site.

b) Partnership with University of Texas Dental School, local dental providers to provide enhanced services to target population.

c) Connect all patients to dental home.

d) Implement provision of services to perinatal women, most of who are on Medicaid, through a combination of education, diagnostic, preventive and surgical services to perinatal women through three months post-partum.

Due to the performing provider's experience and established networks in serving low income population, this program will benefit from these experiences. Nevertheless, program processes will be refined and improved through a Plan-Do-Check-Act process. The goal of continuous quality improvement is to establish a cyclical, continuous process of planning, assessing, monitoring, analyzing, measuring and evaluating performance to improve desired outcomes. It is expected that revisions to the protocol, training requirements, partnership processes and expectations will need to be clarified on a regular basis. These will be improved through the PDSA process. Initial program enrollment of a small number of target population will help iron out the program weaknesses and allow for a continuous improvement process.

Unique community need identification numbers that project addresses:

- CN.4 Inadequate access to dental care
- CN.15 Insufficient access to services for pregnant women, particularly low income women
- CN.22 Insufficient access to services that are specifically designed to address racial, ethnic and cultural health care disparities

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

Currently there are no programs that provide comprehensive population based dental health care to underserved perinatal women. This program will provide dental care to perinatal women, young children and school age children in underserved communities, since there is a lack of access and utilization of care in the targeted communities. This programs aims to close gaps/disparities in access to dental care services and enhance the quality of dental care as well as build capacity in the region by training providers. The project will also expand service capacity in safety net oral health services for children provided at HDHHS dental clinics and expand service capacity in the Project Saving Smiles, dental sealant program.

Related Category 3 Outcome Measures:

OD-7 Oral Health

IT-7.1 Dental Sealant: Percentage of children age 6-9 with a dental sealant on a permanent first molar tooth (Healthy People 2020; CMS Oral Health Initiative goal

IT-7.2 Cavities: Percentage of children with untreated dental caries (Healthy People 2020)

Reasons /rationale for selecting the outcome measures:

The primary outcome measures chosen for this project are: increase in sealant application and reduction in dental caries in elementary school children aged 6-9 years. Elementary school children of this age are a particularly vulnerable because they lose their "baby" teeth and new teeth emerge. In order to ensure the best possible prognosis for the future optimal dental health, both outcomes will be tracked and evaluated. Perinatal women seen in this program will be tracked in terms of an *output measure* to show an increase in number of women served and offered diagnosis, treatment and preventive care. Improved dental health during the perinatal and postnatal period has positive implications for the dental health of both the mother and the child.

Relationship to Other Projects and Plan for Learning Collaborative:

Project results and lessons learned will be disseminated to other members in the regional learning collaborative to share lessons learned and discuss quality improvement strategies. We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system.

Dental services for both adult and children is a service that is currently underfunded and incomplete in access for the targeted patient base. The dental initiatives represented in the RHP plan are specific to community need and location of the patient to ensure strong access to treatment. The outcome measures focus to the reduction of emergency room utilization, patient satisfaction, as well as increase access to the service line. The Region 3 initiative grid in the addendum directly reflects all relationships of dental initiatives.

Project Valuation:

HDHHS utilized two categories to calculate value for each DSRIP project. The first category is Prioritization and the second is Public Health Impact (see attachment for HDHHS Valuation Tool). HDHHS scored the project on a scale of 1 (poor) to 9 (exceptional) for each of the six factors that comprise the Prioritization category. The Prioritization category includes the following factors: 1) Transformational Impact, 2) Population Served / Project Size, 3) Alignment with Community Needs, 4) Cost Avoidance, 5) Partnership Collaboration, and 6) Sustainability. Each factor was then given a weighted score based on the score rated and a pre-determined percentage weight. The six weighted scores were added to get a composite score for the Prioritization category.

Public Health includes activities which seek to achieve the highest level of health for the greatest number of people. Public Health also focuses on preventing problems from happening or re-occurring through programs and activities that promote and protect the health of the entire community. As a public health department, HDHHS added an additional valuation category of Public Health Impact that looked at projects through a public health lens. The Public Health Impact category includes the following factors: 1) Alleviate Health Disparity, 2) Control Communicable and Chronic Disease , 3) Prevention Orientation, 4) Population Health Focus, 5) Access and Connection to Health Services and 6) Evidence Based Health Program. HDHHS scored the project on a scale of 1 (poor) to 9 (exceptional) for each of the six factors that comprise the Public Health Impact category. Each factor was then given a weighted score based on the score rated and a pre-determined percentage weight. The six weighted scores were added to get a composite score for the Public Health Impact category.

HDHHS gave the Prioritization score a weight of 25% and the Public Health Impact score a weight of 75% to determine the overall project value for the plan. Oral Health Service Expansion received a composite Prioritization score of 7.65 and a Public Health Impact score of 7.

0937740-08.1.1	*1.8.9*	*N/A*	***PROJECT TITLE: ORAL HEALTH SERVICES FOR AT-RISK POPULATIONS***
Performing Provider Name: City of Houston Health and Human Services			TPI - 0937740-08
Related Category 3 Outcome Measures:	0937740-08.3.1 0937740-08.3.2	IT – 7.1 IT – 7.2	Dental Sealant: Percentage of children age 6-9 with a dental sealant on a permanent first molar tooth Percentage of children with untreated dental caries

Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Milestone 1 [P-X1]: Project Planning Metric 1 [P-X1.1]: Engage stakeholders, identify resources and potential partnerships, develop relationships, develop implementation plan Goal: Produce a comprehensive report documenting all points above Data Source: Program Documentation Milestone 1 Estimated Incentive Payment: $ 788,717.94 **Milestone 2** [P-4.1]: Establish additional/expand existing dental care clinics or space Metric 1 [P-4.1]: Number of additional clinics, expanded space and existing available space. Provide documentation of expansion or efficient use of space. Goal :Increase services to underserved target population Data Source: New dental care schedule or other project	**Milestone 4** [P-6]: Implement/expand alternative dental care delivery systems to underserved populations Metric 1 [P-6.1]: Implement/expand a mobile dental clinic program with an affiliated fixed-site dental clinic location. Documentation of expansion. Documentation includes descriptions of all services provided as well as program management activities. Goal: Document expansion of services to underserved target population. Data Source: Dental records documenting exams, treatment, consultations, and referrals Milestone 4 Estimated Incentive Payment: $ 655,610.86 **Milestone 5** [P-6]: Implement/expand alternative dental care delivery systems to underserved populations Metric 1 [P-6.3]: Implement school-based sealant program. Number of schools participating in receiving	**Milestone 8** [I-14]: Increase number of special population members that access dental services Metric 1 [I-14.1]: Increasing the number of children and pregnant women, accessing dental services Goal: Increase by 5% over baseline the number of special population members that access services in past 12 months. (Baseline established in DY 3) Data Source: consent forms, other documentation of dental services Milestone 8 Estimated Incentive Payment: $2,791,708.61	**Milestone 9** [I-14]: Increase number of special population members that access dental services Metric 1 [I-14.1]: Increasing the number of children and pregnant women, accessing dental services Goal: Increase by 10% over baseline the number of special population members that access services in past 12 months. Data Source: consent forms, other documentation of dental services Milestone 9 Estimated Incentive Payment: $2,697,943.99

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0937740-08.1.1	*1.8.9*	*N/A*	***PROJECT TITLE: ORAL HEALTH SERVICES FOR AT-RISK POPULATIONS***
Performing Provider Name: City of Houston Health and Human Services			TPI - 0937740-08
Related Category 3 Outcome Measures:	0937740-08.3.1 0937740-08.3.2	IT – 7.1 IT – 7.2	Dental Sealant: Percentage of children age 6-9 with a dental sealant on a permanent first molar tooth Percentage of children with untreated dental caries

Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
documentation regarding expansion Milestone 2 Estimated Incentive Payment: $ 788,717.94 **Milestone 3** [P-4]:Expand and establish additional clinics or space Metric 1 [P-4.2]: Number of additional school-linked health centers/spaces with dental services (dental screenings and off-site mobile sealant and hygiene program for 2nd graders): A) Documentation of establishment of additional school-linked health center/space with description of dental services provided. B) Program Management process documentation on parent education and empowerment of families and follow-up of findings from screenings Goal: Increase access to dental care for elementary school children Data Source: Program	sealants for 12 month period Goal: Increase access through partnerships with dental providers for target population Data Source: MOUs, contracts with sealant partners (UT Dental School) Milestone 5 Estimated Incentive Payment: $ 655,610.86 **Milestone 6** [P-6]: Implement/expand alternative dental care delivery systems to underserved populations. Metric 1 [P-6.4]: Implement program to increase dental services to improve maternal and early childhood oral health. Documentation of implementation (descriptions of all services provided as well as program management activities) Goal: Increase access to dental services for target population Data Source: Program documentation and referrals Milestone 6 Estimated Incentive Payment: $ 655,610.86 **Milestone 7** [P-X]: Increase number		

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0937740-08.1.1	***1.8.9***	***N/A***	***PROJECT TITLE: ORAL HEALTH SERVICES FOR AT-RISK POPULATIONS***
Performing Provider Name: City of Houston Health and Human Services			TPI - 0937740-08
Related Category 3 Outcome Measures:	0937740-08.3.1 0937740-08.3.2	IT – 7.1 IT – 7.2	Dental Sealant: Percentage of children age 6-9 with a dental sealant on a permanent first molar tooth Percentage of children with untreated dental caries
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Documentation of the above. Milestone 3 Estimated Incentive Payment: $ 788,717.94	of special population members that access dental services. Establish baseline for measuring number of children and pregnant women, accessing dental services who have seen a dental provider within the past 12months. Metric 1 [P-X.1]: Collect data to determine the number of children and pregnant women, accessing dental services that have seen by a dental provider within the past 12months. Baseline Goal: Establish baseline number of special population members that access services in past 12 months. Data Source: consent forms, other documentation of dental services Milestone 7 Estimated Incentive Payment: $ 655,610.86		
Year 2 Estimated Milestone Bundle Amount: $2,366,154	Year 3 Estimated Milestone Bundle Amount: $2,622,443	Year 4 Estimated Milestone Bundle Amount: $2,791,709	Year 5 Estimated Milestone Bundle Amount: $2,697,944
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5): $10,478,249.87			

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Project Option 1.7.7 - Implement remote patient monitoring programs for diagnosis and/or management of care for EMS services.

<u>**Unique Project ID:**</u> 0937740-08.1.2

<u>**Performing Provider Name/TPI:**</u> City of Houston Department of Health and Human Services/0937740-08

<u>**Project Summary:**</u> _Provider: The performing provider, Houston Department of Health and Human Services (HDHHS) is the public health authority for Houston. The sub-provider for this project is the City of Houston Fire Department Emergency Medical Services (EMS) which is the primary EMS authority for Houston, Texas, the fourth largest city in the U.S., with a population of 2.1 million in 2010. The City of Houston is a six-hundred plus square mile area spread out over a 1000 square mile region in Southeast Texas. Each year there are over 200,000 EMS incidents involving over 225,000 patients or potential patients. On average, EMS responds to a citizen every 3 minutes. Each EMS response is made by one of 88 City of Houston EMS vehicles. Thirty seven of these are staffed by two paramedics and provide Advanced Life Support (ALS) capabilities. EMS services benefit all Houston residents, and frequently, support those most in need, such as low income mothers and children, the elderly, and Medicaid and minority populations. The telehealth program population is expected to consist of approximately 30% Medicaid enrollees and approximately 20% from the indigent population.

<u>Intervention(s):</u> The City of Houston proposes to make use of telecommunications technologies and connectivity to triage patients with non-life threatening, mild or moderate illnesses via telemedicine with an emergency physician at the City of Houston EMS base station. The clients served will be evaluated on site by Houston Fire Department (HFD) - Emergency Medical Technicians (EMT) and/or paramedics, and if appropriate directed to the Emergency Tele Health and Navigation (ETHAN) Program where they will receive a physician assessment, referrals and follow-up care coordination to assure that they receive appropriate care at the right setting. This new program intends to address 25,000 patients/year in DY4 and 5.

<u>Need for the Project:</u> Rising costs of treating patients with non-emergent conditions that access health care at the ER are well documented. Telehealth provides a viable alternative to direct patients with non-life threatening, mild or moderate illnesses, who would have otherwise been transported to an ED for evaluation.

<u>Target Population:</u> This new program will target callers to 9-1-1 who may be more appropriately served in a setting other than the emergency room**.**

<u>Category 1 or 2 expected patient benefits:</u> Improve by 5% over baseline the percentage of patients using community based nursing, case management, patient education, counseling services for the first time in DY4 and by 10% over baseline in DY5, due to the ETHAN program.

<u>Category 3 outcomes:</u> **IT-9.4: (**ED appropriate utilization) - Reduce all ED visits that are non-emergent among 911 callers by 5% over baseline in DY4 and by 10% over baseline in DY5.

Project Option 1.7.7 - Implement remote patient monitoring programs for diagnosis and/or management of care for EMS services: Emergency Telemedicine and Navigation (ETHAN)

Unique Project ID: 0937740-08.1.2
Performing Provider Name/TPI: City of Houston Department of Health and Human Services &Houston Fire Department (HFD)-EMS /0937740-08

Project Description:
The City of Houston proposes to make use of telecommunications technologies and connectivity to triage patients with non-life threatening, mild or moderate illnesses via telemedicine with an emergency physician at the City of Houston EMS base station. The physician will then determine the most appropriate next step for the patient.

This new program will target callers to 9-1-1 who have been evaluated on site by Houston Fire Department (HFD) - Emergency Medical Technicians (EMT) and/or paramedics, and if appropriate, these callers will be directed to the Emergency Tele Health and Navigation (ETHAN) Program. Seriously or critically ill or injured patients will be treated according to current standard operating procedures and transported to an emergency department (ED). Patients with non-life threatening injuries requiring prompt attention beyond the scope of an EMT or paramedic (severe laceration or apparent fracture) will be transported to an ED. The patients with non-life threatening, mild or moderate illnesses, who would have otherwise been transported to an ED for evaluation, will instead have their case presented via telemedicine to an emergency physician located at the City of Houston EMS base station. The telehealth physician in the ETHAN program will determine the most appropriate next step for the patient. Depending on what the physician decides he or she may offer the patient: 1) taxi transportation to an ED, 2) ambulance transportation to an ED, 3) an appointment the next business day at a federally qualified health care center (FQHC), along with taxi transportation, 4) an appointment the next business day at the patients usual place of primary care, provided the local health care providers participate in this project, along with taxi transportation or 5) homecare instructions with direction to follow-up with the patient's primary care physician.

Houston Fire Department (HFD) ambulances will be equipped with ruggedized iPads (or similar device) to transmit audio-visual communication using wireless Wi-Fi technology to the base station. The Emergency Medical Technicians (EMT) or paramedic will present the patient's history, chief complaint and vitals directly to the physician. The emergency physician will be able to speak directly to and visualize the patient. The patient will also be able to see and speak directly to the physician. If the physician needs additional physical exam findings he or she may request that the EMT or paramedic do the required exam (within their scope of practice).

Clients with a non-life threatening mild or moderate illness who are not referred to the emergency room by the base station physician will be referred to the CareHouston Links program for follow-up of the plan recommended by the physician. CareHouston Links personnel will follow-up with the client within a few hours in order to ensure that the plan is appropriate and achievable. Necessary adjustments to the plan would then be made between the client and navigator. On the following business day, Care Houston Links counselors will follow-up with the patient to determine if the patient in fact followed the advice provided by the physician and navigator, or failed to follow the advice. In situations where the client followed the advice, the

counselor will work with the client and their health care provider to ensure continued compliance with the health care plan. In situations where the client failed to follow the advice, the counselor will determine and record what actually happened and the reasons why. They will also troubleshoot the issues that lead to the failure and work with the client to develop a relationship with an acceptable medical home and health care plan.

ETHAN would initiate care coordination services for 25,000 patients/year by more accurately assessing the 9-1-1 caller's needs and utilizing low cost transportation opportunities to provide the patient more appropriate care in a more appropriate setting than the emergency center. In order to be maximally successful, multiple primary care providers, such as FQHC's, other low cost or publically supported health care clinics, and eventually ACO affiliated physician offices and clinics would need to participate. With adequate provider participation, most non-emergent callers to 9-1-1 can be redirected to the source of health care most appropriate for their level of need. Additional savings would include all direct costs currently incurred to pay for ambulance transportation and emergency department evaluation (potentially unnecessary X-rays, laboratory testing, physician and nursing care costs), as well as the many indirect costs that result from the patients being non-compliant with the overall care plan when they choose to utilize emergency services instead of primary care for primary care problems. The ETHAN program will be implemented city wide in Houston, Texas.

According to a 2008 report from the University of Texas School of Public Health, ER visits related to primary care were rising in Harris County. In 2008, 10.8% of all primary care related ED visits arrived by ambulance transport and 20.9% of all other ED visits arrived by ambulance. The percentage of all ambulance transports that were for a primary care related ED visits was highest among CHIP enrollees (32.5%), followed by Medicaid enrollees (28.2%), and the uninsured (22.4%). The greatest total ambulance transports to the ED were among Medicare enrollees at 53,071 (Table 9, Figure 19).[1] (https://sph.uth.edu/research/centers/chsr/hsrc/).

The ETHAN program will also have a Quality Improvement process in place. The program will institute Plan-Do-Check Act process where the telehealth intervention will initially be administered to a small number of enrolled target population. The goal of continuous quality improvement is to establish a cyclical, continuous process of planning, assessing, monitoring, analyzing, measuring and evaluating performance to improve desired outcomes. At each step and all decision points in the program, detailed records will be kept so that improvements can be made on a continuous basis. Revisions in protocol, retraining of staff and revisions in procedures may be necessary during the initial phase to refine and improve the program early on in the program.

Goals and Relationship to Regional Goals:

The goal of this program is to reduce emergency room transports by ambulance for non-emergent conditions.

Project Goals:

1. Reduce the number of non-emergency ambulance transports
2. Reduce the number of non-emergency ED visits
3. Increase the number of clients appropriately linked to a medical home
4. Increase the number of clients consistently using their medical home
5. Reduce the need for hospitalizations and improve the quality of life of clients

This project meets the following regional goals:

- Increase access to primary and specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their condition, regardless of where they live or their ability to pay.
- Transform health care delivery from a disease-focused model of episodic care to a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary or duplicative services, and builds on the accomplishments of our existing health care system.

Challenges:

1. The project will actively seek cooperative arrangements with primary care providers to assure access to care is provided in the timeframe recommended by the EMS referring physician. This will require active engagements of primary care providers such as federally qualified health centers, public health systems and private providers of care for patients who seek EMS services via 9-1-1.
2. Getting the public to accept the advice of the physician directing them to a more appropriate and cost effective source of health care other than the emergency department. The CareHouston Links program will provide a personal contact with clients which will help patients understand and act on the advice of the referring physician.

5 Year Expected Outcome for Providers and Patients:

ETHAN will result in a reduction in the number of non-emergency EMS transports and ED visits in high 911 call volume zip codes and will facilitate appropriate use of the health care system for non-emergent 911 callers.

Starting Point/Baseline:

Houston Fire Department EMS Division (FY 2012):

EMS Incidents	239,689
EMS events involving patient transports	127,639
Non-emergency transports	102,112
EMS patients transported to the hospital	136,723

Current data shows that there are over 100,000 non-emergency transports. Certain zip-codes have a high percentage of 911 calls. The non-emergency ER transports is expected to decline in the high volume zip codes due to the ETHAN Program. Because this is a new initiative, we will establish a beginning baseline by Yr 3.

Rationale:

This program provides care coordination, by more accurately assessing the 9-1-1 caller's needs via telemedicine and utilizing low cost transportation opportunities to provide the patient more appropriate care in a more appropriate setting than the emergency center. The performing provider and its partners expect to see a reduction in ER usage among non-emergent 911 callers by using telecommunications technologies and connectivity linked with a patient navigation program (CareHouston Links). The MedStar program, a similar program in the Dallas/Fort Worth area, showed large declines in ED charges and costs due to the Medstar program. The number of calls from repeat callers dropped from 342.3 per month to 143.3 per month among the

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186 repeat callers that were enrolled in the program. This saved Medstar over $900,000 in transportation costs and hospital charges fell by $2.8 million. During Fiscal Year 2012, the current CareHouston program, which is similar to the MedStar program and which is a partnership between the HFD and HDHHS to follow-up on frequent 9-1-1 callers, diverted 1,458 clients from using EMS transports to emergency departments for non-emergencies, diverting $2,143,260 in costs for the City of Houston.

There are two major ways this program will be able to demonstrate cost savings to the Health Care System:

1. Diverted ambulance transports
2. Diverted emergency department visits for non-emergencies.

The average cost of a Houston ambulance transport is $1,470. Per the American Hospital Association one ED visit costs approximately $1,318.It is estimated that approximately 48 ambulance transports will be able to be diverted per day. Additional savings would include all direct costs currently incurred to pay for ambulance transportation and emergency department evaluation (potentially unnecessary X-rays, laboratory testing, physician and nursing care costs), as well as the many indirect costs that result from the patients being non-compliant with the overall care plan when they choose to utilize emergency services instead of primary care for primary care problems.

Project Components: There are no required project components for this project option. However, this project will include conduct quality improvement for all aspects of the project. Activities will include Identifying project impacts, "lessons learned" to adapt and scale the program to the local context. Additionally, enhanced telehealth services will be explored based on lessons learned.

Unique Community Need identification numbers that project addresses:

- CN.1- Inadequate access to primary care 2,3
- CN.8- High rates of inappropriate emergency department utilization 2,3

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

Currently the Houston Fire Department uses the Alternate Transportation Program which allows field personnel (EMT's and paramedics) to connect low acuity patients with a paramedic at the centralized base station via telephone where the paramedic interrogates the patient utilizing a telehealth nurse triage algorithm to determine if alternatives to ambulance transportation to an emergency department is safe. Using City of Houston funds through a contract with the Harris County Healthcare Alliance, this program currently financially supports taxi cab transportation and clinic costs (one time only) for patients to be seen at a Houston area federally qualified healthcare center (FQHC). The program is poorly utilized by field personnel for three reasons:

a) The telehealth nurse triage algorithm is designed for a non-emergency setting application and is extremely conservative resulting in a high frequency of recommendations for emergency department evaluation.
b) The interrogation required is time consuming and inefficient
c) The public is unfamiliar with the concept and is not trusting of a non-physician on a telephone giving them advice.

ETHAN is a new program which will replace the Alternative Transportation program which will utilize an emergency physician via technology to assess and determine a recommended course of health care for patients seen by EMTs and paramedics. This program will result in patient's receiving advice from an actual physician who is located at the base station, service does not currently exist.
In addition to having access via technology to a physician, patients will also be referred and followed up by a patient navigator via the Care Houston Links program. Currently the existing Care Houston program only serves frequent 9-1-1 callers. Currently the Houston Fire Department refers persons who call 9-1-1 greater than 3 times in a 3 month period to the Care Houston Program operated by the Houston Department of Health and Human Services. The program is staffed by counselors, navigators, and public health nurses who reach out to the individuals referred through phone, mail, or home visits. Clients are assessed to determine underlying problems such as lack of education regarding health condition, transportation, or any other unmet need. Residents and families are educated about their health and medical condition, the proper use of the EMS system, alternate transportation services and any other unmet needs. ETHAN will provide all clients who do not need to make visits to an emergency room department with access to a care navigation program through the new Care Houston Links program. Care Houston Links staff will assure that clients are connected to medical homes and other needed services. Linking, assessing and referring clients to appropriate services will reduce their need to use emergency services.

Related Category 3 Outcome Measures

OD- 9 Right Care, Right Setting
IT-9.4 Other Outcome Improvement Target (ED appropriate utilization of non-life threatening, mild or moderately ill911 callers)
Rate: Non-life threatening, mild or moderately ill 911 callers connected to further medical care/follow-up during the project year
Reasons/Rationale for selecting the outcome measures:
We chose the outcome measure of inappropriate ED usage in the "Other Outcome Improvement Target" category. By providing access to Telehealth services, this program aims to reduce inappropriate ER usage of non-life threatening, mild or moderately ill 911 callers by telehealth and care coordination; by more accurately assessing the 911 caller's needs to provide the patient more appropriate care in a more appropriate setting than the emergency room. In order to be maximally successful, partnerships with multiple primary care providers, such as FQHC's, other low cost or publically supported health care clinics, and eventually ACO affiliated physician offices and clinics will be needed. With their participation, most non-emergent, non-life threatening, mild or moderately ill 911 callers can be redirected to the most appropriate source of health care.

Relationship to other projects: This project is related to CareHouston Links. This project's focus is on providing appropriate care to non-emergent patients that enter the 911 call system due to a variety of reasons in addition to those callers with non-life threatening, mild or moderately illnesses. By keeping the patients from making an unnecessary ER visit, and providing culturally competent navigation services to redirect patients to an alternate source of care, savings to the health care system per patient will be considerable.

Relationship to other Performing Providers' Projects and Plan for Learning Collaborative:
We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system.

A primary focus of the waiver as well as our region is ensuring appropriate emergency department utilization for our patient base. The lack of primary care, specialty care, and behavioral health treatment currently creates congestion in the emergency departments thus increasing cost and comprehensive treatment of patients with chronic conditions. The ED initiatives focus to outcomes of readmission rates, appropriate ED utilization, and patient satisfaction and all initiative relationships can be found on the Region 3 initiative grid in the addendum.

Project Valuation:

HDHHS utilized two categories to calculate value for each DSRIP project. The first category is Prioritization and the second is Public Health Impact (see attachment for HDHHS Valuation Tool). HDHHS scored the project on a scale of 1 (poor) to 9 (exceptional) for each of the six factors that comprise the Prioritization category. The Prioritization category includes the following factors: 1) Transformational Impact, 2) Population Served / Project Size, 3) Alignment with Community Needs 4)Cost Avoidance 5) Partnership Collaboration and 6)Sustainability. Each factor was then given a weighted score based on the score rated and a pre-determined percentage weight. The six weighted scores were added to get a composite score for the Prioritization category.

Public Health includes activities which seek to achieve the highest level of health for the greatest number of people. Public Health also focuses on preventing problems from happening or re-occurring through programs and activities that promote and protect the health of the entire community. As a public health department, HDHHS added an additional valuation category of Public Health Impact that looked at projects through a public health lens. The Public Health Impact category includes the following factors: 1) Alleviate Health Disparity, 2) Control Communicable and Chronic Disease , 3) Prevention Orientation, 4) Population Health Focus, 5) Access and Connection to Health Services and 6) Evidence Based Health Program. HDHHS scored the project on a scale of 1 (poor) to 9 (exceptional) for each of the six factors that comprise the Public Health Impact category. Each factor was then given a weighted score based on the score rated and a pre-determined percentage weight. The six weighted scores were added to get a composite score for the Public Health Impact category.

HDHHS gave the Prioritization score a weight of 25% and the Public Health Impact score a weight of 75% to determine the overall project value for the plan. The ETHAN Program received a composite Prioritization score of 7.15 and a Public Health Impact score of 8.

0937740-08.1.2	1.7.7	N/A	PROJECT TITLE: Emergency Telemedicine and Navigation (ETHAN)
Performing Provider Name: City of Houston Health and Human Services			*TPI*-0937740-08
Related Category 3 Outcome Measures:	0937740-08,-03,-07.3.3,	*IT-9.4*	*IT-9.4 Other Outcome Improvement Target (ED appropriate utilization)*

Year 2 **(10/1/2012 – 9/30/2013)**	Year 3 **(10/1/2013 – 9/30/2014)**	Year 4 **(10/1/2014 – 9/30/2015)**	Year 5 **(10/1/2015 – 9/30/2016)**
Milestone 1[P –X1]: Determine scope, range, current capacity and needed resources for the ETHAN Project. Metric 1: Provide report identifying ETHAN Program Planning Materials, Meeting minutes, Sign-in sheets, Draft Clinical Protocols, Staff Qualifications, Staffing Plan Goal: Provide reporting identifying information listed above Data Source: Completed report documenting planning activities Milestone 1 Estimated Incentive Payment:$587,767.72 **Milestone 2 [P –X2]:** Establish Baseline Metric 1: Document number of non-emergent 911 calls to EMS Goal: Determine baseline on which program improvements will be based Data Source: HFD Data Electronic Records	**Milestone 5** [P-4]: Implement or expand telehealth program for targeted health services, based upon regional and local community need. Metric 1[P-4.1]: Documentation of program materials including implementation plan, vendor agreements/contracts, staff training and HR documents. Submission of implementation documentation Goal: Implement program based on community need Data Source: Program materials. Milestone 5 Estimated Incentive Payment: $651,431.69 **Milestone 6[P – X3]:** Update scope, range for the ETHAN Project. Metric 1:Updated final clinical protocols, List of Stakeholders Metric 2: Documentation of program process data related to implementation. Goal: Finalize protocol for program implementation	**Milestone 9 [I-18]:** Implement interventions to achieve improvements in access to care of patients receiving telemedicine/telehealth services using innovative project option. Metric 1 [I-18.3]: Improved access to health care services for residents of communities that did not have such services locally before the program. Goal: Improve by 5% over baseline, the total number of unique patients from underserved communities over baseline (baseline established in Yr 3). Data Source: Registry, EHR, claims or other Performing Provider source Milestone 9 Estimated Incentive Payment: $1,386,956.48 **Milestone 10**: [I-17]: Improved access to needed services, e.g. community based nursing, case management, patient education, counseling, etc. Metric 1[I-17.1]: Percentage of patients in the telemedicine/telehealth	**Milestone 9 [I-18]:** Implement interventions to achieve improvements in access to care of patients receiving telemedicine/telehealth services using innovative project option. Metric 1 [I-18.3]: Improved access to health care services for residents of communities that did not have such services locally before the program. Goal: Improve by 10% over baseline, the total number of unique patients from underserved communities over baseline Data Source: Registry, EHR, claims or other Performing Provider source Milestone 11 Estimated Incentive Payment: $1,340,373.02 **Milestone 12:** [I-17]: Improved access to needed services, e.g. community based nursing, case management, patient education, counseling, etc. Metric 1[17.1]: Percentage of patients

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0937740-08.1.2	*1.7.7*	*N/A*	*PROJECT TITLE: Emergency Telemedicine and Navigation (ETHAN)*
Performing Provider Name: City of Houston Health and Human Services			*TPI-0937740-08*
Related Category 3 Outcome Measures:	0937740-08,-03,-07.3.3,	*IT-9.4*	*IT-9.4 Other Outcome Improvement Target (ED appropriate utilization)*

Year 2 **(10/1/2012 – 9/30/2013)**	Year 3 **(10/1/2013 – 9/30/2014)**	Year 4 **(10/1/2014 – 9/30/2015)**	Year 5 **(10/1/2015 – 9/30/2016)**
Metric 2:Collect and Document types of needs of non-emergent 911 callers Goal: Determine baseline on which program improvements will be based Data Source: HFD data Electronic Records Milestone 2 Estimated Incentive Payment: $587,767.72 **Milestone 3** [P-2] Conduct retrospective needs assessment to identify needed services that are needed to be delivered via telehealth. Metric 1[P-2.1]: Needs assessment - submission of completed needs assessment Goal: Match the needs of community with services to be delivered Data Source: Retrospective call records from past year 911 calls. Milestone 3 Estimated Incentive Payment: $587,767.72	Data Source: Program materials Milestone 6 Estimated Incentive Payment: $651,431.69 **Milestone 7[P-8.1**]: Create plan to monitor and enhance internet use for telemedicine/telehealth program. Metric 1[P-8.1]: Documentation of expansion of services utilizing the internet as amedium. Submission of plan identifying which services can be made available through internet applications as well as steps to implement these services. Goal: Utilize internet for enhancing program Data source: Program plan Milestone 7 Estimated Incentive Payment: $651,431.69 **Milestone 8: [P-5]:** Implement remote patient monitoring program based on evidence based models and adapted to fit the needs of the population and local context.	program that are seeing a specialist or using the services for the first time. Goal: Improve by 5% over baseline the percentage of patients using services for the first time. Data source: EMR or other program records Milestone 10 Estimated Incentive Payment: $1,386,956.48	in the telemedicine/telehealth program that are seeing a specialist or using the services for the first time. Goal: Improve by 10% over baseline the percentage of patients using services for the first time. Data source: EMR or other program records Milestone 12 Estimated Incentive Payment: $1,340,373.02

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0937740-08.1.2	*1.7.7*	*N/A*	*PROJECT TITLE: Emergency Telemedicine and Navigation (ETHAN)*
Performing Provider Name: City of Houston Health and Human Services			*TPI*-0937740-08
Related Category 3 Outcome Measures:	0937740-08,-03,-07.3.3,	*IT-9.4*	*IT-9.4 Other Outcome Improvement Target (ED appropriate utilization)*

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 4 [P-X2] Community Engagement and Partnership Building Metric: Engage stakeholders, identify resources and potential partnerships, and develop intervention plan (including implementation, evaluation, and sustainability). Goal: Establish buy-in from community and partners by sharing needs assessment Data Source: Needs Assessment, Meeting minutes, draft intervention plan of services to be offered Milestone 4 Estimated Incentive Payment: $587,767.72	Metric 1 [P-5.1]: Documentation of program materials including implementation plan, vendor agreements/ contracts, staff training and HR documents. Submission of implementation documentation Goal: Conduct patient monitoring Data Source: Program materials Milestone 8 Estimated Incentive Payment: $651,431.69		
Year 2 Estimated Outcome Amount: $2,351,071	Year 3 Estimated Outcome Amount: $2,605,727	Year 4 Estimated Outcome Amount: $2,773,913	Year 5 Estimated Outcome Amount: $2,680,746
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundles amounts over DYs 2-5):* $10,411,457			

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City of Houston Department of Health and Human Services

Pass 3

Project Option - 1.8.11 The implementation of dental services for individuals in long-term care facilities, intermediate care facilities, and nursing homes, and for the elderly, and/or those with special needs by enhancing dental workforce capacity through collaborations and partnerships with dental and dental hygiene schools, LHDs, FQHCs, and/or local dental providers

Unique Project ID: 0937740-08.1.1

Performing Provider Name/TPI: City of Houston Department of Health and Human Services/0937740-08

Project Summary: Provider: The performing provider, Houston Department of Health and Human Services (HDHHS) is the public health authority for Houston, Texas, the fourth largest city in the U.S., with a population of 2.1 million in 2010. Established in 1840, HDHHS has grown to a department of 1,100 employees. HDHHS provides core public health services to all Houston residents such as air and water quality monitoring; restaurant inspections; lead paint safety; cancer screening and family planning for the uninsured; communicable disease prevention and control; disease surveillance; birth and death certificates; leadership in emergencies such as hurricanes; services to seniors; WIC programs; immunizations; and others. HDHHS operates 11 multi-service centers, 4 health centers, 14 WIC (Women, Infants and Children nutrition program) sites, the Harris County Area Agency on Aging, a comprehensive regional reference laboratory, and 44 health and human service programs. While HDHHS provides services that benefit all Houston residents, the department also takes additional steps to support those most in need, such as low income mothers and children, the elderly, and minority populations.
Intervention(s): This new project will improve oral health by providing diagnostic, preventive, restorative, and surgical oral health services for the elderly to improve the health and quality of life for Houston area at-risk seniors. Training the next public health work force is also a goal of the program. 4th year dental students from the University of Texas School of Dentistry (UTSD), dental hygiene students from UTSD, and dental hygiene students from Houston Community College (HCC)will be trained to provide dental care for the seniors within one of the HDHHS safety net dental clinics,

Need for the Project: By 2040, the number of US seniors, over the age of 65, is expected to double to 71 million. By 2030, the number of seniors, over the age of 85, is expected to be 9.6 million. As the US seniors live longer, many will be retaining their teeth and many will experience co-morbidities.). Older persons who live below the poverty line were almost three (3) times as likely to report unmet dental needs as those who live at or above the poverty line (11 and 4 percent, respectively).
Target Population: The primary target population will be at risk seniors seen at public clinics and FQHC's.
Category 1 or 2 expected patient benefits: [I-14] Increase by 5% over baseline of special population members that access dental services in DY4 and by 10% over baseline in DY5.
Category 3 outcomes: IT-7.8: Increase by 5% over baseline percentage of patients with chronic disease conditions accessing dental services following referral by their medical provider in DY4 and by 10% over baseline in DY 5.

1.8.11 The implementation of dental services for individuals in long-term care facilities, intermediate care facilities, and nursing homes, and for the elderly, and/or those with special needs by enhancing dental workforce capacity through collaborations and partnerships with dental and dental hygiene schools, LHDs, FQHCs, and/or local dental providers.

Unique Project ID: 0937740-08.1.3 / Pass 3
Performing Provider: City of Houston Department of Health and Human Services/ 0937740-08

Project Description:
The Houston Health and Human Services (HDHHS) proposes to a) provide ongoing diagnostic, preventive, restorative, and surgical oral health services for the low income at-risk elderly in the community; b) provide oral health services for previously screened elderly patients from Area Agency on Aging, Harris Health System, and area Federally Qualified Health Centers; and c) link more elderly to a dental home.

Many older Americans do not have dental insurance. Often these benefits are lost when they retire. The situation may be worse for older women, who generally have lower incomes and may never have had dental insurance. By providing diagnostic, preventive, restorative, and surgical oral health services for the elderly, the HDHHS will improve the health and quality of life for Houston area at-risk seniors. The HDHHS currently contracts with the Harris County Area Agency on Aging (HCAAA) to provide limited dental care for at-risk seniors. In efforts to train the next public health work force, 4th year dental students from the University of Texas School of Dentistry (UTSD), dental hygiene students from UTSD, and dental hygiene students from Houston Community College (HCC) provide dental care for the seniors within one of the HDHHS safety net dental clinics. It is critical for the up-coming work force to be prepared to serve this population. By 2040, the number of US seniors, over the age of 65, is expected to double to 71 million. By 2030, the number of seniors, over the age of 85, is expected to be 9.6 million. As the US seniors live longer, many will be retaining their teeth and many will experience co-morbidities.

In 2013, the HDHHS will provide oral health services at-risk seniors, in conjunction with UTSD and HCC students, in a first time endeavor with HCAAA and neighboring Fort Bend County Area Agency on Aging. The UTSD has already donated dental chairs for this initiative.

Cost savings are realized with prevention. At-risk seniors, having a history of oral health neglect and dry mouth issues, often present with chronic oral health problems, e.g., caries, non-restorable teeth, and lesions, and an inability to chew healthy foods. To assist these seniors from poor oral health to improved oral health can be costly. However, once better oral health is realized and with proper guidance, cost-effective preventive care can ensue. Early detection of oral cancers has shown to be cost effective. At a cost of $84/person/year, significant health benefits and cost savings can be realized. The earlier a cancer is detected, the better the outcome, and the treatment, if needed, is less costly as well. The cost of screening and early detection is approximately 46% less than treatment alone, e.g., $260,351 vs $478,742.

Quality of life is compromised as one ages and takes on chronic debilitating conditions. Rates of depression increase from 1 – 13.5%, as a person ages and moves from an independent to a more dependent situation. Optimal oral health results in an improved quality of life which includes the ability to eat nutritious food, to swallow, to breathe, to speak, to enjoy social interaction, to optimize self-esteem and self-image. Without these valued qualities, it can lead to chronic stress, depression, and economic costs. If we can maintain a healthy condition, costs associated with mental health treatment and dependent care can be reduced.

In general, socioeconomic characteristics play a significant role in who receives dental care. Overall, persons with more than a high school education are twice as likely to have visited the dentist in the past year than were persons with less than a high school education. Non-Hispanic whites were also much more likely to have visited a dentist than were racial/ethnic minorities. (CDC, http://www.cdc.gov/nchs/data/ahcd/agingtrends/03oral.pdf). Older persons who live below the poverty line were almost three (3) times as likely to report unmet dental needs as those who live at or above the poverty line (11 and 4 percent, respectively). 15 Persons from lower socioeconomic groups are also more likely to report having untreated cavities.16 The greater need for dental care among older persons at low socioeconomic levels is coupled with their lower level of private insurance coverage, which leaves this group at a significant disadvantage compared with those at higher socioeconomic levels.[1]

Goals and Relationship to Regional Goals:

The goal of this project is to partner with dental providers, dental and dental hygiene schools, Harris Health System, area FQHCs, and other stakeholders to provide services for underserved population who are at risk for poor oral health. The primary goal is to close gaps in access to dental care in certain sub-population groups. The target population addressed for this project will be the elderly, many of whom also suffer from other chronic conditions. This is directly related to the regional goal of alleviating dental health disparities by provision of access to dental care. By enhancing access to Preventive Care in high risk populations, a long term investment in oral health ensues.

Project Goals:

The overall goal of this program is to improve oral health in underserved seniors.

- Close gaps/disparities in access to dental care services

This project meets the following regional goals:

- Increase access to primary and specialty care services, with a focus on underserved seniors, to ensure patients receive the indicated dental care for their condition, regardless of where they live or their ability to pay.
- Transform health care delivery from a disease-focused model of episodic care to a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary or duplicative services, and builds on the accomplishments of our existing health care system.

Challenges:

Some of the challenges the provider anticipates follow:

1) Developing an efficient and effective referral process: For dental procedures beyond the HDHHS' scope of services, refer to Harris Health System and UTSD for oral surgery, UTSD School of Dentistry for Endodontics and Periodontics.

2. Identifying sustainable funding stream
3. Identifying and hiring trained dentists

5 Year Expected Outcome for Providers and Patients:
As the primary provider, the HDHHS expects to see a reduction in number of elderly patients who present with poor oral health. Due to the comprehensive nature and scope of the program, oral health in underserved areas is likely to improve among high-risk populations.

Starting Point/Baseline:
Currently, no comprehensive program exists that targets improvement in oral health of elderly living in the community in underserved areas. Baseline will be established by the end of in DY 3 of the project for proportion of elderly that are seen by program.

Rationale:
Oral disease is common in the underserved population. Oral disease can result in poor nutrition; serious systemic illnesses and conditions such as poor birth outcomes, diabetes, and cardiovascular disease; and a diminished quality of life and life expectancy. Inadequate access to oral health services compounds other health issues. It can result in untreated dental disease that not only affects the mouth, but can also have physical, mental, economic, and social consequences. Fortunately, many of the adverse effects associated with poor oral health can be prevented with quality regular dental care, both at home and professionally. Increasing, expanding, and enhancing oral health services to the elderly will improve health outcomes. As with other health issues, older people have very different oral health needs to children and younger adults. They are more likely to take medication that causes dry mouth, leading to tooth decay and infections of the mouth. More than 400 commonly used medications — many of them for chronic conditions to which the elderly are susceptible — can dry out the mouth.

Nearly one-third of persons 65 years of age and older have untreated dental caries. Slightly more than one-half of non-institutionalized persons 65 years of age and older in 1997 had a dental visit in the past year. Oral health problems can hinder an elderly person's ability to be free of pain and discomfort, to maintain a satisfying and nutritious diet, and to enjoy interpersonal relationships and a positive self-image. Overall, oral health problems are more frequently found in an older adult population for whom other health problems are often a priority.http://www.cdc.gov/nchs/data/ahcd/agingtrends/03oral.pdf).

Project Components:
This project has no required core components. Major features of the project include:

a) Increase dental services for at-risk and low income elderly who have limited or no access to dental care services.
b) Partnership with UTSD, Harris Health System and local dental providers to provide enhanced services to target population.
c) Connect all elderly patients to a dental home.

Due to the performing provider's experience and established networks in serving low income population, this program will benefit from these experiences and community partnerships. Nevertheless, program processes will be refined and improved through a Plan-Do-Check-Act process. The goal of continuous quality improvement is to establish a cyclical, continuous process of planning, assessing, monitoring, analyzing, measuring and evaluating performance to improve desired outcomes. It is expected that revisions to the protocol, training requirements, partnership processes and expectations will need to be clarified on a regular basis. These will be improved through the PDSA process. Initial program enrollment of a small number of target population will iron out program weaknesses and allow for a continuous quality improvement process.

Unique community need identification numbers that project addresses:

- CN.4 Inadequate access to dental care
- CN.22 Insufficient access to services that are specifically designed to address racial, ethnic and cultural health care disparities

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
Currently there are very few programs that provide comprehensive population based dental health care for underserved older adults. This program will provide dental care for at-risk and low income elderly who have limited or no access to dental care. This programs aims to close gaps/disparities in access to dental care services and enhance the quality of dental care as well as build capacity in the region by training providers. The project will also expand service capacity in safety net geriatric oral health services for elderly provided within an HDHHS safety net dental clinic.

Related Category 3 Outcome Measures:
OD-7 Oral Health
IT-7.8 Chronic Disease Patients Accessing Dental Services: Percentage of patients with chronic disease conditions accessing dental services following referral by their medical provider.

Reasons /rationale for selecting the outcome measures:
The primary outcome measures chosen for this project are increase in number of elderly patients with chronic diseases who access dental care through the program. Multiple comorbidities may place this target population at an even higher risk for complications if they also suffer from poor oral health. By providing dental care and connecting these patients to a dental home, the performing provider expects to see improved oral health in the patients who access this program.

Relationship to Other Projects and Plan for Learning Collaborative:
Project results and lessons learned will be disseminated and shared with other members in the regional learning collaborative in efforts to identify and implement quality improvement strategies. We plan to participate in a region-wide learning collaborative as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region, that have similar projects, will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous quality improvement in our Region's healthcare system.

Dental services for adult and children are currently underfunded and incomplete in access for the targeted patient base. The dental initiatives represented in the RHP plan are specific to community need and location of the patients to ensure strong access to treatment. The outcome measures focus on the reduction of emergency room utilization, patient satisfaction, as well as increase access to the service line. The Region 3 initiative grid in the addendum directly reflects all relationships of dental initiatives.

Project Valuation:

The HDHHS utilized two categories to calculate value for each DSRIP project. The first category is Prioritization and the second is Public Health Impact (see attachment for HDHHS Valuation Tool). HDHHS scored the project on a scale of 1 (poor) to 9 (exceptional) for each of the six factors that comprise the Prioritization category. The Prioritization category includes the following factors: 1) Transformational Impact, 2) Population Served / Project Size, 3) Alignment with Community Needs, 4) Cost Avoidance, 5) Partnership Collaboration, and 6) Sustainability. Each factor was then given a weighted score based on the score rated and a pre-determined percentage weight. The six weighted scores were added to get a composite score for the Prioritization category.

Public Health includes activities which seek to achieve the highest level of health for the greatest number of people. Public Health also focuses on preventing problems from happening or re-occurring through programs and activities that promote and protect the health of the entire community. As a public health department, HDHHS added an additional valuation category of Public Health Impact that looked at projects through a public health lens. The Public Health Impact category includes the following factors: 1) Alleviate Health Disparity, 2) Control Communicable and Chronic Disease , 3) Prevention Orientation, 4) Population Health Focus, 5) Access and Connection to Health Services and 6) Evidence Based Health Program. HDHHS scored the project on a scale of 1 (poor) to 9 (exceptional) for each of the six factors that comprise the Public Health Impact category. Each factor was then given a weighted score based on the score rated and a pre-determined percentage weight. The six weighted scores were added to get a composite score for the Public Health Impact category.

The HDHHS gave the Prioritization score a weight of 50% and the Public Health Impact score a weight of 50% to determine the overall project value for the plan. Geriatric Oral Health received a composite Prioritization score of 1.88 and a Public Health Impact score of 1.88.

References

1. Cohen RA, Bloom B, Simpson G, and Parsons PE. Access to health care. Part 3: Older adults. National Center for Health Statistics. Vital Health Stat. 10(198), 1997.

<table>
<tr><td>0937740-08.1.3</td><td>1.8.11</td><td colspan="2">N/A</td><td colspan="2">PROJECT TITLE: ORAL HEALTH SERVICES FOR ELDERLY AT-RISK POPULATIONS</td></tr>
<tr><td colspan="5">Performing Provider Name: Houston Department of Health and Human Services</td><td>TPI - 0937740-08</td></tr>
<tr><td>Related Category 3 Outcome Measures:</td><td>0937740-08.3.15</td><td>IT-7.8</td><td colspan="3">Chronic Disease Patients Accessing Dental Services</td></tr>
<tr><th>Year 2
(10/1/2012 – 9/30/2013)</th><th colspan="2">Year 3
(10/1/2013 – 9/30/2014)</th><th colspan="2">Year 4
(10/1/2014 – 9/30/2015)</th><th>Year 5
(10/1/2015 – 9/30/2016)</th></tr>
<tr><td>Milestone 1 [P-X1]: Project Planning

Metric 1 [P-X1.1]: Engage stakeholders, identify resources and potential partnerships, develop relationships, develop implementation plan
Goal: Produce a comprehensive report documenting all points above
Data Source: Program Documentation

Milestone 1 Estimated Incentive Payment$61,053

Milestone 2 [P-4.1]: Establish additional/expand existing dental care clinics or space

Metric 1 [P-4.1]: Number of additional clinics, expanded space and existing available space. Provide documentation of expansion or efficient use of space.
Goal :Increase services to underserved target population
Data Source: New dental care schedule or other project</td><td colspan="2">Milestone 4 [P-6]: Implement/expand alternative dental care delivery systems to underserved populations

Metric 1 [P-6.1]: Implement/expand a mobile dental clinic program with an affiliated fixed-site dental clinic location. Documentation of expansion. Documentation includes descriptions of all services provided as well as program management activities.
Goal: Document expansion of services to underserved target population.
Data Source: Dental records documenting exams, treatment, consultations, and referrals

Milestone 4 Estimated Incentive Payment $52,482

Milestone 5 [P-6]: Implement/expand alternative dental care delivery systems to underserved populations

Metric 1 [P-6.5]: Metric: Implement program to increase dental services to individuals in long-term</td><td colspan="2">Milestone 8 [I-14]: Increase number of special population members that access dental services

Metric 1 [I-14.1]: Increasing the number of elderly accessing dental services
Goal: Increase by 5% over baseline the number of special population members that access services in past 12 months. (Baseline established in DY 3)
Data Source: consent forms, other documentation of dental services

Milestone 8 Estimated Incentive Payment: $227,223</td><td>Milestone 9 [I-14]: Increase number of special population members that access dental services

Metric 1 [I-14.1]: Increasing the number of elderly accessing dental services
Goal: Increase by 10% over baseline the number of special population members that access services in past 12 months.
Data Source: consent forms, other documentation of dental services

Milestone 9 Estimated Incentive Payment: $218,552</td></tr>
</table>

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0937740-08.1.3	*1.8.11*	*N/A*	*PROJECT TITLE: ORAL HEALTH SERVICES FOR ELDERLY AT-RISK POPULATIONS*
Performing Provider Name: Houston Department of Health and Human Services			TPI - 0937740-08
Related Category 3 Outcome Measures:	*0937740-08.3.15*	*IT-7.8*	*Chronic Disease Patients Accessing Dental Services*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3** (10/1/2013 – 9/30/2014)	**Year 4** (10/1/2014 – 9/30/2015)	**Year 5** (10/1/2015 – 9/30/2016)
documentation regarding expansion Milestone 2 Estimated Incentive Payment $61,053 **Milestone 3** [P-4]:Expand and establish additional clinics or space Metric 1 [P-4.2]: Number of additional school-linked health centers/spaces with dental services (dental screenings and off-site mobile sealant and hygiene program for 2nd graders): C) Documentation of establishment of additional school-linked health center/space with description of dental services provided. D) Program Management process documentation on parent education and empowerment of families and follow-up of findings from screenings Goal: Increase access to dental care for elderly Data Source: Program	care facilities, intermediate care facilities, nursing homes, the elderly, and/or individuals with special needs, implement school-based sealant program. Number of venues participating in offering new services to the elderly for 12 month period Goal: Increase access through partnerships with dental providers for target population Data Source: MOUs, contracts with sealant partners (UT Dental School) Milestone 5 Estimated Incentive Payment: $52,483 **Milestone 6** [P-10]: Milestone: Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. Metric [P-10.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: Identify improvements for		

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0937740-08.1.3	*1.8.11*	*N/A*		*PROJECT TITLE: ORAL HEALTH SERVICES FOR ELDERLY AT-RISK POPULATIONS*
Performing Provider Name: Houston Department of Health and Human Services				TPI - 0937740-08
Related Category 3 Outcome Measures:	*0937740-08.3.15*	*IT-7.8*	*Chronic Disease Patients Accessing Dental Services*	

Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Documentation of the above. Milestone 3 Estimated Incentive Payment $61,053	"raise the floor" initiatives for improved delivery of services. Data Source: Documentation of semiannual meetings including meeting agendas, meeting notes. Milestone 6 Estimated Incentive Payment: $52,483 **Milestone 7** [P-X]: Increase number of special population members that access dental services. Establish baseline for measuring number of elderly target population, accessing dental services who have seen a dental provider within the past 12months. <u>Metric 1</u> [P-X.1]: Collect data to determine the number of elderly target population, accessing dental services that have seen by a dental provider within the past 12months. Baseline Goal: Establish baseline number of special population members that access services in past 12 months. Data Source: consent forms, other documentation of dental services Milestone 7 Estimated Incentive		

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0937740-08.1.3	***1.8.11***	***N/A***	***PROJECT TITLE: ORAL HEALTH SERVICES FOR ELDERLY AT-RISK POPULATIONS***
Performing Provider Name: Houston Department of Health and Human Services			TPI - 0937740-08
Related Category 3 Outcome Measures:	*0937740-08.3.15*	*IT-7.8*	*Chronic Disease Patients Accessing Dental Services*

Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
	Payment: $52,483		
Year 2 Estimated Milestone Bundle Amount: $183,160	Year 3 Estimated Milestone Bundle Amount: $209,931	Year 4 Estimated Milestone Bundle Amount: $227,223	Year 5 Estimated Milestone Bundle Amount: $218,552
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5): $836,866			

DRAFT

Columbus Community Hospital

Pass 1

Project Option 1.7.1 - Implement Telemedicine Program to Provide or Expand Specialist Referral Services in an Area Identified as needed to the region

Unique RHP Project Identification Number: 135033204.1.1.

Performing Provider/TPI - Columbus Community Hospital (CCH)/135033204

Project Description Summary:

Provider: Columbus Community Hospital is a 40-bed hospital in Columbus, Texas serving a 25 square mile area and a population of approximately 21,000.

Intervention(s): This project will implement telemedicine to provide clinical support and 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 70% of our patients are either Medicaid/Medicare eligible or indigent, so, a significant benefit is expected for the patients as well as for the Medicare/Medicaid programs.

Category 1 expected patient benefits:

The project seeks to reduce medication areas by 3% in year 3, additional 3% in year 4 and additional 4% in Year 5.

The project seeks to provide 150 telemedicine consults in DY4 and 200 in DY5.

Category 3 outcomes: IT-6.1 Our goal is to reduce the 30-day potentially preventable all-cause current readmission rate of 21.4% by 1% in year 2, an additional 1% in year 3, an additional 2% in year 4, and an additional 2% in year 5.

Project Option 1.7.1 - Implement telemedicine program to provide or expand specialist referral services: Implement Telemedicine Program to Provide or Expand Specialist Referral Services in an Area Identified as needed to the region

Unique RHP Project Identification Number: 135033204.1.1.

Performing Provider/TPI - Columbus Community Hospital (CCH)/135033204

Project Description:

Improve patient safety through improving pharmacist oversight of prescriber orders by implementing telemedicine/telehealth patient consultations.

CCH is a 40-bed not-for-profit general hospital located in Columbus, Texas. Its service area of 25 square miles includes a population of approximately 21,000. The city of Columbus has a population of 3,900 and is located in Colorado County. Columbus is near Interstate 10 between San Antonio and Houston, Texas.

Colorado County has a median household income of $36,295 which is considerably lower than the income rate of the State of Texas which is $48,259. The county faces several healthcare problems and adult diabetes is one of them with a rate of 10.8%. Adult obesity rate is at a high rate of 28.2%. Another alarming factor is the low income preschool obesity rate at 14.6%. Heart disease is at a high rate of 234.8 compared to the State average of 186.7. Cancer is at a disturbing rate of 190.2 and the State rate is 167.6. As a result of these alarming statistics CCH is confronting with two major factors. First, there is a significant growth in the number of inpatient admissions and second a new EHR went live on February 1, 2012. Based on the above information there is a need to reduce medical errors in the pharmacy area. Presently we have a pharmacist five days a week, Monday – Friday only. We will be adding an offsite pharmacist capability via telemedicine for the weekends starting with four hours per day and expanding to eight hours per day. This type of telemedicine will be a cost effective alternative to adding a full time pharmacist in house on the weekends. Columbus Community Hospital has identified project 1.7., Introduce, Expand, or Enhance Telemedicine/Telehealth, that will provide patient consultations by health professionals (pharmacists) using telemedicine.

Goals and Relationship to Regional Goals:

Project Goals:

Provide electronic health care services to increase patient access to health care.

Telemedicine is viewed as a cost-effective alternative to the more traditional face-to-face way of providing medical care.

Provide pharmacy service for weekend hours not currently available for inpatients.

This project meets the following Region 3 goals:

Increase access to primary and specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their condition, regardless of where they live or their ability to pay.

Challenges:

Finding and contracting with a Pharmacy consulting company to provide telehealth services needed. This challenge was addressed by requesting current pharmacy providers to expand services offered to include this telemedicine service.

Incorporating the telemedicine procedure into the workflow and thereby changing the culture for the employees. This will be addressed by additional education for the pharmacy staff and nursing staff.

Without a Pharmacist on duty, there are a higher number of medication errors in hospitals. The challenges are from medications the patient was on prior to admission, to equivalent medications stocked by the admitting hospital, the administration of these different medications by pharmacy staff and errors upon dismissal.

5 Year Expected Outcome for Provider and Patients:

We expect to see a reduction of medical errors by 4% by DY5.

Starting Point/Baseline:

As of March 31, 2012 Columbus Community Hospital had a medication error rate of 16.4% and there is no pharmacy weekend coverage. This will be used as the baseline.

Rationale:

Columbus Community Hospital wants to improve patient safety through improving pharmacist oversight of prescriber orders. The use of remote service will increase the percentage of orders that are reviewed prospectively prior to initiation of therapy or decrease the amount of time between initiation of therapy and retrospective pharmacist order review. Remote pharmacists will perform a drug regimen review of all patients (including psychiatric and pediatric patients), that will include review for allergy contraindications; reasonable dose (special scrutiny of pediatric patients), route and directions for use; drug/drug, drug/food, and drug/disease interactions; and therapy duplications. Remote pharmacists will make clinical interventions to address any identified issues and to clarify orders. The pharmacist will intervene to make dosage adjustments for renal, vancomycin, aminoglycoside or other dosage recommendations. Pediatric doses can be assessed and a double check performed by a pharmacist for increased patient safety.

More timely review of orders will help prevent near misses from becoming medication administration errors. Adverse drug reactions will be identified and reported. Remote pharmacists can assist with cost containment by assisting with conversion of IV to bioequivalent oral therapy, identification and use of patient's own medication, and recommendations for non-formulary to formulary agents.

From the American Society of Healthcare Pharmacists': Review of medication orders. All medication orders shall be prospectively reviewed by a pharmacist and assessed in relation to pertinent patient and clinical information before the first dose is administered or made available in an automated dispensing device, except in emergent situations in which the treatment of the patient would be significantly compromised by the delay that would result from pharmacist review of the order. There shall be a procedure for retrospective review of these orders. Any questions regarding an order shall be resolved with the prescriber prior to administration, and any action taken as a result of this intervention should be documented in the patient's medical record. Information concerning changes shall be communicated to the appropriate health professionals caring for the patient.[69]

Patient counseling will be provided by the remote pharmacist utilizing audio-visual communication. This will allow the patient to interact with the pharmacist for a one-on-one dialogue to provide information and answer any questions the patient may have to increase medication therapy compliance. In summary, remote services will increase patient safety through more timely review of prescriber orders.

Project Components:

Through the Columbus Telemedicine Project (1.7.1) we will implement telemedicine to provide patient consultations by pharmacists and propose to meet all project core components as listed below:

Provide patient consultation by medical and surgical specialists as well as other types of health professionals using telecommunications

Conduct quality improvement for project using methods such as rapid cycle improvement. Activities 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

Milestones and Metrics:

[69] (American Society of Hospital Pharmacists, ASHP technical assistance bulletin on hospital drug distribution and control. Am J Hosp Pharm. 1980; 37:1097–103.)

The following milestones and metrics were chosen for the Telemedicine Project based on the core components and the needs of the target population:

Process Milestones and Metrics: P-4 (P-4.1, P-4.2)

Improvement Milestones and Metrics: I-12 (I-12.1)

Unique community needs identification numbers:

CN 2. – Insufficient access to specialty care (pharmacist)

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

This project represents a new initiative for our hospital. We will implement telemedicine to provide oversight and guidance to our patients for pharmacy services after hours and on weekends and supports our efforts to reduce medication errors.

Related Category 3 Outcome Measure

OD 3 Potentially preventable readmissions – 30 day readmission rates

IT-3.1 All-cause 30 day readmission rate – readmissions will be reduced thereby reducing hospital's 30 day readmission rate

Reasons/rationale for selecting the outcome measures:

It is important to expand telemedicine to areas where greatest need and highest potential for impact is demonstrated in order to have optimal effect. There is a direct relationship between higher medication errors and readmission. It is the goal to reduce medication errors using the telehealth technology and thereby reducing readmission factors.

Relationship to other Projects:

Columbus Community Hospital contracts with Hunter Pharmacy for pharmacists and pharmacy technicians. This project is being implemented in other small and rural hospitals around the state through the same vendor. This will allow for collaborations with other hospitals as the workforce is often shared and ideas are circulated by the district manager to encourage improvements in the process and performance at each hospital. CCH is only doing one project and is contracting with Hunter Pharmacy.

Relationship to Other Performing Providers' Projects in the RHP:

An innovative approach to increasing access to primary care and specialty care has been created by the miracles of the internet and computer systems. Telemedicine is leading edge for those communities who cannot easily access behavioral health or specialty care due to remote locations, lack of physicians, or urgency of encounter needs. Numerous telemedicine projects have been proposed, as seen in the Region 3 Initiative grid in the addendum, and all focus to outcomes such as appropriate emergency department utilization, 30-day readmission rates, and patient satisfaction scores.

Plan for Learning Collaboration:

We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system.

Project Valuation:

Utilizing Telemedicine for the services of a adding a professional pharmacist during times when none has been available in the past will assist in more timely care and administration of medication for inpatients and thereby increase the quality of patient outcomes and satisfactions. The results will be lower medication errors and subsequently reduce readmission rates to the hospital.

Between 2015-2010, $10,877,459 of hospital charges was potentially preventable according to the Texas Department of Health Services. In the second quarter of 2012 the readmission rate for Columbus Community Hospital surpassed the 80th percentile at 21.4% for 30 day readmission for short term care. These above statistics along with admissions increasing in the short term because of a closure of a nearby hospital (Colorado Fayette) make this project is an identified need for our community.

Columbus is a rural community with 44.8% of the population over the age of 45. Unplanned readmissions are difficult for the adult and geriatric population and reducing rate of unnecessary admissions. This project has important benefits to the community at large.

<table>
<tr><td>135033204.1.1</td><td>1.7.1.</td><td colspan="2">A-B</td><td colspan="2">Implement telemedicine program to provide or expand specialist referral services in an area identified as needed to the region</td></tr>
<tr><td colspan="3">Columbus Community Hospital</td><td colspan="3">135033204</td></tr>
<tr><td>Related Category 3 Outcome Measures:</td><td>135033204.3.1</td><td colspan="3">IT-3.1</td><td>Potentially Preventable Re-Admissions</td></tr>
<tr><th>Year 2
10/10/2012-9/30/2013</th><th colspan="2">Year 3
10/01/2013-9/30/2014</th><th colspan="2">Year 4
10/01/2014-9/30/2015</th><th>Year 5
10/01/2015-09/30/2016</th></tr>
<tr>
<td>Milestone 1 [P-4]: Implement or expand telehealth program for targeted health services, based upon regional and local community need.

Metric 1 [P-4.1]: Documentation of program materials including implementation plan, vendor agreements/contracts, staff training and HR documents.
Baseline/Goal: Increase from no pharmacy weekend coverage to 8 hours of total coverage per weekend (4 hours each Saturday and Sunday).
Data Source: Schedule of contract pharmacy coverage for Columbus Community Hospital

Milestone 1: Estimated Incentive Payment: $61,920.00</td>
<td colspan="2">Milestone 2 [P-4]: Implement or expand telehealth program for targeted health services, based upon regional and local community need.

Metric 1 [P-4.1]: Documentation of program materials including submission of implementation documentation with increased hours and improved clinical outcomes
Baseline: Increase from 4 hours each Saturday and Sunday to 8 hours plus all holidays to provide pharmacist overnight via telemedicine.
Goal: Reduction of the medication error rate by 3% during the year.
Data Source: In house statistics from EHR medication errors.

Milestone 2: Estimated Incentive Payment : $134,790.00</td>
<td colspan="2">Milestone 3 [P-4]: Implement or expand telehealth program for targeted health services, based upon regional and local community need.

Metric 1 [P-4.2]: Documentation of the quantity of actual telehealth services delivered after implementation with improved clinical outcomes.
Goal: Reduction of the medication error rate by 3% during the year.
Data Source: In house statistics from EHR medication errors.

Milestone 3 Estimated Incentive Payment: $90,940

Milestone 4 [I-12]: Increase number of telemedicine visits for each specialty identified as high need

Metric 1 [I-12.1]: Number of telemedicine consultations
Baseline/Goal: Increase by 5% over current which is 0
Data Source: EHR, or electronic referral processing system; encounter records from telemedicine program

Milestone 4 Estimated Incentive $43,000</td>
<td>Milestone 5 [P-4]: Implement or expand telehealth program for targeted health services, based upon regional and local community need.

Metric 1 [P-4.2]: Documentation of the quantity of actual telehealth services delivered after implementation with improved clinical outcomes.
Goal: Reduction of the medication error rate by 4% during the year.

Milestone 5 Estimated Incentive Payment: $85,300

Milestone 6 [I-12]: Increase number of telemedicine visits for each specialty identified as high need

Metric 1 [I-12.1]: Number of telemedicine consultations
Baseline/Goal: Increase by 10% over current which is 0
Data Source: EHR, or electronic referral processing system; encounter records from telemedicine program

Milestone 6 Estimated Incentive $34,000</td>
</tr>
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Year 2 Estimated Milestone Bundle Amount: $61,920.00	Year 3 Estimated Milestone Bundle Amount: $134,790.00	Year 4 Estimated Milestone Bundle Amount: $133,940.00	Year 5 Estimated Milestone Bundle Amount $119,300.00
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5): $449,950.00			

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Fort Bend County Clinical Health Services

Pass 1

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Project Summary – Fort Bend County 2967606-01 1.1
Development of behavioral health crisis stabilization services as alternatives to hospitalization – Behavioral Health Crisis Response and Intervention

Provider: Fort Bend County Clinical Health Services is a division of the Fort Bend County Health & Human Services Department (FBCHHS), the local health department for the County. Fort Bend County is located in the Houston metropolitan area of southeast Texas. It encompasses a total of 875.0 square miles (562,560 acres). The current population is estimated at almost 607,000. FBCHHS services include: Animal Services, Clinical Health Services, EMS, Environmental Health, Social Services, Veterans Services and Public Health Preparedness. Fort Bend County also has a Behavioral Health Services program.

Intervention: Fort Bend County (FBC) proposes to develop a crisis system that better identifies people with behavioral health needs, responds to those needs and links persons with their most appropriate level of care. The FBC project will include: (1) assessment and enhancement of 911 dispatch system to identify and respond to behavioral health crises, (2) development of a specialized crisis intervention team (CIT) within Fort Bend County Sheriff's Office, and (3) implementation of cross systems training and linkages to appropriate services and supports.

Need for the project: First responders have become the default interveners for behavioral health crises in FBC, with limited options for these patients. The majority of persons experiencing a behavioral health crisis in FBC access assistance through the 911 system. In 2011, FBC Emergency Medical Services (EMS) responded to 1, 171 mental health crisis calls, representing almost a 100% percent increase in the past 6 years. In most cases, multiple entities respond to behavioral health crises that often result in transportation to an emergency room or the FBC jail.

Target population: Persons in FB County experiencing a behavioral health crisis at risk of incarceration. The majority of these patients are uninsured or underinsured.

Category 1 patient benefit milestones: FBC expects to see a reduction in the percentage of patients with behavioral health needs that are incarcerated, or who access EMS and emergency departments. A 10% (160 individuals) decrease in mental health admission and readmissions to criminal justice settings (jail) is expected in DY *4* and 10% in DY and 1600 individuals will receive crisis intervention and/ or follow-up services by the specialized FB CIT.

Category 3 outcome measures: IT 9.2 Reduce emergency visits for behavioral health/ substance abuse by 10%.

Project Option 1.13 - Develop behavioral health crisis stabilization services as alternatives to hospitalization: Fort Bend County Behavioral Health Crisis Response and Intervention

Unique RHP Project Identification Number: 2967606-01 1.1
Performing Provider Center/TPI: Fort Bend County/2967606-01

Project Description:
Fort Bend County (FBC) proposes to develop a crisis system that better identifies people with behavioral health needs, responds to those needs and links persons with their most appropriate level of care.

Our goal is to keep individuals healthy and safe, develop processes and interventions to manage challenging behaviors, and avoid unnecessary use of the emergency room, hospitalization, or incarceration. First responders have become the default interveners for behavioral health crises in FBC, with limited options for these patients. The majority of persons experiencing a behavioral health crisis in FBC access assistance through the 911 system. In 2011, FBC Emergency Medical Services (EMS) responded to 1, 171 mental health crisis calls, representing almost a 100% percent increase in the past 6 years. In most cases, multiple entities respond to behavioral health crises that often result in transportation to an emergency room or the FBC jail. Many of these situations involve non-violent offenses and non-medical emergencies that could be redirected to less restrictive community based services if available. Unfortunately, many persons with mental illness end up in the ER for several hours waiting for an evaluation or transported to the FBC Jail. In 2011, approximately 20% of the population was identified as having a mental illness and even though there was a decrease in the overall jail population, the percentage of persons with mental illness has increased.

The lack of services and coordination has resulted in the jail and emergency rooms becoming the default crisis assessment and stabilization centers for patients with behavioral health needs. These patients often end up for extended periods in local hospital emergency rooms and/or the jail as a last resort. The most recent Needs Assessment of FBC conducted by the Lyndon Baines Johnson School of Public Affairs in the summer of 2011 states that the lack of services for the mentally ill has resulted in "mental health becoming a law enforcement issue."[70]

In order to effectively implement crisis stabilization services in FBC, identification, triage, and referral to the appropriate response system are integral to the process. Thus, the focus of the FBC project is on the identification and appropriate response at the dispatch and first responder levels. Focusing on the front end of the "community crisis system" will ensure that patients' needs (medical and behavioral) and safety are addressed in the timeliest and most appropriate manner. Coordination with behavioral health providers, such as Texana Center, physical health providers (e.g., Fort Bend Family Health), substance abuse treatment (e.g. Fort Bend Regional) and community organizations (e.g., Mental Health America (MHA), National Alliance on Mental Illness (NAMI) will ensure that patients receive clinically necessary and appropriate services and supports. The FBC Behavioral Health Crisis Response and Intervention Team (BHCRIT) Program will enhance the safety net, provide necessary intervention and diversion services, and as a result serve to reduce EMS transports, emergency room admissions,

[70] http://www.rgkcenter.org/sites/default/files/file/research/FB%20Report_for_posting.pdf

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and incarcerations. The FBC BHCRIT Program will identify these patients at dispatch and refer them to the appropriate intervention system. The trained law enforcement team (the Crisis Intervention Team (CIT)) will respond and work collaboratively with Texana Center, FBC's Health and Human Services, MHA, NAMI, other behavioral health providers and organizations in the community to assess the patients' needs and provide crisis services as appropriate.

A major gap in Fort Bend County is the lack of a "place" for the assessment and stabilization of crises. Texana Center, the local mental health authority for the county, is proposing a project for the development of these much needed services. The FBC and Texana projects will work collaboratively to ensure coordinated and appropriate care for patients with behavioral health needs. The FBC project will also partner with other behavioral health providers in the region that may be able to provide crisis stabilization services, follow-up services, substance abuse treatment, housing, family and patient education, wraparound supports, and information and referral. As a result, patients with behavioral health needs will be more likely to receive care in the right setting at the right time.

The FBC BHCRIT Program will enhance the safety net, provide necessary intervention and diversion services and as a result serve as the main gatekeeper to EMS transports, admissions to the emergency room, and incarcerations. The FBC project will include: (1) assessment and enhancement of 911 dispatch system to identify and respond to behavioral health crises, (2) development of a specialized crisis intervention team (CIT) within Fort Bend County Sheriff's Office, and (3) implementation of cross systems training and linkages to appropriate services and supports.

The unique community need this project addresses is CN.2 – Insufficient access to behavioral healthcare services, resulting in lack of care or delay of care, delivery of inappropriate and insufficient care, unnecessary and preventable complications, and increased demand on the criminal justice system.

Goals and Relationship to Regional Goals:

Project Goals:

FBC expects to see a reduction in the percentage of patients with behavioral health needs that are incarcerated, or who access EMS and emergency departments. The FBC project presents a major opportunity for infrastructure development and systems transformation. The FBC project is the result of extensive collaboration and commitment among county officials, law enforcement, health and human services, courts, EMS, and many community organizations to redesign current county operations to effectively respond to the behavioral health needs in the community. Through a county led initiative, preliminary work has been done around several of the core components. FBC will expand on the work of this initiative to include additional partners in the region and address emerging needs (e.g., additional community based services, family supports, peer supports, wraparound supports, and physical health). The FBC BHCRIT Program is the critical component of a "community crisis stabilization system" and has the potential to impact the largest number of patients and divert them from entering the criminal justice or hospital systems.

This project meets the following Region 3 goals:

- Develop a regional approach to health care delivery that leverages and improves on existing programs and infrastructure that is responsive to patient needs throughout the entire region, and improves health care outcomes and patient satisfaction;

- Increase access to primary and specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their condition, regardless of where they live or their ability to pay; and,
- Develop a culture of ongoing transformation and innovation that maximizes the use of technology and best-practices, facilitates regional collaboration and sharing, and engages patients, providers, and other stakeholders in the planning, implementation, and evaluation processes.

The FBC BHCRIT Program leverages existing resources (911 dispatch system, law enforcement, data systems, emergency medical services, community providers), enhances services, cross-systems training, and data sharing to identify patients with behavioral health needs and link them to appropriate services. First responders, law enforcement and EMS have become the default interveners for behavioral health crises in FBC, who are equipped with limited tools and resources to effectively handle these complex situations. The majority of persons experiencing a behavioral health crisis in FBC access assistance through the 911 system. In order to effectively divert persons with behavioral health needs from the unnecessary use of the emergency rooms, hospitalization, and incarceration, we must change the response and intervention systems that currently exist starting with dispatch and first responders.

Challenges:

Access to appropriate levels of care will be a challenge. There are limited resources for stabilizing and supporting persons with behavioral health disorders in the community. The FBC project will address this by engaging with public and private providers of behavioral health services, community organizations, and volunteer groups. For example, FBC will work with MHA of FBC to develop an on-line resource directory with special attention to high risk populations (e.g., discharged from hospitals, jails, veterans with mental illness, patients with mental illness with children, co-occurring disorders). This project will also focus on the expansion of wraparound supports necessary for keeping persons in the community and developing resiliency to prevent future crises.

The integration of data systems will also be a challenge**.** FBC has well developed data tracking systems but these need to be integrated to facilitate communication regarding patients' needs, linking them to appropriate services and tracking outcomes. The availability of integrated data tracking systems will allow us to continuously identify unmet needs and new resources. The project will work with various partners in the region as well as the county's Information Technology department to develop the most efficient data tracking system. These data elements will be used as part of the project's quality improvement process.

5-year Expected Outcome for Provider and Patients:

FBC expects to see a reduction in the percentage of patients with behavioral health needs that are incarcerated, access EMS and emergency departments. The project will be county wide and include the following zip codes:

77053	77406	77407	77417	77441	77444
77451	77459	77461	77464	77469	77471
77476	77477	77478	77479	77481	77487
77489	77494	77496	77497	77498	77545

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Starting Point/Baseline:
Currently a Crisis Response and Intervention program, focusing on 911 dispatch, specialized law enforcement training, and increased community services and supports, does not exist. This is a new program; therefore, the baseline for all metrics and milestones will be established after the project is implemented.

Rationale:
Reasons for selecting the project option: 1.13.1 Develop and implement crisis stabilization services to address the identified gaps in the current community crisis system. For this reason, the focus of the FBC project is on the identification and appropriate response at the dispatch and first responder levels.

Project Components:
Through the FBC BHCRIT Program, we propose to meet all the required project components below and the selected milestones and metrics that relate to the project components.

a. Convene community stakeholders who can support the development of crisis stabilization services to conduct a gap analysis of the current community crisis system and develop a specific action plan that identifies specific crisis stabilization services to address identified gaps. A great deal of work has been done by FBC through the Criminal Justice Mental Health Initiative during the past 4 years with a focus in the past year on the development of law enforcement Crisis Intervention Team and additional behavioral health services.
b. Analyze the current system of crisis stabilization services available in the community including capacity of each service, current utilization patterns, eligibility criteria, and discharge criteria for each service.
c. Assess the behavioral health needs of patients currently receiving crisis services in the jails, emergency departments, or psychiatric hospitals. Determine the types and volume of services needed to resolve crises in community-based settings. Then conduct a gap analysis that will result in a data-driven plan to develop specific community-based crisis stabilization alternatives that will meet the behavioral health needs of the patients (e.g., a minor emergency stabilization site for first responders to utilize as an alternative to costly and time consuming ER settings). FBC has developed data tracking systems for the jail and EMS that allow us to identify persons with behavioral health needs and determine their use of jail and emergency rooms. FBC has worked extensively with various county departments and the Sheriff's Office to identify and assess behavioral health needs of patients in the jail. The FBC project will expand on this work.
d. Explore potential crisis alternative service models and determine acceptable and feasible models for implementation.
e. Review the impact of intervention(s) on access to and quality of behavioral health crisis stabilization services, and identify "lessons learned," opportunities to scale all or part of the intervention(s) to a broader patient population, and key challenges associated with expansion of the intervention(s), including special considerations for safety-net populations.

Milestones & Metrics:
FBC has selected the following process milestones and metrics. These were chosen to ensure core components, some of which have already been fulfilled, are completed and documented appropriately.

- P-2 – Conduct mapping and gap analysis of current crisis system.
- P-3 – Develop implementation plans for needed crisis services.
- P-4 - Hire and train staff to implement identified crisis stabilization services.
- P-5 – Develop administration of operational protocols and clinical guidelines for crisis services.
- P-9 – Participate in face-to-face learning (i.e., meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around similar or shared projects.

Since this is a start-up project and these services are not available, all of these milestones/metrics are necessary for a successful project.
The following improvement milestone and metrics were chosen:
I-10.1: 10% decrease in mental health admission and readmissions to criminal justice settings such as jails or prisons in DY 4 and 10% in DY 5.
The proposed project focusing on the development of a coordinated crisis response system in Fort Bend County, which includes the development of a Crisis Intervention Team, has the main objective of connecting persons with appropriate services and preventing unnecessary incarceration and emergency room utilization. Interventions that prevent individuals from entering and/or cycling through the criminal justice system, such as CIT, can help avert poor health and mental health outcomes, reduce long term medical costs and improve functioning. This milestone was chosen to ensure that the FBC Behavioral Health Crisis Response and Intervention Project is responding appropriately to crisis calls and diverting them from jails and unnecessary hospitalization.

How the project represents a new initiative for the Performing Provider or significantly enhances an existing service delivery reform initiative:
This is a new initiative for FBC and will improve response to patients with behavioral health needs. In addition, this initiative will further the development of needed infrastructures and partnerships to leverage existing resources, develop additional resources based on identified needs, and improve access to care in the community.

Related Category 3 Outcome Measure(s):
The Category 3 Outcome Measure chosen falls within OD-9-Right Care, Right Setting.
Reasons/rationale for selecting the outcome measure(s):
The goal of the FBC project is to divert persons experiencing behavioral health crisis from the incarceration and unnecessary use of emergency departments. The FBC project will focus on the identification of behavioral health crisis, triage and appropriate intervention from the onset of the 911 call followed by the referral to the specialized CIT team and follow-up services. This will divert persons with behavioral health needs to the appropriate services as opposed to EMS transports and admissions to the ER or jails.

Relationship to Other Projects: This project will interface with Crisis Stabilization projects proposed by Texana. Once a law enforcement team is trained to recognize mental illness and

appropriate law enforcement interventions to use for this population, they must have a place to take these individuals other than the jail and emergency rooms for complete evaluation and assessment. The proposed Crisis Stabilization Center will be a critical component to the development of a "coordinated crisis response and intervention" system.

This project will also interface with other FBC projects such as Expand Medical Home, Redesign of Primary Care, and "Ask the Nurse". All of these will facilitate access to essential primary care, which is often overlooked for persons with behavioral health disorders.

Relationship to Other Performing Providers' Projects in the RHP:
The FBC project will interface with other Performing Provider's (PP's) in the region to ensure access to necessary behavioral health services to prevent admissions and readmissions to the jail as well as the unnecessary use of the emergency rooms (e.g., Oak Bend Hospital).
Numerous community needs assessments reflect an extreme need for behavioral health services to include outpatient treatment centers, crisis stabilization units, inpatient beds, and much more. The lack of funding as well as complexity of the regions patient base has limited the amount of behavioral health treatments available to our region and continues to drive cost in emergent and inpatient situations. The Crisis Stabilization Unit has a direct correlation to all behavioral health programs recommended in the RHP plan and will be a focus of two of the largest Local Mental Health Authorities of our region. Both CSU's share the outcome measures of mental health admissions & readmissions, and improvement of patient satisfaction scores. The Region 3 Initiative Grid attached in the addendum reflects the direct relationships of this initiative.

Plan for Learning Collaborative: We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system.

Project Valuation: This project addresses the top priority identified by the FBC 1115 planning group – a system for responding to behavioral health crises and providing appropriate care. This project addresses key components of the "community crisis system" by enhancing the county's dispatch system, cross training dispatchers, law enforcement, EMS and other first responders, developing a specialized law enforcement team (CIT), and developing protocols and systems to connect patients with the most appropriate care in a timely manner. The project was valued based on cost-avoidance by projecting savings associated with incarceration and unnecessary use of emergency departments by patients in Fort Bend County with behavioral health needs. FBC has analyzed data from EMS and the Sheriff's Office for the past several years to determine the number of persons with behavioral health crises that access those systems. Annual cost savings are estimated to be: $450k for avoided ER visits to Oak Bend; $1.8m in avoided incarceration costs; $560k for avoided EMS calls; $1.2m for avoided State Hospital visits; and $80k for avoided transports by law enforcement. This program is projected to avoid costs totaling $4.1m annually or $16.4m over four years.

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2967606 1.1	*1.13.1*	*(A–E)*	***Develop and implement crisis stabilization services to address the identified gaps in the current community crisis system***
Fort Bend County			*2967606-01*
Related Category 3 Outcome Measures	*2967606-01 3.1*	*IT-9.2*	*ED Appropriate Utilization*
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P- 2]: Conduct mapping and gap analysis of current crisis system. Metric 1 [P-2.1]: Produce a written analysis of community needs for crisis services. Baseline/ Goal: TBD/Analysis of Fort Bend County crisis services Data Source: Written report Process Milestone 1 Estimated Incentive Payment: $1,037,413 **Milestone 2** [P-3]: Develop implementation plans for needed crisis services. Metric 1 [P-3.1]: Produce data-driven written action plan for development of specific crisis stabilization alternatives that are needed in each community based on gap analysis and assessment of needs. Baseline/Goal: Action plan based on needs assessment Data Source: Written implementation/ action plans Process Milestone 2 Estimated Incentive Payment: $1,037,413	**Milestone 3** [P-4]: Hire and train staff to implement identified crisis stabilization services. Metric 1 [P-4.1]: Number of staff hired and trained. Baseline/Goal: TBD/Goal is to hire and train 9 CIT staff. Goal is to train 23 (50% of workforce) 911 dispatchers. Data Source: Training curricula, training logs, training evaluation Process Milestone 3 Estimated Incentive Payment: $1,063,323 **Milestone 4** [P-5]: Develop administration of operational protocols and clinical guidelines for crisis services. Metric 1 [P-5.1]: Completion of policies and procedures. Baseline/Goal: Develop agreed upon guidelines for crisis services Data Source: Fort Bend County operational and clinical guidelines manuals for crisis services Process Milestone 4 Estimated Incentive Payment: $1,063,322	**Milestone 5** [P-9]: Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around similar or shared projects . Metric 1 [P-9.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Baseline/Goal: Promote continuous learning and best practices in twice-yearly meetings. Data Source: Documentation of semiannual face-to-face meetings including meeting agendas, slides from presentations, and/or meeting notes. Process Milestone 5 Estimated Incentive Payment: $1,180,609 **Milestone 6** [I-10]: Criminal Justice Admissions / Readmissions Metric 1 [I-10.1]: 10% decrease in mental health admission and readmissions to criminal justice settings such as jails or prisons in DY3 Baseline/Goal: TBD / 10%	**Milestone 7** [P-9]: Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around similar or shared projects. Metric 1 [P-9.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Baseline/Goal: Promote continuous learning and best practices in twice yearly meetings. Data Source: Documentation of semiannual face-to-face meetings including meeting agendas, slides from presentations, and/or meeting notes. Process Milestone 7 Estimated Incentive Payment: $1,138,667 **Milestone 8** [I-10]: Criminal Justice Admissions / Readmissions Metric 1 [I-10.1] : 20% decrease in mental health admission and readmissions to criminal justice settings such as jails or prisons in DY3 Baseline/Goal: DY4 Baseline / 20% decrease

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2967606 1.1	*1.13.1*	*(A–E)*	***DEVELOP AND IMPLEMENT CRISIS STABILIZATION SERVICES TO ADDRESS THE IDENTIFIED GAPS IN THE CURRENT COMMUNITY CRISIS SYSTEM***
Fort Bend County			*2967606-01*
Related Category 3 Outcome Measures	*2967606-01 3.1*	*IT-9.2*	*ED Appropriate Utilization*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
		decrease a. 160 individuals will have a preventable admission/ readmission to the FBC jail within DY 4. b. 1600 individuals will receive crisis intervention and/ or follow-up services by the specialized FB CIT. Data Source: CIT reports, jail data, clinical records Milestone 6 Estimated Incentive Payment*:*$1,180,608	a. 160 individuals will have a preventable admission/ readmission to the FBC jail within DY 4. b. 1600 individuals will receive crisis intervention and/ or follow-up services by the specialized FB CIT. Data Source (1-10.1): CIT reports, jail data, clinical records Milestone 8 Estimated Incentive Payment*:* $1,138,666
Year 2 Estimated Milestone Bundle Amount: $2,074,826	Year 3 Estimated Milestone Bundle Amount: $2,126,645	Year 4 Estimated Milestone Bundle Amount: $2,361,217	Year 5 Estimated Milestone Bundle Amount: $2,277,333
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over DYs 2-5)***:** $8,840,021			

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Fort Bend County Clinical Health Services

Pass 3

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Project Summary - Fort Bend County 2967606-01 1.2
Expand Existing Primary Care Capacity – Expand Hours of Service

Provider: Fort Bend County Clinical Health Services is a division of the Fort Bend County Health & Human Services Department (FBCHHS), the local health department for the County. Fort Bend County is located in the Houston metropolitan area of southeast Texas. It encompasses a total of 875.0 square miles (562,560 acres). The current population is estimated at almost 607,000. FBCHHS services include: Animal Services, Clinical Health Services, EMS, Environmental Health, Social Services, Veterans Services and Public Health Preparedness. Fort Bend County also has a Behavioral Health Services Program.

Intervention: This project will expand the hours of operation of the local Federally Qualified Health Center (FQHC) to increase access to primary care for the Medicaid, uninsured and underinsured populations in the county. One of the barriers to establishing a medical home for primary care and chronic care management is that of lack of after-hours care for the working population with no health care coverage or Medicaid coverage. This gap encourages the use of EMS and ED services inappropriately for non-emergent conditions and does not allow for establishment of a medical home. The project will provide increased access to primary care as well as a patient navigation system (expanded in another project) to promote the medical home and provide primary care, prevention services and chronic condition management. In addition, linkages to social service agencies to resolve other issues will be provided. Navigation will include follow up for appointment and medication compliance.

Need for the project: While the county population as a whole is wealthy, 8% of the population (48,560) live below the federal poverty level and 19% of the population has no health insurance coverage (>115,000). In one of the county census divisions, more than 17% of the population lives below the federal poverty level. The county has no hospital district and the only health care payment available to the population that does not qualify for Medicaid/Medicare is the Indigent Health Care program which covers only those with an existing medical condition who have an income of less than 21% of the federal poverty level. The program covers up to $30,000 of eligible medical care per year for individuals who qualify for the program, approximately 1,000 per year. In some areas and some populations in the county, when no primary care is available or affordable, the EMS and ED are by default the primary care providers.

Target Population: Uninsured, underinsured and Medicaid covered individuals who do not access primary care and use emergency services in lieu of a medical home. Patients will receive the benefit of ongoing assistance with medical care for primary care, prevention and chronic conditions as well as being linked to needed social services and transportation.

Category 1 patient benefit milestones: The program will divert patients from high cost EMS transportation and ED visits to the FQHC medical home.

Category 3 outcome measures: IT 1.1 – 10% (DY4) and 20% (DY5) reduction in third next appointment interval in the target population. IT 9.2 - 25% (DY4) and 30% (DY5) reduction in ED use in the target population.

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Project Option 1.1.1 – Expand Existing Primary Care Capacity – Expand Hours of Service

Unique RHP Project Identification Number: 2967606-01 1.2 / Pass 3
Performing Provider Name /TPI: Fort Bend County Clinical Health Services / 2967606-01

Project Description:

Fort Bend County proposes a project to expand the hours of operation of the local Federally Qualified Health Center (FQHC) to accommodate the expected increase in use by Indigent Health Care, Medicaid and uninsured patients who are referred into the clinic from the other projects proposed by Fort Bend County. The projects include:

- an expansion of patient navigation designed to improve primary care/medical home use as opposed to emergency department (ED) and emergency medical service transport (EMS) for non-emergent conditions and to improve management of chronic conditions in these populations (2967606-01 2.1)
- a community paramedic project to provide primary care in the home setting with a referral in to the FQHC patient navigation program (2967606-01 2.3), and
- a primary care screening program for colorectal cancer which includes ongoing primary care for overall wellbeing in the FQHC (2967606-01 2.4).

The local FQHC has in place the protocol to manage patients at the level of preventive care, for management of chronic conditions and outpatient acute illnesses. However, the clinic has varied hours by specialty and by day based on the availability of staffing teams to man the clinic. The proposed project would enhance the capacity of the clinic to respond to the number of clients anticipated to be referred in a and followed by the FQHC by increasing the hours of the clinic to a consistent 7am to 7pm schedule and including all Saturdays

Target Zip codes for the program are:

77053	77406	77407	77417	77441	77444
77451	77459	77461	77464	77469	77471
77476	77477	77478	77479	77481	77487
77489	77494	77496	77497	77498	77545

Goals and Relationship to Regional Goals:

The goal of this project is to provide expanded access to primary care by increasing the staffing at the local FQHC and thereby expanding the hours of operation. The goal will increase the number of medically indigent, uninsured, and Medicaid eligible clients who have a medical home, prevention services and chronic disease management. At the same time, the project will reduce the number of patients from this population who use EMS and the ED to serve as their medical care providers. In so doing, the cost of more expensive care will be reduced and the quality of life of impacted community members will be enhanced.

<u>The project meets the following regional goals:</u>

- Increase access to primary and specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their condition, regardless of where they live or their ability to pay.
- Transform health care delivery from a disease-focused model of episodic care to a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary or duplicative services, and builds on the accomplishments of our existing health care system.

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Challenges:
The populations that this project seeks to serve have established patterns of behavior that are not conducive to improved health or to cost effective use of existing medical resources. As with any intervention that seeks to change current behavior, the project will need to be patient centered and be flexible to encourage the change in behavior that is desired. Data collection for baseline and rapid cycle evaluation will need to come from a variety of providers and agencies and will need a systematic collection methodology.

5-year Expected Outcome for Provider and Patients:
Fort Bend County expects to see decreases in use of the ED and EMS for non-urgent conditions, to see improvements in health status of the targeted population, improved follow up with appointments and medications or other interventions and an improvement in recognition of available community resources and the concept of a medical home for all.

Starting Point/Baseline:
Baseline data is not established, although community partners and the FQHC have some data points as background rationale for the project. Data will be gathered on past and current users of the FQHS, the EMS transportation system, hospital EDs and the Fort Bend County Indigent Care program for non-emergent and for frequent users of the high-end resources to establish the patterns of resource use as a starting point for the proposed program. In the first six months of the program, data gathering systems will be put in place to monitor the successful referral and engagement of patients from the target populations.

Rationale:
Fort Bend County does not have a hospital district structure for indigent healthcare or for the uninsured and underinsured population of the County. The County participates in the state mandated Indigent Health Care Program which provides care for qualifying individuals whose income is below 22% of the Federal Poverty Level. With a population estimate of 606,000, there are more than 48,500 (8%) individuals living below the Federal Poverty Level and up to 145,000 uninsured at this time in the County[1]. For these individuals, medical care is often beyond their economic reach. Cash payment options and even sliding scale fees take lower priority than housing payments and food. One of the ways that the indigent population of the County avoids payment up front is to utilize the EMS 9-1-1 response system to obtain a "free" ride to the hospital, to receive priority care in the Emergency Department because of EMS transport and to not have a co-pay on site at the hospital.

Data from the local hospital handling the majority of indigent or uninsured/ underinsured clients in the county, shows that more than two thirds of the ED visits in 2011 were not of an emergent nature. In addition, of the approximately 10,000 patients seen in the first half of this year, 20% were Medicare enrollees, 37% Medicare and Medicaid managed care, and 1% county indigent health care. The remaining 42% are self-pay of which the majority have no means to pay for their health care.

Along with the use of expensive EMS and ED services for non-emergent illnesses, is the use of these same resources for chronic conditions which could better be managed and controlled in an outpatient setting using a medical home approach. Barriers to patients voluntarily seeking

this option include lack of knowledge and understanding of their own medical conditions and of the resources available, lack of transportation, inability to pay fees and available hours for care.

In addition to these issues, the working but uninsured or underinsured population cannot afford to take off work to attend doctor appointments for themselves or their dependents during normal working hours. Expanding the hours of operation will assist with allowing referred patients from the target population to take advantage of the FQHC and establish a medical home.

The County Indigent Health Care program currently focuses on the need for care once an illness has developed and does not include a preventive or chronic care model.

When a patient is provided stabilization care by the County EMS department and then refuses transportation to the hospital, valuable continuing care coordination and follow-up is lost. A study of frequent users of the County EMS service showed 15,000 patients with more than three uses of the EMS service in a span of 18 months. The highest number was 20 calls in 18 months. The highest number of calls for one individual in the calendar year 2011 was 16 calls, but one individual has already reached 18 calls in the first 8 months of 2012.

Project Components:

Required core project components: 1.1.1

a) Expand primary care clinic space (this component is not needed for the project)

the additional staff and hours will be in the same location(s) of the FQHC and additional space is not required to accomplish this project.

b) Expand primary care clinic hours

The FQHC clinic currently has different hours each day, and is only open on certain Saturdays. This project will add one full team of providers and the shifts will be adjusted to allow a full 7am to 7pm schedule each week day and to cover each Saturday. The standard schedule will provide increased access to primary care for the target population, particularly those who are employed and cannot make appointments from 8-5..

c) Expand primary care clinic staffing

As noted above, one full team of providers, include medical and support staff, will be added to the clinic roster to allow rotation of shifts to cover a standard 7am to 7pm schedule each weekday and to cover every Saturday.

Milestones and Metrics:

Process Milestones and Metrics

P-4. Milestone: Expand the hours of a primary care clinic, including evening and/or weekend Hours (Metric P-4.1)

P-5. Milestone: Train/hire additional primary care providers and staff and/or increase the number of primary care clinics for existing providers (Metric P-5.1).

Improvement Milestones and Metrics

I-12. Milestone: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. (Metric I-12.1)

I-15. Milestone: Increase access to primary care capacity. (Metric I-15.1)

Unique community need identification number the project addresses:

- CN.7 Insufficient access to care coordination practice management and integrated care treatment programs.

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- CN.8 High rates of inappropriate emergency department utilization
- CN.9 High rates of preventable hospital admissions
- CN.11 High rates of chronic disease and inadequate access to treatment programs and services for illnesses associated with chronic disease

How the project represents a new initiative for the Performing Provider or significantly enhances an existing delivery system reform initiative.
This project uses the existing medical practice in the local FQHC and expands the available hours of access to primary care at the clinic. It additionally provides access to the care coordination protocol for those traditionally not involved in coordinated care systems which can lead to improved health outcomes and reduction in encounters with EMS and the ED.

Related Category 3 Outcome Measures:
OD-1 Primary and Chronic Disease Management (IT 1.1 – Third Next Available Appointment)
OD-9 Right Care, Right Setting (IT 9.2 – ED Appropriate Utilization / Reduce ED use in target population referred to Care Coordination Program)
Reasons/Rationale for selecting the outcome measures:
The target populations of Medicaid patients, County Indigent Care patients, uninsured or underinsured patients have habitually used high end medical resources such as the ED due to lack of financial resources to pay for medical care, or lack of access to primary care sites in the evenings or on weekends. The measures will allow measurement of improvements in access and reduction in use of the ED.

Relationship to other Projects: This project supports the Chronic Disease registry and intervention projects proposed by our partners, the local hospital authority, and the FQHC as well as the care coordination, colorectal screening and community paramedic programs proposed by the county. The intention of all projects is to decrease the burden of care on the EMS and emergency departments as well as to establish a medical home and improved coordination of care model for chronic and non-emergent conditions that will improve the health of the individuals involved, resulting in improved health and reduce the cost of care.

Relationship to Other Performing Providers' Projects in the RHP:
Primary Care/Ambulatory Care clinics are a top priority to Region 3 due to the acuity of the regional patient mix, population concentration, and lack of primary care access points for our patient base. The regional approach of collaboration as well as existing patient referral pattern relationships allowed our team to properly identify the community needs based on the necessity of population, uninsured, and medically underserved patient bases. This program is consistent with our region and similar to numerous initiatives in our RHP plan sharing both concepts as well as outcome measures focused to percent improvement over baseline of patient satisfaction scores, reduction of inappropriate ED utilization, and third next available appointment status. The Region 3 Initiative Grid attached as a RHP Plan addendum reflects a grid of relationship for all initiatives.

Plan for Learning Collaborative: We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have

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similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system.

Project Valuation:

This project addresses a top priority identified by the FBC 1115 Access to Care planning group – increased hours of service for community residents who are medically indigent, uninsured or underinsured. The project aims to reduce EMS and ED use in this population, thereby improving the health of the targeted population by access to ongoing preventive and chronic disease care in a patient centered program as opposed to episodic disease care in high cost resource settings. Valuation is based on cost avoidance, projecting savings associated with reducing unnecessary EMS and ED use by patients in the target population. Fort Bend County has an estimated annual utilization of ED totaling 20,000 patients. 42% (8,400) are self-pay with no insurance coverage and 2/3's of these ED uses (5,600) were not of an emergent nature. With successful diversion of 7% of these ED uses (392/yr), Fort Bend County will avoid ED costs of $2.2 million over four years based on a cost per visit of $1,400.

References:

1. http://www.rgkcenter.org/sites/default/files/file/research/FB%20Report_for_posting.pdf

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2967606-01 1.2		***1.1.2***	***B AND C***	***ESTABLISH PRIMARY CARE CAPACITY (EXPAND HOURS OF SERVICE)***
Fort Bend County				***2967606-01***
Related Category 3 Outcome Measure(s):	*3.10* *3.11*	*IT 1.1* *IT 9.2*	*Third Next Available Appointment* *ED Appropriate Utilization*	

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-4]: Planning stage for expansion of hours. Metric 1 [P-4.1]: Determine the following: • Targeted patient population characteristics (e.g., patients with no PCP or medical home, frequent ED utilization, homelessness, insurance status, low health literacy). • Gaps in services and service needs. • Structure of coverage teams • Ideal number of medical providers needed for the expanded hours. • Number of support staff needed to be hired • Establish third next appointment baseline Goal: To produce a report including the above data for program planning and implementation Data Source: Program documentation, EHR, claims, needs assessment survey, partner organization data Milestone 1 Estimated Incentive Payment: $405,09	**Milestone 2** [P-4]:Expand clinic hours Metric 1 [P-4.1]: Increased number of hours at clinic over baseline Baseline: TBD Goal: increase hours to standardized 7am to 7pm weekdays and include Saturday hours Data Source: Clinic documentation Milestone 2 Estimated Incentive Payment: $229,941 **Milestone 3** [P-5]: Train/hire additional primary care providers and staff Metric 1 [P-5.1]: Documentation of increased number of providers and staff Baseline: TBD Goal: - Increase number of providers to cover hours of clinic operation Data Source: Clinic documentation Milestone 3 Estimated Incentive Payment $229,941	**Milestone 4** [P-4]:Expand clinic hours Metric 1 [P-4.1]: Increased number of hours at clinic over baseline (maintain as in DY3) Baseline: DY3 hours of operation Goal: increase hours to standardized 7am to 7pm weekdays and include Saturday hours Data Source: Clinic documentation Milestone 4 Estimated Incentive Payment: $251,275 **Milestone 5** [P-5]: Train/hire additional primary care providers and staff Metric 1 [P-5.1]: Documentation of increased number of providers and staff Baseline: DY3 number of providers and staff Goal: - Maintain number of providers to cover hours of clinic operation as in DY3 Data Source: Clinic documentation Milestone 5 Estimated Incentive Payment $251,274	**Milestone 6** [P-4]:Expand clinic hours Metric 1 [P-4.1]: Increased number of hours at clinic over baseline (maintain as in DY4) Baseline: DY4 hours of operation Goal: increase hours to standardized 7am to 7pm weekdays and include Saturday hours Data Source: Clinic documentation Milestone 6 Estimated Incentive Payment: $161,124 **Milestone 7** [P-5]: Train/hire additional primary care providers and staff Metric 1 [P-5.1]: Documentation of increased number of providers and staff Baseline: DY4 number of providers and staff Goal: - Maintain number of providers to cover hours of clinic operation as in DY4 Data Source: Clinic documentation Milestone 7 Estimated Incentive Payment $161,124

2967606-01 1.2	***1.1.2***	***B AND C***	***ESTABLISH PRIMARY CARE CAPACITY (EXPAND HOURS OF SERVICE)***
Fort Bend County			***2967606-01***
Related Category 3 Outcome Measure(s):	*3.10* *3.11*	*IT 1.1* *IT 9.2*	*Third Next Available Appointment* *ED Appropriate Utilization*
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
			Milestone 8 [I-13]: Enhanced Capacity to provide urgent care services in the Primary Care setting. Metric 1 [I-13.1]: 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 Baseline: TBD determined for DY3 Goal: 10% improvement in receiving urgent care appointment in primary care setting Milestone 14 Estimated incentive Payment $161,124
Year 2 Estimated Milestone Bundle Amount: $405,096	Year 3 Estimated Milestone Bundle Amount: $459,882	Year 4 Estimated Milestone Bundle Amount: $502,549	Year 5 Estimated Milestone Bundle Amount: $483,372
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over DYs 2-5)*: $1,850,899			

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Gulf Coast Medical Center

Pass 1

Project Option 1.9.2-Expand Specialty Care Capacity: Establish Adult Inpatient Psychiatric Unit
Unique RHP Project ID: 178815001.1.1
Performing Provider Name/TPI: Gulf Coast Medical Center/178815001

Project Summary:
Provider: Gulf Coast Medical Center, located in Wharton County, is a for profit acute care facility licensed for 161 beds. Services provided include general medical care, surgical services, women's services, radiology, cardiopulmonary, wound care center, intensive care (12 beds), emergency department, and gero-psych (17 beds). Although November is not yet final this facility has provided charity care for a total of $8,831,031 for 2012 year to date.

Volume Statistics-Year to Date 2012	Patient Payor Mix	Patient Demographics
Hospital Admissions 1,323 Births 236 Emergency Visits 8,948	Self Pay 16% Medicaid 17% Medicare 44% Other Funding 2% Commercial Ins. 21%	Hispanic 36% African American 31% Caucasian 31% Other 2%

Intervention (s):
This project will establish a 28 bed adult inpatient psychiatric unit within Gulf Coast Medical Center which will be dedicated to the treatment of general psychiatric disorders for the age population of 18 through 64 years of age and evaluate outpatient center development for follow up care.
Need for the Project: Wharton County and the surrounding rural area are currently underserved with regard to Psychiatric Care. In addition, finding an accepting facility for those patients presenting to the Emergency Department (ED) in need of inpatient psychiatric treatment is most difficult. Treatment delay has been known to occur frequently due to lack of beds at treatment facilities which require patients to remain in our ED until such time that a bed is secured and transfer can occur.
Target Population: All patients requiring inpatient level of care for the treatment of psychiatric disorders from within Wharton County and the surrounding rural areas may benefit from this project. Currently no baseline data is available as inpatient psychiatric treatment facilities are non existent in the County.
Category 1 Expected Patient Benefits: Our goal is to implement a process by which referrals are processed in a timely for inpatient psychiatric admission to prevent delay of treatment. Baseline will be established in DY 2 with a time improvement DY 3, 4, and 5. In addition, average daily census will improve DY 3, 4, and 5 as compared to baseline established in DY2.
Category 3 Outcomes: IT-1.18 Our goal is to improve follow up rates with mental health practitioner by 5% in DY4 and 10%in DY5 as compared to baseline which will be established in DY3.
IT-1.20 Our goal is to improve timeliness of inpatient admission for mental illness by % of increase of admission rate DY4 and DY 5 as compared to baseline established in DY 3.

Project Option 1.9.2- Expand Specialty Care Capacity: Establish Adult Inpatient Psychiatric Unit

Unique RPH Provider Identification Number: 178815001.1.1

Performing Provider Name/TPI: Gulf Coast Medical Center/178815001

Project Description:
Gulf Coast Medical Center proposes a project (1.9 Expand Specialty Care Capacity) which would allow access to inpatient level of treatment for adults with psychiatric disorders.

The performing provider is currently in the planning stages of establishing a 28 bed ~~patient~~ adult psychiatric unit ~~with 14 inpatient beds being~~ dedicated to the treatment of general psychiatric disorders. ~~and 14 inpatient beds being dedicated to the treatment of the military forces and their dependents with the focus being post traumatic stress disorder~~. Current challenges facing the provider include the lack of adult inpatient psychiatric care within Wharton County and the surrounding rural areas. In addition, finding an accepting facility for inpatient treatment for this diagnosis specific population is most difficult. Treatment delay is common with the psychiatric patient remaining in the Emergency Department until such time that a bed becomes available and the transfer is secured. This delay in care has been noted to be greater than 60 hours in some cases. The addition of an inpatient adult psych unit aligns with the regional goal of increasing access to specialty services and to ensure patients receive the most appropriate care for their condition. Inadequate access to specialty care has contributed to the limited scope and size of safety net health systems. To achieve success as an integrated network, gaps must be thoroughly assessed and addressed. The expected outcome of the project allows for the treatment of psychiatric disorders of adult patients requiring inpatient level of care within Wharton County. Currently specialty treatment on an inpatient level for psychiatric conditions is nonexistent for the adult patient population less than 65 years of age.

Goal (s) and Their Relationship to Regional Goals:

The goal of this project is to provide inpatient level of psychiatric care for the adult patients in Wharton County and the surrounding rural areas. ~~as well as treatment for post traumatic stress to the military population and their dependents.~~

Project Goals:

- Provide inpatient psychiatric care to the adult population by establishing an inpatient Psych Unit with ~~14~~ 28 beds designated for the treatment of general psychiatric disorders.
- ~~Provide inpatient psychiatric care to the military forces and their dependents with emphasis on the treatment of post traumatic stress syndrome.~~

This project meets the following Region 3 goals:

- Increase access to specialty care services to ensure patient receive the most appropriate care for their condition.

Challenges:

Wharton County and the surrounding rural area are currently underserved with regard to Psychiatric Care. Information obtained from the United States Census Bureau for 2011 the population of Wharton County is estimated at 41,314. Of those, approximately 58.50% are between the ages of 18 and 65 (this does not include the census of the surrounding areas).

Although this total will not require treatment for psychiatric disorders the potential for need has been observed and witnessed frequently in the Emergency Department of Gulf Coast Medical Center. The challenge of obtaining the most appropriate care for their condition as noted in the regional goals is being experienced firsthand.

~~According to an April, 2012 report in the Medical Surveillance Monthly Report (MSMR) which is a publication of the Military Forces Healthy Surveillance Center the number one (1) ranked hospitalization diagnosis among the military for 2011 was mental disorders. This diagnosis ranked number (2) for 2007 as well as 2009. ICD-9-CM codes were utilized to report the primary discharge diagnoses.~~

Starting Point/Baseline:

Currently the only clients that have an inpatient treatment option for psychiatric disorders in Wharton County are those individuals age 65 and over. Gulf Coast Medical Center has a 17 -bed inpatient Geropsych Unit. Adult inpatient psychiatric care is non-existent however with the development of an inpatient unit this performing provider will be able to provide inpatient care to a total population of 28 at a given time. Therefore, the baseline for all milestones and metrics will be established following project implementation.

Rationale:

Gulf Coast Medical Center continuously faces challenges in attempting to meet the care needs of those patients presenting with psychiatric disorders to the Emergency Department (ED). Without inpatient treatment capabilities the only option is to transfer patients to facilities that provide inpatient psychiatric care which are very limited and most often at capacity. Patients requiring the most appropriate care for their psychiatric condition are not receiving the care due to lack of inpatient facilities within the county, or they experience a delay in the care if a transfer is successful outside of the county.

Project Components:

Through the establishment of an Adult Inpatient Psychiatric Unit, we propose to meet all required project components listed below and believe the selected milestones and metrics relate to the project components.

- ~~a) Identify high impact/most impacted specialty services and gaps in care and coordination. (P-1; P-4)~~
- ~~b) Increase the number of trainees choosing targeted shortage specialties. (P-2)~~
- ~~c) Design workforce enhancement initiatives to support access to specialty providers in underserved markets and areas (recruitment and retention). (P-3)~~
- ~~d) Conduct quality improvement for project using methods such as rapid cycle improvement. (P-5)~~
- a) Increase service availability with extended hours
- b) Increase number of specialty clinic locations
- c) Implement transparent, standardized referrals across the system.
- d) Conduct quality improvement for project using methods such as rapid cycle improvement. Activities may include, but not limited to, identifying project impacts, “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.

Milestones and Metrics:
The following milestones and metrics have been chosen for the Establishment of an Adult Inpatient Psychiatric Unit:

- Process Milestones and Metrics: P-1 (P-1.1); P-2 (P-2.1); P-4 (P-4.2); P-5 (P-5.1); P-21 (P-21.1)
- Improvement Milestone and Metrics: I-33 (LW1)
- Improvement Target and Metrics: OD-1 (IT-1.18); (IT-1.20)

Unique Community Needs Identification Number the Project Addresses:
The project addresses the following unique community needs as identified in the community needs assessment:

- CN.2 Inadequate access to specialty care
- CN.3 Inadequate access to behavioral health care
- ~~CN.5 Inadequate access to care for veterans and active military, particularly mental health and substance abuse services~~

How the project represents a new initiative for the performing provider or significantly enhances an existing delivery system reform initiative:
Currently, an Inpatient Adult Psychiatric Unit does not exist at Gulf Coast Medical Center nor in Wharton County. This initiative will be new and will provide access for inpatient treatment for the target population of those individuals requiring inpatient hospitalization for the treatment of mental disorders. In addition, as part of this performing providers Category 1 project the possibility of an outpatient center for following up will be explored.

<u>Related Category 3 Outcome Measures:</u>
OD-1 Primary Care and Chronic Disease Management
IT-1.18 Follow-up after Hospitalization for Mental Illness—NFQ 0576

- Rate 1: An outpatient visit, intensive outpatient encounter or partial hospitalization with a mental health practitioner within 30 days after discharge.
- Rate 2: An outpatient visit, intensive outpatient encounter or partial hospitalization with a mental health practitioner within 7 days after discharge.

IT-1.20 Timeliness of Inpatient Admission for Mental Illness (referral/admission to Unit).

Reasons/Rational for Selecting the Outcome Measure:
Follow up after hospitalization for mental illness was selected as the Category 3 outcome measure by this performing provider to ensure that the treatment plan established for the patient prior to discharge continues through the continuum of care for outpatient care. Non compliance for follow up care on an outpatient basis results in possible readmission. In addition, the necessity of a fast track approach from referral to admission/arrival on the unit is of utmost importance to avoid delay in the initiation of treatment.

<u>Relationships to Other Projects:</u>
The expansion of specialty care is the only DSRIP project for Gulf Coast Medical Center.

Relationship to Other Performing Provider Projects in the RHP:
The behavioral health inpatient crisis in Region 3 is considerable and the increased capacity proposed in the RHP plan will only contribute a small impression into the overall community need for inpatient treatment. The outpatient focus of many RHP Plan initiatives will help numerous facilities focus to treating the patients in an ambulatory setting as well as continued navigation of services with a focus to keeping patients from the inpatient unit. This initiative is only similar to others in the sense of the category of behavioral health but is different in the sense that it focuses to inpatient bed capacity versus outpatient comprehensive treatments. The Region 3 Initiative Grid attached in the addendum will show the relationship to other programs.

Plan for Learning Collaborative:
We plan to participate in a region wide learning collaborative as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system.

Project Valuation:
The following allocation for DY 2 through DY 5 is as follow for a total of $3,823,217:
Y2 $936,218 (72%)
Y3 1,007,685 (65%)
Y4 1,077,987 (51%)
Y5 801,327 (51%)

Areas considered when allocating funds for this project included the importance of ensuring individuals within Wharton County and the surrounding rural areas ~~as well as the military~~ the care needed with regard to mental disorders. A 28 - bed inpatient adult psychiatric unit would allow individual's timely access to care for mental disorders whereas currently delay in care is experienced frequently as bed availability is limited and waiting lists for beds are being utilized.

178815001.1.1	***1.9.2***	***1.9.2(A-D)***	***EXPAND SPECIALTY CARE CAPACITY*** ***ESTABLISH ADULT INPATIENT PSYCHIATRIC UNIT***	
Gulf Coast Medical Center				*178815001*
Related Category 3 Outcome Measure(s):	*178815001.3.1* *178815001.3.2*	*IT-1.18* *IT-1.20*	*Follow up after Hospitalization for Mental Illness* *Timeliness of Inpatient Admission for Mental Illness (referral/admission to Unit)*	

Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Milestone 1 [P-1]: Identify high impact/most impacted specialty services and gaps in care and coordination. Metric 1 [P-1.1]: Provide report identifying the following: • Targeted patient population. • Gaps in services and needs—consider outpatient center for follow up care. • Redesign /renovate previous Med/Surg Unit to meet state specifications for a psychiatric unit. • Program Development • Market Analysis • Program Planning • Orientation and Training • Regulatory Compliance and Licensure • Pro Forma Analysis Goal: Produce a comprehensive report documenting all points noted above. Data Source: Potential management company documentation; AIA architect discussion; ~~military contact discussion.~~	**Milestone 4** [P-5]: Provide reports on the number of days to process referral from receipt of referral to inpatient admission. Metric 1 [P-5.1]: Generate and provide reports on average referral process time from receipt of referral to inpatient hospitalization. Baseline/Goal: Baseline will be established in DY 2. Data Source: Generated reports on file. Milestone 4 Estimated Incentive Payment: $503,842.5 **Milestone 5** [P-21]: Participate in face to face learning at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face to face meeting all providers should identify and agree upon several improvements simple initiatives that all providers can do to "raise the floor" for performance) Each participating provider should publicly commit to implementing these improvements.	**Milestone 6** [P-21]: Participate in face to face learning at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face to face meeting all providers should identify and agree upon several improvements 9simple initiatives that all providers can do to "raise the floor" for performance) Each participating provider should publicly commit to implementing these improvements. Metric 1 [P-21.1]: Participate in semi-annual face to face meetings or seminars organized by the RHP. Goal: Participate in all semi annual face to face meetings or seminars. Data Source: Documentation of semi-annual meetings to include agenda, presentation info Milestone 6 : Estimated Incentive Payment $503842.5 **Milestone 7** [P-5]: Provide reports on the number of days to process referral from receipt of referral to inpatient admission.	**Milestone 9** [P-21]: Participate in face to face learning at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face to face meeting all providers should identify and agree upon several improvements 9simple initiatives that all providers can do to "raise the floor" for performance) Each participating provider should publicly commit to implementing these improvements. Metric 1 [P-21.1]: Participate in semi-annual face to face meetings or seminars organized by the RHP. Goal: Participate in all semi annual face to face meetings or seminars. Data Source: Documentation of semi-annual meetings to include agenda, presentation info Milestone 9 Estimated Incentive Payment $267,109 **Milestone 10** [P-5]: Provide reports on the number of days to process referral from receipt of referral to inpatient admission.

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178815001.1.1	*1.9.2*	*1.9.2(A-D)*	*EXPAND SPECIALTY CARE CAPACITY* *ESTABLISH ADULT INPATIENT PSYCHIATRIC UNIT*
Gulf Coast Medical Center			*178815001*
Related Category 3 Outcome Measure(s):	*178815001.3.1* *178815001.3.2*	*IT-1.18* *IT-1.20*	*Follow up after Hospitalization for Mental Illness* *Timeliness of Inpatient Admission for Mental Illness (referral/admission to Unit)*
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Milestone 1 Estimated Incentive Payment*:* $500,000 **Milestone 2** [P-2.1]:Train care providers and staff on processes guidelines for referrals and consultations into selected medical specialties. Metric 1 [P-2.1]: Number of staff trained and documentation of training materials. Goal: Establish/develop process for training/guidelines for seamless referral and acceptance of patients to the psychiatric unit. Establish baseline to develop target time from referral to admission in DY 3. Data Source: Training materials Milestone 2 Estimated Incentive Payment*:* $200,000 **Milestone 3** [P-4]: Expand psychiatric specialty referral management department and related functions. Metric 1 [P-4.2]: Policy development for staff training for the utilization of	Metric 1 [P-21.1]: Participate in semi-annual face to face meetings or seminars organized by the RHP. Goal: Participate in all semi annual face to face meetings or seminars. Data Source: Documentation of semi-annual meetings to include agenda, presentation info Milestone 5 Estimated Incentive Payment: $503842.5	Metric 1 [P-5.1]: Generate and provide report on average referral process time from receipt of referral to inpatient hospitalization. Baseline/Goal: Baseline will be established in DY 2. Goal: Improve rate for DY 4 as compared to DY 2. Increase patient admission rate to an average daily census -TBD Data Source: Generated reports on file. Milestone 7 Estimated Incentive Payment: $251,921.25 **Milestone 8** [I-33]: Increase specialty care capacity using innovative project option. Metric 1 [I-33.1]: Increase percentage of target population reached. Baseline/Goal: TBD Data Source: Reports and data collection Milestone 8 Estimated Incentive Payment $:251,921.25	Metric 1 [P-5.1]: Generate and provide reports on average referral process time from receipt of referral to inpatient hospitalization. Baseline/Goal: Baseline will be established in DY 2. Goal: Improve rate for DY 5 as compared to DY 2. Increase patient admission rate to an average daily census -TBD. Data Source: Generated reports on file. Milestone 10 Estimated Incentive Payment: $267,109 **Milestone 11** [I-33]: Increase specialty care capacity using innovative project option. Metric 1 [I-33.1]: Increase percentage of target population reached. Baseline/Goal: TBD Data Source: Reports and data collection Milestone 11 Estimated Incentive Payment $267,109

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<table>
<tr><td>178815001.1.1</td><td>1.9.2</td><td>1.9.2(A-D)</td><td colspan="2">EXPAND SPECIALTY CARE CAPACITY
ESTABLISH ADULT INPATIENT PSYCHIATRIC UNIT</td></tr>
<tr><td colspan="4">Gulf Coast Medical Center</td><td>178815001</td></tr>
<tr><td>Related Category 3 Outcome Measure(s):</td><td>178815001.3.1
178815001.3.2</td><td>IT-1.18
IT-1.20</td><td colspan="2">Follow up after Hospitalization for Mental Illness
Timeliness of Inpatient Admission for Mental Illness (referral/admission to Unit)</td></tr>
<tr><th>Year 2
(10/1/2012 – 9/30/2013)</th><th colspan="2">Year 3
(10/1/2013 – 9/30/2014)</th><th>Year 4
(10/1/2014 – 9/30/2015)</th><th>Year 5
(10/1/2015 – 9/30/2016)</th></tr>
<tr><td>a referral management plan.
Goal: Develop a robust referral management plan in which referrals are processed, patient screened, and placement of patient in psychiatric care is done in a timely manner.
Data Source: Written description of the process of managing referral into the inpatient adult psychiatric unit

Milestone 3 Estimated Incentive Payment $228,218</td><td colspan="2"></td><td></td><td></td></tr>
<tr><td>Year 2 Estimated Outcome Amount: $936,218 (72%)</td><td colspan="2">Year 3 Estimated Outcome Amount: <b>$ 1,007,685 (65%)</td><td>Year 4 Estimated Outcome Amount: $ 1,077,987 (51%)</td><td>Year 5 Estimated Outcome Amount: $801,327 (51%)</td></tr>
<tr><td colspan="5">TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5):$ 3,823,217</td></tr>
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Harris County Hospital District

Ben Taub General Hospital

Pass 1

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Project Option 1.1.1- Establish more primary care clinics: Gulfgate Area Same Day Access Clinic

Unique RHP Project ID: 133355104.1.1 / Pass 1

Performing Provider Name/TPI: Harris Health System / 133355104

Project Summary:

Provider: Harris Health System is comprised of 16 community health centers, seven school-based clinics, a dental center, dialysis center, five mobile health units, one outpatient specialty services clinic, and three hospitals. With a tax base of $511.6 million, Harris Health System was able to provide more than $1.254 billion in charity care during FY 2012.

Volume Statistics - FY2012	Patient Payor Mix	Patient Demographics
Hospital admissions- 35,343 Births (babies delivered)- 6,643 Emergency visits- 173,263 Outpatient clinic visits- 1,054,770	Self-Pay- 62.6% Medicaid and CHIP- 23.4% Medicare- 8.6% Other Funding- 3.6% Commercial Insurance- 1.8%	Hispanic- 57.4% African American- 26.3% Caucasian- 9.2% Asian- 4.8% Other- 2.2% American Indian- 0.2%

Intervention(s): Harris Health System proposes to expand the capacity of primary care by establishing an adult-focused primary care same day access clinic near the Gulfgate Health Center that offers same day visits during extended hours to meet demand that saturated existing Harris Health System health centers cannot meet.

Need for the project: Currently, Harris Health System health centers are designated NCQA Primary Care Medical Homes with increasingly limited capacity. Health center providers are currently 95% empaneled. For the Gulfgate health center, there were 792 unduplicated patients for which there were no Family Practice appointments available in the month of September 2012 alone.

Target Population: All current and potential patients within the system may benefit from this project (Medicaid and CHIP-23.4% / Self-Pay- 62.6%), specifically those in the zip code 77012.

Category 1 or 2 expected patient benefits: Our goal is to increase primary care clinic completed visits at same day access clinic by 5% over baseline in DY4 and 10% over baseline in DY5. The project seeks to increase completed visits for same day access by 31,000 visits in DY5 over the baseline in DY3.

Category 3 outcomes: IT-6.1: Our goal is to increase "Ease of scheduling appointments" score by 1% above baseline in DY4 and 2% above baseline in DY5 (Press Ganey).

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Project Option 1.1.1- Establish more primary care clinics: Gulfgate Area Same Day Access Clinic

Unique RHP Project ID: 133355104.1.1 / Pass 1

Performing Provider Name/TPI: Harris Health System / 133355104

Project Description:

Harris Health System proposes to expand the capacity of primary care by establishing adult-focused primary care same day access clinics that offer same day visits during extended hours to meet demand that saturated existing Harris Health System health centers cannot meet. Same day access clinics will better accommodate the needs of the community by allowing them to receive the right care, at the right time, in the right setting.

The same day access clinic will ideally be located in or around the following zip code to meet the adult primary care demand surrounding the Gulfgate Health Center: 77012. The clinic will be approximately 3,000-4,000 square feet of leased space. The Facilities and Planning department at the Harris Health System has confirmed that such lease space is available in or around the target zip code(s). Harris Health System plans to add new providers and staff to operate the clinic for extended evening hours and weekend hours, in addition to regular weekday hours, based on demand. Point of Care lab testing will be available. If patients are in need of imaging or pharmacy services, the clinic will be located near a health center that provides those services.

Goals and Relationship to Regional Goals:

The goals of this project are to:

- Increase capacity for same day primary care through establishment of more accessible care locations across Harris County
- Increase access to same day primary care during extended hours and weekends

Expanding the capacity of primary care through additional clinics across the county and extended operating hours to better accommodate the needs of the community will allow patients to receive the right care at the right time in the right setting.

This project meets the following Region 3 goals:

- Increase access to primary and specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their condition, regardless of where they live or their ability to pay.

The Gulfgate same day access clinic will increase access to primary care in a high-demand area of underserved individuals while ensuring that patients have access to care in the appropriate setting. Harris County residents will be treated, and care discounted, according to Harris Health's sliding fee scale, with determination of eligibility for financial assistance.

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Challenges and how to address:

General primary care capacity has been a challenge for the Harris Health System. The same day access clinic will provide same day access for Medical Home and non-Medical Home patients. A significant challenge for the Harris Health System has been adequate capacity to offer Medical Homes for patients who do not have a primary care provider. As patients are seen in the same day clinic setting, this will continue to be a problem for those patients who need care for chronic conditions or other specialized care. In addition, meeting the demand for intensive behavioral health care needs that will present at same day access clinics will prove to be a challenge. To address these challenges we propose to direct patients with chronic conditions into the Medical Home setting at a Harris Health System health center or refer to a primary care setting at a local FQHC. Patients with behavioral health needs will be referred to behavioral health providers.

5-Year Expected Outcome for Provider and Patients:

Over the course of the 5-Year Waiver, Harris Health System expects to realize:

- Increased adult-focused primary care capacity through same day care clinics for primary care treatable conditions

Starting Point/Baseline:

For performance purposes, the baseline will be set at 0 visits since this is a new clinic that currently is not operational.

Rationale:

Reasons for selecting the project option:

Currently, Harris Health System health centers are designated NCQA Primary Care Medical Homes with increasingly limited capacity. Health center providers are currently 95% empaneled. Moreover, physicians in Harris Health health centers carry a panel of 2,250 patients, which is higher than the industry standard of approximately 1,500 patients. Full panels lead to decreased access to primary care appointments at health centers. These health centers are approaching maximum capacity for empaneled patients. From March 2012-September 2012, the Patient Appointment Center was unable to schedule 68,247 unduplicated patients for primary care. For the Gulfgate health center, there were 792 unduplicated patients for which there were no Family Practice appointments available in the month of September 2012 alone. Gulfgate received 144 Ask My Nurse in-basket messages per month for patients that needed same day appointments that could not be scheduled by the Patient Appointment Center. Within the Harris Health System, 26% of all requests received in September 2012 for Family Practice appointments that could not be scheduled were for patients living in zip codes served by the Gulfgate health center. These numbers, however, do not capture the full volume of unmet demand due to the fact that some calls were dropped as patients were placed on hold and some

patients who needed care did not attempt to obtain an appointment based on previous difficulties obtaining same day appointments. Based on 2012 data of incoming patient calls to the Patient Appointment Center over 22,400 unduplicated patients living near the Gulfgate Health Center were unable to get an appointment.

The addition of same day access clinics will result in increased access to same day care for primary care treatable conditions, a more cost effective and appropriate setting than emergency centers and a more accessible setting than saturated Medical Home health centers.

Project Components:

Not Applicable / The project option 1.1.1 do not have components

Milestones & Metrics:

- Process Milestones and Metrics- P-1 (P-1.1); P-5 (P-5.1); P-X (P-X.1); P-X2 (P-X2.1)
- Improvement Milestones and Metrics- I-12 (I-12.1)

Unique community need identification number the project addresses:

This project addresses the following community needs according to the community needs assessment:

- CN.1- Inadequate access to primary care
- CN.8- High rates of inappropriate emergency department utilization
- CN.2- Inadequate access to specialty care

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

Currently, Harris Health System does not guarantee same day care for patients who are not enrolled in a Medical Home and empaneled to a primary care physician. Thus, the same day access clinic will be a new initiative for Harris Health by providing access to same day visits regardless of Medical Home enrollment. Moreover, current health centers offer an array of ancillary services, including full service outpatient pharmacies and laboratories, in addition to various specialty and radiology services. The same day access clinic will offer limited laboratory services and will not offer radiology or pharmacy services but will refer patients to other facilities for these services as needed.

Related Category 3 Outcome Measure(s):

OD-6 Patient Satisfaction

- IT-6.1- Percent improvement over baseline of patient satisfaction scores (standalone)
    - (1) are getting timely care, appointments, and information

Reasons/rationale for selecting the outcome measure(s):

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IT- 6.1 will measure improvement in satisfaction scores over time relating to timeliness of care at the Gulfgate same day access clinic, specifically measuring the mean score for the Press Ganey survey question- “Ease of scheduling appointments.” The same day access clinic will increase capacity for primary care visits within the Harris Health System, which will enhance access and improve the patient’s experience in obtaining services. Patient satisfaction scores have been historically poor for health centers regarding timely access to care. The same day access clinic will offer an efficient venue that offers same day visits, affording patients the opportunity to seek care in a setting that is appropriate for the level of care they need and more cost effective than other alternatives.

Relationship to other Projects:

Primary Care/Ambulatory Care clinics are a top priority to Region 3 due to the acuity of the regional patient mix, population concentration, and lack of primary care access points for our patient base. The regional approach of collaboration as well as existing patient referral pattern relationships allowed our team to properly identify the community needs based on the necessity of population, uninsured, and medically underserved patient bases. This program is consistent with our region and similar to numerous initiatives in our RHP plan sharing both concepts as well as outcome measures focused on percent improvement over baseline of patient satisfaction scores, reduction of inappropriate ED utilization, and third next available appointment status. The Region 3 Initiative Grid attached as a RHP Plan addendum reflects a grid of relationship for all initiatives.

Plan for Learning Collaborative: We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region’s healthcare system.

Project Valuation: This project addresses one of the main objectives of the 1115 Waiver; increasing access to primary care for the underserved population in this area of Harris County. The value of the project is based on the clinic’s capacity to provide primary care services, including laboratory point-of-care testing, along with timely referrals for specialty care, imaging and other needed services within the Harris Health System network. The clinic can ultimately care for the episodic primary care needs of over ten thousand patients annually, and refer new patients with chronic disease management needs to one of the NCQA certified medical home clinics that are operated by Harris Health. In addition, the availability of same day primary care appointments will result in fewer emergency room visits for public and private hospitals located in the service area. Early detection, treatment and education regarding wellness and prevention will also help to prevent future downstream inpatient admissions.

133355104.1.1	*1.1.1*	*N/A*	*ESTABLISH MORE PRIMARY CARE CLINICS: GULFGATE AREA SAME DAY ACCESS CLINIC*
Harris Health System			*133355104*
Related Category 3 Outcome Measure(s):	*133355104.3.1*	*IT-6.1*	*Percent improvement over baseline of patient satisfaction scores*

Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Milestone 1 [P-X]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Metric 1 [P-X.1]: Planning documentation Goal: Produce a comprehensive implementation plan for the establishment of same day access clinic Data Source: Project plan Milestone 1 Estimated Incentive Payment *(maximum amount):* $7,132,488	**Milestone 2** [P-1]: Establish additional primary care clinics Metric 1 [P-1.1]: Number of additional clinics or expanded hours or space Baseline: 0 same day access clinics in target area in DY2 Goal: Establish one same day access clinic Data Source: New primary care schedule Milestone 2 Estimated Incentive Payment *(maximum amount):* $2,593,720 **Milestone 3** [P-5]: Hire additional primary care providers and staff Metric 1 [P-5.1]: Documentation of increased number of providers and	**Milestone 5** [I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 [I-12.1]: Documentation of increased number of visits. Baseline: Established in DY3 Goal: Increase completed visits at same day access clinic by 3% over baseline Data Source: EHR Milestone 5 Estimated Incentive Payment *(maximum amount):* $7,803,781	**Milestone 6** [I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 [I-12.1]: Documentation of increased number of visits. Baseline: Established in DY3 Goal: Increase completed visits at same day access clinic by 5% over baseline Data Source: EHR Milestone 6 Estimated Incentive Payment *(maximum amount):* $6,446,602

133355104.1.1	***1.1.1***	***N/A***	***ESTABLISH MORE PRIMARY CARE CLINICS: GULFGATE AREA SAME DAY ACCESS CLINIC***
Harris Health System			*133355104*
Related Category 3 Outcome Measure(s):	*133355104.3.1*	*IT-6.1*	*Percent improvement over baseline of patient satisfaction scores*

Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
	staff. Baseline: 0 providers and staff hired in DY2 Goal: Hire providers and support staff Data Source: Contract documentation Milestone 3 Estimated Incentive Payment *(maximum amount):* $2,593,720 **Milestone 4** [P-X2]: Establish baseline number of completed visits at same day access clinic Metric 1 [P-X2.1]: Documentation of completed visits at same day access clinic Baseline: 0 completed visits in DY2 Goal: Document completed visits (6 months) to create baseline Data Source: EHR		

133355104.1.1	***1.1.1***	***N/A***	***ESTABLISH MORE PRIMARY CARE CLINICS: GULFGATE AREA SAME DAY ACCESS CLINIC***
Harris Health System			*133355104*
Related Category 3 Outcome Measure(s):	*133355104.3.1*	*IT-6.1*	*Percent improvement over baseline of patient satisfaction scores*

Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
	Milestone 4 Estimated Incentive Payment *(maximum amount):* $2,593,721		
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $7,132,488	Year 3 Estimated Milestone Bundle Amount: $7,781,161	Year 4 Estimated Milestone Bundle Amount: $7,803,781	Year 5 Estimated Milestone Bundle Amount: $6,446,602
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:** $29,164,032			

Project Option 1.1.1- Establish more primary care clinics: People's Area Same Day Access Clinic

Unique RHP Project ID: 133355104.1.2 / Pass 1

Performing Provider Name/TPI: Harris Health System / 133355104

Project Summary:

Provider:

Harris Health System is comprised of 16 community health centers, seven school-based clinics, a dental center, dialysis center, five mobile health units, one outpatient specialty services clinic, and three hospitals. With a tax base of $511.6 million, Harris Health System was able to provide more than $1.254 billion in charity care during FY 2012.

Volume Statistics - FY2012	Patient Payor Mix	Patient Demographics
Hospital admissions- 35,343 Births (babies delivered)- 6,643 Emergency visits- 173,263 Outpatient clinic visits- 1,054,770	Self-Pay- 62.6% Medicaid and CHIP- 23.4% Medicare- 8.6% Other Funding- 3.6% Commercial Insurance- 1.8%	Hispanic- 57.4% African American- 26.3% Caucasian- 9.2% Asian- 4.8% Other- 2.2% American Indian- 0.2%

Intervention(s):

Harris Health System proposes to expand the capacity of primary care by establishing an adult-focused primary care same day access clinic near the People's Health Center that offers same day visits during extended hours to meet demand that saturated existing Harris Health System health centers cannot meet.

Need for the project:

Currently, Harris Health System health centers are designated NCQA Primary Care Medical Homes with increasingly limited capacity. Health center providers are currently 95% empaneled. For the People's health center, there were 465 unduplicated patients for which there were no Family Practice appointments available in the month of September 2012 alone.

Target Population:

All current and potential patients seeking primary care services within the system may benefit from this project (Medicaid and CHIP-23.4% / Self-Pay- 62.6%), specifically those in the zip code 77449.

Category 1 or 2 expected patient benefits:

Our goal is to increase primary care clinic completed visits at same day access clinic by 3% over baseline in DY4 and 5% over baseline in DY5. The project seeks to increase primary care completed visits for same day access by 31,000 visits by DY5 over the baseline in DY3.

Category 3 outcomes:

IT-6.1: Our goal is to increase "Ease of scheduling appointments" score by 1% above baseline in DY4 and 2% above baseline in DY5 (Press Ganey).

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Project Option 1.1.1- Establish more primary care clinics: People's Area Same Day Access Clinic

Unique RHP Project ID: 133355104.1.2 / Pass 1

Performing Provider Name/TPI: Harris Health System / 133355104

Project Description:

Harris Health System proposes to expand the capacity of primary care by establishing adult-focused primary care same day access clinics that offer same day visits during extended hours to meet demand that saturated existing Harris Health System health center health centers cannot meet. Same day access clinics will better accommodate the needs of the community by allowing them to receive the right care, at the right time, in the right setting.

The same day access clinic will ideally be located in or around the following zip code to meet the adult primary care demand surrounding the People's Health Center: 77057. The clinic will be approximately 3, 000-4,000 square feet of leased space. The Facilities and Planning department at the Harris Health System has confirmed that such lease space is available in or around the target zip code. Harris Health System plans to add new providers and staff to operate the clinic for extended evening hours and weekend hours, in addition to regular weekday hours, based on demand. Point of Care lab testing will be available. If patients are in need of imaging or pharmacy services, the clinic will be located near a health center that provides those services.

Goals and Relationship to Regional Goals:

The goals of this project are to:

- Increase capacity for same day primary care through establishment of more accessible care locations across Harris County
- Increase access to same day primary care during extended hours and weekends

Expanding the capacity of primary care through additional clinics across the county and extended operating hours to better accommodate the needs of the community will allow patients to receive the right care at the right time in the right setting.

This project meets the following Region 3 goals:

- Increase access to primary and specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their condition, regardless of where they live or their ability to pay.

The People's same day access clinic will increase access to primary care in a high-demand area of underserved individuals while ensuring that patients have access to care in the appropriate setting. Harris County residents will be treated, and care discounted, according to Harris Health's sliding scale, with determination of eligibility for financial assistance.

Challenges and how to address:

General primary care capacity has been a challenge for the Harris Health System. The same day access clinic will provide same day access for Medical Home and non-Medical Home patients. A significant challenge for the Harris Health System has been adequate capacity to offer Medical Homes for patients who do not have a primary care provider. As patients are seen in the same day clinic setting, this will continue to be a problem for those patients who need care for chronic conditions or other specialized care. In addition, meeting the demand for intensive behavioral health care needs that will present at same day access clinics will prove to be a challenge. To address these challenges we propose to direct patients with chronic conditions into the Medical Home setting at a Harris Health System health center or refer to a primary care setting at a local FQHC. Patients with behavioral health needs will be referred to behavioral health providers.

5-Year Expected Outcome for Provider and Patients:

Over the course of the 5-Year Waiver, Harris Health System expects to realize:

- Increased adult-focused primary care capacity through same day care clinics for primary care treatable conditions

Starting Point/Baseline:

For performance purposes, the baseline will be set at 0 visits since this is a new clinic that currently is not operational.

Rationale:

Reasons for selecting the project option:

Currently, Harris Health System health centers are designated NCQA Primary Care Medical Homes with increasingly limited capacity. Health center providers are currently 95% empaneled. Moreover, physicians in Harris Health centers carry a panel of 2,250 patients, which is higher than the industry standard of approximately 1,500 patients. Full panels lead to decreased access to primary care appointments at health centers. These health centers are approaching maximum capacity for empaneled patients. From March 2012-September 2012, the Patient Appointment Center was unable to schedule 68,247 unduplicated patients for primary care. For the People's health center, there were 465 unduplicated patients for which there were no Family Practice appointments available in the month of September 2012 alone. People's Health Center
received 60 Ask My Nurse in-basket messages per month for patients that needed same day appointments that could not be scheduled by the Patient Appointment Center. Within the Harris Health System, 15% of all requests received in September 2012 for Family Practice appointments that could not be scheduled were for patients living in zip codes served by the People's Health Center. These numbers, however, do not capture the full volume of unmet

demand due to the fact that some calls were dropped as patients were placed on hold and some patients who needed care did not attempt to obtain an appointment based on previous difficulties obtaining same day appointments. Based on 2012 data of incoming patient calls to the Patient Appointment Center over 19,200 unduplicated patients living near the People's Health Center were unable to get an appointment.

The addition of same day access clinics will result in increased access to same day care for primary care treatable conditions, a more cost effective and appropriate setting than emergency centers and a more accessible setting than saturated Medical Home health centers.

Project Components:

Not Applicable / The project option 1.1.1 do not have components

Milestones & Metrics:

- Process Milestones and Metrics- P-1 (P-1.1); P-5 (P-5.1); P-X (P-X.1); P-X2 (P-X2.1)
- Improvement Milestones and Metrics- I-12 (I-12.1)

Unique community need identification number the project addresses:

This project addresses the following community needs according to the community needs assessment:

- CN.1- Inadequate access to primary care
- CN.8- High rates of inappropriate emergency department utilization
- CN.2- Inadequate access to specialty care

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

Currently, Harris Health System does not guarantee same day care for patients who are not enrolled in a Medical Home and empaneled to a primary care physician. Thus, the same day access clinic will be a new initiative for Harris Health by providing access to same day visits regardless of Medical Home enrollment. Moreover, current health centers offer an array of ancillary services, including full service outpatient pharmacies and laboratories, in addition to various specialty and radiology services. The same day access clinic will offer limited laboratory services and will not offer radiology or pharmacy services.

Related Category 3 Outcome Measure(s):

OD-6 Patient Satisfaction

- IT-6.1- Percent improvement over baseline of patient satisfaction scores (standalone)
    - (1) are getting timely care, appointments, and information

Reasons/rationale for selecting the outcome measure(s):

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IT- 6.1 will measure improvement in satisfaction scores over time relating to timeliness of care at the People's same day access clinic, specifically measuring the mean score for the Press Ganey survey question- "Ease of scheduling appointments." The same day access clinic will increase capacity for primary care visits within the Harris Health System, which will enhance access and improve the patient's experience in obtaining services. Patient satisfaction scores have been historically poor for health centers regarding timely access to care. The same day access clinic will offer an efficient venue that offers same day visits, affording patients the opportunity to seek care in a high-satisfaction setting that is appropriate for the level of care they need and more cost effective than other alternatives.

Relationship to other Projects:

Primary Care/Ambulatory Care clinics are a top priority to Region 3 due to the acuity of the regional patient mix, population concentration, and lack of primary care access points for our patient base. The regional approach of collaboration as well as existing patient referral pattern relationships allowed our team to properly identify the community needs based on the necessity of population, uninsured, and medically underserved patient bases. This program is consistent with our region and similar to numerous initiatives in our RHP plan sharing both concepts as well as outcome measures focused to percent improvement over baseline of patient satisfaction scores, reduction of inappropriate ED utilization, and third next available appointment status. The Region 3 Initiative Grid attached as a RHP Plan addendum reflects a grid of relationship for all initiatives.

Plan for Learning Collaborative: We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system.

Project Valuation: This project addresses one of the main objectives of the 1115 Waiver; increasing access to primary care for the underserved population in this area of Harris County. The value of the project is based on the clinic's capacity to provide primary care services, including laboratory point-of-care testing, along with timely referrals for specialty care, imaging and other needed services within the Harris Health System network. The clinic can ultimately care for the episodic primary care needs of over ten thousand patients annually, and refer new patients with chronic disease management needs to one of the NCQA certified medical home clinics that are operated by Harris Health. In addition, the availability of same day primary care appointments will result in fewer emergency room visits for public and private hospitals located in the service area. Early detection, treatment and education regarding wellness and prevention will also help to prevent future downstream inpatient admissions.

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133355104.1.2	***1.1.1***	***N/A***	***ESTABLISH MORE PRIMARY CARE CLINICS: PEOPLE'S AREA SAME DAY ACCESS CLINIC***
Harris Health System			*133355104*
Related Category 3 Outcome Measure(s):	*133355104.3.2*	*IT-6.1*	*Percent improvement over baseline of patient satisfaction scores*

Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Milestone 1 [P-X]: Project planning **-** engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Metric 1 [P-X.1]: Planning documentation Goal: Produce a comprehensive implementation plan for the establishment of same day access clinic Data Source: Project plan Milestone 1 Estimated Incentive Payment *(maximum amount):* $8,348,125	**Milestone 2** [P-1]: Establish additional primary care clinics Metric 1 [P-1.1]: Number of additional clinics or expanded hours or space Baseline: 0 same day access clinics in target area in DY2 Goal: Establish one same day access clinic for the health center Data Source: New primary care schedule Milestone 2 Estimated Incentive Payment *(maximum amount):* $2,619,020 **Milestone 3** [P-5]: Hire additional primary care providers and staff Metric 1 [P-5.1]: Documentation of increased number of providers and staff. Baseline: 0 providers and staff	**Milestone 5** [I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 [I-12.1]: Documentation of increased number of visits. Baseline: Established in DY3 Goal: Increase completed visits at same day access clinic by 3% over baseline Data Source: EHR Milestone 5 Estimated Incentive Payment *(maximum amount):* $7,365,993	**Milestone 6** [I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 [I-12.1]: Documentation of increased number of visits. Baseline: Established in DY3 Goal: Increase completed visits at same day access clinic by 5% over baseline Data Source: EHR Milestone 6 Estimated Incentive Payment *(maximum amount):* $5,598,155

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133355104.1.2	*1.1.1*	*N/A*	*ESTABLISH MORE PRIMARY CARE CLINICS: PEOPLE'S AREA SAME DAY ACCESS CLINIC*
Harris Health System			*133355104*
Related Category 3 Outcome Measure(s):	*133355104.3.2*	*IT-6.1*	*Percent improvement over baseline of patient satisfaction scores*

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
	hired in DY2 Goal: Hire providers and support staff Data Source: Contract documentation Milestone 3 Estimated Incentive Payment *(maximum amount):* $2,619,020 **Milestone 4** [P-X2]: Establish baseline number of completed visits at same day access clinic <u>Metric 1</u> [P-X2.1]: Documentation of completed visits at same day access clinic Baseline: 0 completed visits in DY2 Goal: Document completed visits (6 months) to create baseline Data Source: EHR Milestone 4 Estimated Incentive Payment *(maximum amount):* $2,619,020		

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133355104.1.2	***1.1.1***	***N/A***	***ESTABLISH MORE PRIMARY CARE CLINICS: PEOPLE'S AREA SAME DAY ACCESS CLINIC***
Harris Health System			*133355104*
Related Category 3 Outcome Measure(s):	*133355104.3.2*	*IT-6.1*	*Percent improvement over baseline of patient satisfaction scores*

Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $7,132,488	Year 3 Estimated Milestone Bundle Amount: $7,781,161	Year 4 Estimated Milestone Bundle Amount: $7,803,781	Year 5 Estimated Milestone Bundle Amount: $6,446,602
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)**:*** $29,164,032			

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Project Option 1.1.2- Expand existing primary care capacity: Expand Capacity of existing Health Centers
Unique RHP Project ID: 133355104.1.3 / Pass 1
Performing Provider Name/TPI: Harris Health System / 133355104
Project Summary:
Provider:
Harris Health System is comprised of 16 community health centers, seven school-based clinics, a dental center, dialysis center, five mobile health units, one outpatient specialty services clinic, and three hospitals. With a tax base of $511.6 million, Harris Health System was able to provide more than $1.254 billion in charity care during FY 2012.

Volume Statistics - FY2012	Patient Payor Mix	Patient Demographics
Hospital admissions- 35,343 Births (babies delivered)- 6,643 Emergency visits- 173,263 Outpatient clinic visits- 1,054,770	Self-Pay- 62.6% Medicaid and CHIP- 23.4% Medicare- 8.6% Other Funding- 3.6% Commercial Insurance- 1.8%	Hispanic- 57.4% African American- 26.3% Caucasian- 9.2% Asian- 4.8% Other- 2.2% American Indian- 0.2%

Intervention(s):
This project will expand the existing capacity of primary care by adding full time equivalent primary care providers to meet the adult primary care demand surrounding the Health Centers. Harris Health System plans to add additional providers and support staff to maximize the use of our existing clinical space, thereby increasing appointment availability.
Need for the project:
Currently, Harris Health System Health Centers are designated NCQA Primary Care Medical Homes with increasingly limited capacity. Health Center providers are currently 95% empaneled.
Target Population:
All current and potential medical home patients within the system with may benefit from this project (Medicaid and CHIP-23.4% / Self-Pay- 62.6%).
Category 1 or 2 expected patient benefits:
Our goal is to increase primary care clinic completed visits by additional primary care providers by 3% over baseline in DY4 and 5% in DY5. The project seeks to increase primary care completed visits by an additional 68,500 visits by DY5.
Category 3 outcomes:
IT-6.1: Our goal is to increase “Getting Timely Care, Appointments, and Information” survey dimension score by 1% above baseline in DY4 and 2% in DY5 (Press Ganey).

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Project Option 1.1.2- Expand existing primary care capacity: Expand Capacity of existing Health Centers

<u>Unique RHP Project ID:</u> 133355104.1.3 / Pass 1

<u>Performing Provider Name/TPI:</u> Harris Health System / 133355104

<u>Project Description:</u>

Harris Health System proposes to expand the existing capacity of primary care by adding primary care providers to the Health Centers. Adding providers will increase appointment availability.

The clinic will be adding full time equivalent primary care providers to meet the adult primary care demand surrounding the Health Centers. Harris Health System plans to add additional providers and support staff to maximize the use of our existing clinical space. The additional providers will work from existing exam rooms that are currently not being utilized. The hours of operation will be Monday through Friday, 8 -5 pm. The additional providers will assist in providing capacity to offer Medical Homes for patients who do not have a primary care provider.

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

<u>The goals of this project are to:</u>

- Increase capacity for primary care through the addition of primary care providers in the Medical Home setting.

Expanding the capacity of primary care through additional providers will increase appointment availability, allowing patients to receive timely care for the management of their chronic conditions.

<u>This project meets the following Region 3 goals:</u>

- Increase access to primary and specialty services with a focus on underserved populations, to ensure patients receive the most appropriate care for their condition, regardless of where they live or their ability to pay.

The expansion of primary care capacity will increase access to primary care in high demand areas of underserved individuals while ensuring that patients have access to care in the appropriate setting. Harris County residents will be treated, and care discounted, according to the Harris Health System sliding scale, with determination of eligibility of financial assistance.

Challenges:

The general primary care capacity has been a challenge for the Harris Health System. The providers are approximately 95% empaneled and thus unable to accept new patients at most Health Centers. The clinics currently have existing clinical space that’s being underutilized. To

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address these challenges, we propose to add additional physicians to maximize the use of clinical space for patient care. The additional providers will increase the access to new patients and improve appointment availability.

5-Year Expected Outcome for Provider and Patients:

Over the course of the 5-Year Waiver, Harris Health System expects to realize:

- Increased capacity to offer Medical Homes primarily for adults by adding providers in the existing primary care setting.
- Over time, overall patient satisfaction for Access at targeted health centers will increase.

Starting Point/Baseline:

The baseline for Harris Health System FY2012 is 228,070 primary care visits.

The baseline for Ease of scheduling appointments as measured by Press Ganey for the period October 2011 through September 2012 Patient Satisfaction Survey year is 71.3%.

Rationale:

Currently, Harris Health System Health Centers are designated NCQA Primary Care Medical Homes with increasingly limited capacity. Health Center providers are currently 95% empaneled. Moreover, physicians in Harris Health System Health Centers carry a panel of 2,250 patients, plus an additional 500 patients for each midlevel provider who works with the physician to manage the patient panel. These panel sizes are higher than the industry standard of approximately 1,500 patients. Full panels lead to decreased access to primary care appointments at the Health Centers. These Health Centers are approaching maximum capacity for empaneled patients. From March 2012-September 2012, the Harris Health System Patient Appointment Center was unable to schedule 68,247 unduplicated patients for primary care. Additionally, the Health Centers received 716 Ask My Nurse in-basket messages per month for patients that needed same day appointments that could not be scheduled by the Patient Appointment Center. These numbers, however, do not capture the full volume of unmet demand due to the fact that some calls were dropped as patients were placed on hold and some patients who needed care did not attempt to obtain an appointment based on previous difficulties obtaining same day appointments.

Project Components:

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

Expansion of primary care clinic space is not necessary at this time because the clinic has underutilized exam rooms. The visit demand is for regular operating hours.

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Milestones & (Metrics):

- Process Milestones and Metrics- P-5 (P-5.1); P-X (P-X.1)
- Improvement Milestones and Metrics- I-12 (I-12.1)

Unique community need identification number the project addresses:

This project addresses the following community needs according to the community needs assessment:

- CN.1- Inadequate access to primary care
- CN.11- High rates of chronic disease and inadequate access to treatment programs and services for illnesses associated with chronic disease, including: Cancer, Diabetes, Obesity, Cardiovascular disease, Asthma, AIDS/HIV

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

The addition of primary care providers in the existing Health Centers complements the proposed projects to establish same day access . As patients are treated in same day access clinics, patients in need of a Medical Home will be routed to Harris Health System Health Centers.

Related Category 3 Outcome Measure(s):

OD-6 Patient Satisfaction

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

Reasons/rationale for selecting the outcome measure(s):

The expansion of primary care capacity in the existing Health Centers will increase capacity for primary care visits within the Harris Health System, which will enhance access and improve the patient experience in obtaining services. Patient satisfaction scores for timely access to care for the Health Centers have historically been below expectations. The expansion of primary care capacity in the existing Health Centers will offer additional access, affording patients the opportunity to seek care in the right setting. The current score for Ease of scheduling appointment for the Health Centers is 71.3%. The additional providers will add capacity for appointments, which will increase appointment availability for both new and return patients. The enhanced access to care will result in improved patient satisfaction scores as related to Ease of scheduling appointments.

Relationship to other Projects:

Primary Care/Ambulatory Care clinics are a top priority to Region 3 due to the acuity of the regional patient mix, population concentration, and lack of primary care access points for our patient base. The regional approach of collaboration as well as existing patient referral pattern

relationships allowed our team to properly identify the community needs based on the necessity of population, uninsured, and medically underserved patient bases. This program is consistent with our region and similar to numerous initiatives in our RHP plan sharing both concepts as well as outcome measures focused to percent improvement over baseline of patient satisfaction scores, reduction of inappropriate ED utilization, and third next available appointment status. The Region 3 Initiative Grid attached as a RHP Plan addendum reflects a grid of relationship for all initiatives.

Plan for Learning Collaborative: We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system.

Project Valuation: This project addresses one of the main objectives of the 1115 Waiver; increasing access to primary care for the underserved population in Harris County. The value of the project is based on the expansion of services in Harris Health System's NCQA certified medical home clinics, substantially increasing our capacity to provide primary care services, including laboratory testing, imaging, and other ancillary services, along with prescription medications and timely referrals for specialty care and other needed services within the Harris Health System network. The increase in provider staffing throughout the existing medical home network can ultimately care for the primary care needs of an additional twenty-three thousand patients annually, including the coordination of chronic disease education and management for patients needing those services. In addition, the availability of incremental primary care appointments will result in fewer emergency room visits for public and private hospitals located in the service area. Early detection, treatment and education regarding wellness and prevention will also help to prevent future downstream inpatient admissions.

133355104.1.3	***1.1.2***	***N/A***	***EXPAND EXISTING PRIMARY CARE CAPACITY: EXPAND CAPACITY OF EXISTING HEALTH CENTERS***
Harris Health System			*133355104*
Related Category 3 Outcome Measure(s):	*133355104.3.3*	*IT-6.1*	*Percent improvement over baseline of patient satisfaction scores*

Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 09/30/2016)**
Milestone 1 [P-X]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Metric 1 [P-X.1]: Planning documentation Goal: Produce a comprehensive implementation plan for expansion of providers at Health Center Data Source: Project plan Milestone 1 Estimated Incentive Payment *(maximum amount):* $14,167,705	**Milestone 2** [P-5]: Hire additional primary care providers and staff Metric 1 [P-5.1]: Documentation of increased number of providers and staff. Baseline: 0 providers and staff hired in DY2. Goal: Hire providers and support staff Data Source: Contract documentation Milestone 2 Estimated Incentive Payment *(maximum amount):* $7,728,103 **Milestone 3** [P-X2]: Establish baseline number of completed visits by additional primary care providers	**Milestone 4** [I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 [I-12.1]: Documentation of increased number of visits. Baseline: Established in DY3 Goal: Increase completed visits by additional primary care providers by 3% over baseline Data Source: HER Milestone 4 Estimated Incentive Payment *(maximum amount):* $15,501,136	**Milestone 5** [I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 [I-12.1]: Documentation of increased number of visits. Baseline: Established in DY3 Goal: Increase completed visits by additional primary care providers by 5% over baseline Data Source: HER Milestone 5 Estimated Incentive Payment *(maximum amount):* $12,805,286

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133355104.1.3	*1.1.2*	*N/A*	*EXPAND EXISTING PRIMARY CARE CAPACITY: EXPAND CAPACITY OF EXISTING HEALTH CENTERS*
Harris Health System			*133355104*
Related Category 3 Outcome Measure(s):	*133355104.3.3*	*IT-6.1*	*Percent improvement over baseline of patient satisfaction scores*

Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 09/30/2016)**
	Metric 1 [P-X2.1]: Documentation of completed visits by additional primary care providers Baseline: 0 completed visits in DY2 Data Source: EHR Milestone 3 Estimated Incentive Payment *(maximum amount):* $7,728,102		
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $14,167,705	Year 3 Estimated Milestone Bundle Amount: $15,456,205	Year 4 Estimated Milestone Bundle Amount: $15,501,136	Year 5 Estimated Milestone Bundle Amount: $12,805,286
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)**:*** $57,930,332			

Project Option 1.1.1- Establish more primary care clinics: West and Northwest 1 Area Health Centers

Unique RHP Project ID: 133355104.1.4 / Pass 1

Performing Provider Name/TPI: Harris Health System / 133355104

Project Summary:

Provider:

Harris Health System is comprised of 16 community health centers, seven school-based clinics, a dental center, dialysis center, five mobile health units, one outpatient specialty services clinic, and three hospitals. With a tax base of $511.6 million, Harris Health System was able to provide more than $1.254 billion in charity care during FY 2012.

Volume Statistics - FY2012	Patient Payor Mix	Patient Demographics
Hospital admissions- 35,343 Births (babies delivered)- 6,643 Emergency visits- 173,263 Outpatient clinic visits- 1,054,770	Self-Pay- 62.6% Medicaid and CHIP- 23.4% Medicare- 8.6% Other Funding- 3.6% Commercial Insurance- 1.8%	Hispanic- 57.4% African American- 26.3% Caucasian- 9.2% Asian- 4.8% Other- 2.2% American Indian- 0.2%

Intervention(s):

Harris Health System proposes to expand the capacity of primary care by adding the West and Northwest 1 Area Health Centers to the complement of existing health centers to establish Medical Homes primarily for the adult population.

Need for the project:

Currently, Harris Health System health centers are designated NCQA Primary Care Medical Homes with limited capacity. Health center providers are currently 95% empaneled. For the Northwest and El Franco Lee Health Centers combined, there were 852 unduplicated patients for which there were no Family Practice appointments available in September 2012 alone.

Target Population:

All current and potential patients seeking primary care services within the system may benefit from this project (Medicaid and CHIP-23.4% / Self-Pay- 62.6%), specifically those in the zip codes: 77449 and 77065.

Category 1 or 2 expected patient benefits:

Our goal is to increase primary care clinic completed visits at West and Northwest 1 Area Health Centers by 3% over baseline in DY4 and 5% over baseline in DY5. The project seeks to increase primary care completed visits by an additional 15,000 visits at each center by DY5 over the baseline in DY3.

Category 3 outcomes:

IT-1.10: Our goal is to decrease the percentage of patients with poorly controlled diabetes by 0.5% below baseline in DY4 and 1% in DY5.

Project Option 1.1.1- Establish more primary care clinics: West and Northwest 1 Area Health Centers
<u>Unique RHP Project ID:</u> 133355104.1.4 / Pass 1

<u>Performing Provider Name/TPI:</u> Harris Health System / 133355104

<u>Project Description:</u>

Harris Health System proposes to expand the capacity of primary care by adding the West and Northwest 1 Area Health Centers to the complement of existing health centers to establish Medical Homes primarily for the adult population. The additional Health Centers will better accommodate the needs of the community by allowing them to receive the right care, at the right time, in the right setting.

The Health Centers will be located in the following zip codes to meet the adult primary care demand surrounding the Northwest and El Franco Lee Health Centers: 77449 and 77065. The Health Centers will be approximately 5,000-10,000 square feet of leased space. The Facilities and Planning department at the Harris Health System has confirmed that lease space is available at 5503 North Fry Road, Katy, Texas 77449 and such lease space is available in or around the target zip code of 77065. Harris Health System plans to add new providers and staff to operate the Health Centers for extended hours, in addition to regular weekday hours, based on demand. Point of Care lab testing will be available. The clinic will also offer limited imaging services. Patient prescriptions will be available through a Central Fill Pharmacy, a complementary submitted project, which will facilitate delivery of prescriptions to the patient's home or to the Health Center within 24 hours.

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

The goals of this project are to:

- Increase capacity for primary care through the addition of a primary care Health Center that will serve as a Medical Home primarily for the adult population.

Expanding the capacity of primary care through additional Health Centers across the county and extended operating hours to better accommodate the needs of the community will allow patients to receive the right care at the right time in the right setting.

<u>This project meets the following Region 3 goals:</u>

- Increase access to primary and specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their condition, regardless of where they live or their ability to pay.

The West and Northwest 1 clinics will increase access to primary care in a high-demand area of underserved individuals while ensuring that patients have access to care in the appropriate setting. Harris County residents will be treated, and care discounted, according to Harris Health's sliding fee scale, with determination of eligibility for financial assistance.

Challenges and how to address:

General primary care capacity has been a challenge for the Harris Health System. The West and Northwest 1 Area Health Centers will provide access to a Medical Home for patients. A significant challenge for the Harris Health System has been adequate capacity to offer Medical Homes for patients who do not have a primary care provider. The providers are approximately 95% empaneled and thus unable to accept new patients at most Health Centers. To address these challenges, we propose to add these Health Centers to increase access for new patients and improve appointment availability.

5-Year Expected Outcome for Provider and Patients:

Over the course of the 5-Year Waiver, Harris Health System expects to realize:

- Increased adult-focused primary care capacity through the addition of the West and Northwest 1 Area Health Centers.

Starting Point/Baseline:

For performance purposes, the baseline will be set at 0 visits since these are new Health Centers that currently are not operational.

Rationale:

Currently, Harris Health System Health Centers are designated NCQA Primary Care Medical Homes with increasingly limited capacity. Health Center providers are currently 95% empaneled. Moreover, physicians in Harris Health System Health Centers carry a panel of 2,250 patients, which is higher than the industry standard of approximately 1,500 patients. Full panels lead to decreased access to primary care appointments at Health Centers. These Health Centers are approaching maximum capacity for empaneled patients. From March 2012-September 2012, the Harris Health System Patient Appointment Center was unable to schedule 68,247 unduplicated patients for primary care. For the Northwest and El Franco Lee Health Centers combined, there were 852 unduplicated patients for which there were no Family Practice appointments available in the month of September 2012 alone. The Northwest and El Franco Lee Health Centers received 145 Ask My Nurse in-basket messages per month for patients that needed same day appointments that could not be scheduled by the Patient Appointment Center. Within the Harris Health System, 28% of all requests received in September 2012 for Family Practice appointments that could not be scheduled were for patients living in zip codes served by the El Franco Lee and Northwest Health Centers. These numbers, however, do not capture the full volume of unmet demand due to the fact that some patients may be likely to hang up when placed on hold and some patients who needed care likely did not attempt to obtain an appointment based on previous difficulties obtaining appointments. Based on 2012 data of

incoming patient calls to the Patient Appointment Center over 34,000 unduplicated patients were unable to get an appointment.

Additional Health Centers will result in increased access to primary care and establishment of more Medical Homes in light of the high level of saturation at existing Health Centers. The Health Centers also offer a more cost effective and appropriate care setting for primary care treatable conditions than emergency centers.

Project Components:

Not Applicable / The project option 1.1.1 does not have components

Milestones & (Metrics):

- Process Milestones and Metrics- P-1 (P-1.1); P-5 (P-5.1); P-X (P-X.1); P-X2 (P-X2.1)
- Improvement Milestones and Metrics- I-12 (I-12.1)

Unique community need identification number the project addresses:

This project addresses the following community needs according to the community needs assessment:

- CN.1- Inadequate access to primary care
- CN.8- High rates of inappropriate emergency department utilization

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

The addition of Health Centers to the existing platform of Health Centers that offer Medical Homes complements the proposed establishment of same day clinics. As patients are treated in same day access sites, patients in need of care management available at Medical Home sites will be routed to Harris Health System Health Centers.

Related Category 3 Outcome Measure(s):

OD-1 Primary Care and Chronic Disease Management

- IT-1.10- Diabetes care: HbA1c poor control (>9.0%)

Reasons/rationale for selecting the outcome measure(s):

The West and Northwest 1 Area Health Centers will increase capacity for primary care visits within the Harris Health System, which will enhance access and improve the patient's experience in obtaining services. The West and Northwest 1 Area Health Centers will offer additional access, affording patients the opportunity to seek care. The improved appointment

availability to care will allow diabetes patients enhanced access to better manage diabetes. The West and Northwest 1 Area Health Centers will establish the baseline of percentage of poorly controlled diabetes (>9.0%) in DY3. The Health Center will increase appointment availability for both new and return patients. The enhanced access to care will result in improved hemoglobin A1c (<9.0%).

Relationship to other Projects: Patient prescriptions will be available through a Central Fill Pharmacy, a complementary submitted project, which will facilitate delivery of prescriptions to the patient's home or to the Health Center within 24 hours. Harris Health System proposes to expand the existing capacity of primary care by adding primary care providers to the Health Centers. Adding providers will increase appointment availability.

Relationship to Other Performing Providers' Projects in the RHP:

Primary Care/Ambulatory Care clinics are a top priority to Region 3 due to the acuity of the regional patient mix, population concentration, and lack of primary care access points for our patient base. The regional approach of collaboration as well as existing patient referral pattern relationships allowed our team to properly identify the community needs based on the necessity of population, uninsured, and medically underserved patient bases. This program is consistent with our region and similar to numerous initiatives in our RHP plan sharing both concepts as well as outcome measures focused to percent improvement over baseline of patient satisfaction scores, reduction of inappropriate ED utilization, and third next available appointment status. The Region 3 Initiative Grid attached as a RHP Plan addendum reflects a grid of relationship for all initiatives.

Plan for Learning Collaborative: We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system.

Project Valuation: This project addresses one of the main objectives of the 1115 Waiver; increasing access to primary care for the underserved population in this area of Harris County. The value of the project is based on the clinic's capacity to provide a medical home for primary care services, including laboratory point-of-care testing, some imaging, other ancillary services and prescription medications along with timely referrals for specialty care and other needed services within the Harris Health System network. The clinic can ultimately care for the comprehensive primary care needs of over five thousand patients annually, including the coordination of chronic disease education and management for patients needing those services. In addition, the availability of timely primary care appointments will result in fewer emergency room visits for public and private hospitals located in the service area. Early detection, treatment

and education regarding wellness and prevention will also help to prevent future downstream inpatient admissions.

133355104.1.4	***1.1.1***	***N/A***	***ESTABLISH MORE PRIMARY CARE CLINICS: WEST AND NORTHWEST 1 AREA HEALTH CENTERS***
Harris Health System			*133355104*
Related Category 3 Outcome Measure(s):	*133355104.3.4*	*IT-1.10*	*Diabetes care: HbA1c poor control (>9.0%)*

Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Milestone 1 [P-X]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Metric 1 [P-X.1]: Planning documentation Goal: Produce a comprehensive implementation plan for the establishment of West and Northwest 1 Area Health Centers Data Source: Project plan Milestone 1 Estimated Incentive Payment *(maximum amount):* $7,032,432	**Milestone 2** [P-1]: Establish additional primary care clinics Metric 1 [P-1.1]: Number of additional clinics or expanded hours or space Baseline: 0 additional clinics in target area in DY2 Goal: Establish one additional clinics for the West and Northwest 1 area Data Source: New primary care schedule Milestone 2 Estimated Incentive Payment *(maximum amount):* $2,557,336 **Milestone 3** [P-5]: Hire additional primary care providers and staff	**Milestone 5** [I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 [I-12.1]: Documentation of increased number of visits. Baseline: Established in DY3 Goal: Increase completed visits at West and Northwest 1 Area Health Centers by 3% over baseline Data Source: EHR Milestone 5 Estimated Incentive Payment *(maximum amount):* $7,694,308	**Milestone 6** [I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 [I-12.1]: Documentation of increased number of visits. Baseline: Established in DY3 Goal: Increase completed visits at West and Northwest 1 Area Health Centers by 5% over baseline Data Source: EHR Milestone 6 Estimated Incentive Payment *(maximum amount):* $6,356,168

133355104.1.4	***1.1.1***	*N/A*	***ESTABLISH MORE PRIMARY CARE CLINICS: WEST AND NORTHWEST 1 AREA HEALTH CENTERS***
Harris Health System			*133355104*
Related Category 3 Outcome Measure(s):	*133355104.3.4*	*IT-1.10*	*Diabetes care: HbA1c poor control (>9.0%)*

Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
	Metric 1 [P-5.1]: Documentation of increased number of providers and staff. Baseline: 0 providers and staff hired in DY2 Goal: Hire providers and support staff Data Source: Contract documentation Milestone 3 Estimated Incentive Payment: $2,557,335 **Milestone 4** [P-X2]: Establish baseline number of completed visits at West and Northwest 1 Area Health Centers Metric 1 [P-X2.1]: Documentation of completed visits at West and Northwest 1 Area Health Centers Baseline: 0 completed visits in		

133355104.1.4	***1.1.1***	***N/A***	***ESTABLISH MORE PRIMARY CARE CLINICS: WEST AND NORTHWEST 1 AREA HEALTH CENTERS***
Harris Health System			*133355104*
Related Category 3 Outcome Measure(s):	*133355104.3.4*	*IT-1.10*	*Diabetes care: HbA1c poor control (>9.0%)*

Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
	DY2 Data Source: EHR Milestone 4 Estimated Incentive Payment *(maximum amount):* $2,557,335		
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $7,032,432	Year 3 Estimated Milestone Bundle Amount: $7,672,006	Year 4 Estimated Milestone Bundle Amount: $7,694,308	Year 5 Estimated Milestone Bundle Amount: $6,356,168
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)**:*** $28,754,914			

Project Option 1.1.1- Establish more primary care clinics: Northwest 2 ~~and Northwest 3~~ Area Health Center~~s~~

<u>Unique RHP Project ID:</u> 133355104.1.5 / Pass 1

<u>Performing Provider Name/TPI:</u> Harris Health System / 133355104

<u>Project Summary:</u>

<u>Provider:</u>

Harris Health System is comprised of 16 community health centers, seven school-based clinics, a dental center, dialysis center, five mobile health units, one outpatient specialty services clinic, and three hospitals. With a tax base of $511.6 million, Harris Health System was able to provide more than $1.254 billion in charity care during FY 2012.

Volume Statistics - FY2012	**Patient Payor Mix**	**Patient Demographics**
Hospital admissions- 35,343 Births (babies delivered)- 6,643 Emergency visits- 173,263 Outpatient clinic visits- 1,054,770	Self-Pay- 62.6% Medicaid and CHIP- 23.4% Medicare- 8.6% Other Funding- 3.6% Commercial Insurance- 1.8%	Hispanic- 57.4% African American- 26.3% Caucasian- 9.2% Asian- 4.8% Other- 2.2% American Indian- 0.2%

<u>Intervention(s):</u>

Harris Health System proposes to expand the capacity of primary care by adding the Northwest 2 ~~and Northwest 3~~ Area Health Center~~s~~ to the complement of existing health centers to establish Medical Homes primarily for the adult population.

<u>Need for the project:</u>

Currently, Harris Health System health centers are designated NCQA Primary Care Medical Homes with increasingly limited capacity. Health center providers are currently 95% empaneled. For the Northwest and El Franco Lee Health Centers combined, there were 852 unduplicated patients for which there were no Family Practice appointments available in the month of September 2012 alone.

<u>Target Population:</u>

All current and potential patients seeking primary care services within the system may benefit from this project (Medicaid and CHIP-23.4% / Self-Pay- 62.6%), specifically those in the zip codes: 77447 and 77429.

<u>Category 1 or 2 expected patient benefits:</u>

Our goal is to increase primary care clinic completed visits at Northwest 2 ~~and Northwest 3~~ Area Area Health Center~~s~~ by 3% over baseline in DY4 and 5% over baseline in DY5. The project seeks to complete 10,000 visits for ~~each~~ the- center by DY5.

<u>Category 3 outcomes:</u>

IT-1.10: Our goal is to decrease the percentage of patients with poorly controlled diabetes by 0.5% below baseline in DY4 and 1% in DY5.

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Project Option 1.1.1- Establish more primary care clinics: Northwest 2 ~~and Northwest 3~~ Area Health Center~~s~~

Unique RHP Project ID: 133355104.1.5 / Pass 1

Performing Provider Name/TPI: Harris Health System / 133355104

Project Description:

Harris Health System proposes to expand the capacity of primary care by adding the Northwest 2 ~~and Northwest 3~~ Area Health Center~~s~~ to the complement of existing health centers to establish Medical Homes primarily for the adult population.

Harris Health System proposes to expand the capacity of primary care by adding the Northwest 2 ~~and Northwest 3~~ Area Health Center~~s~~ to the complement of existing health centers to establish Medical Homes primarily for the adult population. The additional Health Centers will better accommodate the needs of the community by allowing them to receive the right care, at the right time, in the right setting.

The Health Center~~s~~ will be located in or around the following zip codes to meet the adult primary care demand surrounding the Northwest and El Franco Lee Health Centers: 77447 and 77429. The Health Center~~s~~ will be approximately 5,000-10,000 square feet of leased space. The Facilities and Planning department at the Harris Health System has confirmed that such lease space is available in or around the target zip codes. Harris Health System plans to add new providers and staff to operate the Health Centers. Point of care lab testing will be available. The clinic will also offer limited imaging services. Patient prescriptions will be available through a Central Fill Pharmacy, a complementary submitted project, which will facilitate delivery of prescriptions to the patient's home or to the Health Center within 24 hours.

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

The goals of this project are to:

- Increase capacity for primary care through the addition of a primary care Health Centers that will serve as a Medical Home primarily for the adult population.

Expanding the capacity of primary care through additional Health Centers across the county to better accommodate the needs of the community will allow patients to receive the right care at the right time in the right setting.

This project meets the following Region 3 goals:

- Increase access to primary and specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their condition, regardless of where they live or their ability to pay.

The Northwest 2 ~~and Northwest 3~~ clinic~~s~~ will increase access to primary care in a high-demand area of underserved individuals while ensuring that patients have access to care in the

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appropriate setting. Harris County residents will be treated, and care discounted, according to Harris Health's sliding fee scale, with determination of eligibility for financial assistance.

Challenges:

General primary care capacity has been a challenge for the Harris Health System. The Northwest 2 ~~and Northwest 3~~ Area Health Centers will provide access to a Medical Home for patients. A significant challenge for the Harris Health System has been adequate capacity to offer Medical Homes for patients who do not have a primary care provider. The providers are approximately 95% empaneled and thus unable to accept new patients at most Health Centers. To address these challenges, we propose to add this Health Center to increase access to new patients and improve appointment availability.

5-Year Expected Outcome for Provider and Patients:

Over the course of the 5-Year Waiver, Harris Health System expects to realize:

- Increased adult-focused primary care capacity through the addition of the Northwest 2 ~~and Northwest 3~~ Area Health Centers.

Starting Point/Baseline:

For performance purposes, the baseline will be set at 0 visits since these are new Health Centers that currently are not operational.

Rationale:

Currently, Harris Health System Health Centers are designated NCQA Primary Care Medical Homes with increasingly limited capacity. Health Center providers are currently 95% empaneled. Moreover, physicians in Harris Health System Health Centers carry a panel of 2,250 patients, which is higher than the industry standard of approximately 1,500 patients. Full panels lead to decreased access to primary care appointments at Health Centers. These Health Centers are approaching maximum capacity for empaneled patients. From March 2012-September 2012, the Harris Health System Patient Appointment Center was unable to schedule 68,247 unduplicated patients for primary care. For the Northwest and El Franco Lee Health Centers combined, there were 852 unduplicated patients for which there were no Family Practice appointments available in the month of September 2012 alone. The Northwest and El Franco Lee Health Centers received 145 Ask My Nurse in-basket messages per month for patients that needed same day appointments that could not be scheduled by the Patient Appointment Center. Within the Harris Health System, 28% of all requests received in September 2012 for Family Practice appointments that could not be scheduled were for patients living in zip codes served by the El Franco Lee and Northwest Health Centers. These numbers, however, do not capture the full volume of unmet demand due to the fact that some patients may be likely to hang up when

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placed on hold and some patients who needed care likely did not attempt to obtain an appointment based on previous difficulties obtaining appointments. Based on 2012 data of incoming patient calls to the Patient Appointment Center over 34,000 unduplicated patients living near the El Franco Lee and Northwest Health Centers were unable to get an appointment.

Additional Health Centers will result in increased access to primary care and establishment of more Medical Homes in light of the high level of saturation at existing Health Centers. The Health Centers also offer a more cost effective and appropriate care setting for primary care treatable conditions than emergency centers.

Project Components:

Not Applicable / The project option 1.1.1 does not have components

Milestones & (Metrics):

- Process Milestones and Metrics- P-1 (P-1.1); P-5 (P-5.1); P-X (P-X.1); P-X2 (P-X2.1)
- Improvement Milestones and Metrics- I-12 (I-12.1)

Unique community need identification number the project addresses:

This project addresses the following community needs according to the community needs assessment:

- CN.1- Inadequate access to primary care
- CN.8- High rates of inappropriate emergency department utilization

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

The addition of Health Centers to the existing platform of Health Centers that offer Medical Homes complements the proposed establishment of same day clinics. As patients are treated in same day access sites, patients in need of care management available at Medical Home sites will be routed to Harris Health System Health Centers.

Related Category 3 Outcome Measure(s):

OD-1 Primary Care and Chronic Disease Management

- IT-1.10- Diabetes care: HbA1c poor control (>9.0%)

Reasons/rationale for selecting the outcome measure(s):

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The Northwest 2 ~~and Northwest 3~~ Area Health Center~~s~~ will increase capacity for primary care visits within the Harris Health System, which will enhance access and improve the patient's experience in obtaining services. The Northwest 2 ~~and Northwest 3~~ Area Health Center~~s~~ will offer additional access, affording patients the opportunity to seek care. The improved appointment availability to care will allow diabetes patients enhanced access to better manage diabetes. The Northwest 2 ~~and Northwest 3~~ Area Health Center~~s~~ will establish the baseline of percentage of poorly controlled diabetes (>9.0%) in DY3. The Health Center~~s~~ will increase appointment availability for both new and return patients. The enhanced access to care will result in improved hemoglobin A1c (<9.0%).

Relationship to other Projects: Patient prescriptions will be available through a Central Fill Pharmacy, a complementary submitted project, which will facilitate delivery of prescriptions to the patient's home or to the Health Center within 24 hours. Harris Health System proposes to expand the existing capacity of primary care by adding primary care providers to the Health Centers. Adding providers will increase appointment availability.

Relationship to Other Performing Providers' Projects in the RHP:

Primary Care/Ambulatory Care clinics are a top priority to Region 3 due to the acuity of the regional patient mix, population concentration, and lack of primary care access points for our patient base. The regional approach of collaboration as well as existing patient referral pattern relationships allowed our team to properly identify the community needs based on the necessity of population, uninsured, and medically underserved patient bases. This program is consistent with our region and similar to numerous initiatives in our RHP plan sharing both concepts as well as outcome measures focused on percent improvement over baseline of patient satisfaction scores, reduction of inappropriate ED utilization, and third next available appointment status. The Region 3 Initiative Grid attached as a RHP Plan addendum reflects a grid of relationship for all initiatives.

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Plan for Learning Collaborative: We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system.

Project Valuation: This project addresses one of the main objectives of the 1115 Waiver; increasing access to primary care for the underserved population in this area of Harris County. The value of the project is based on the clinic's capacity to provide a medical home for primary care services, including laboratory point-of-care testing, some imaging, other ancillary services and prescription medications along with timely referrals for specialty care and other needed services within the Harris Health System network. Each clinic can ultimately care for the comprehensive primary care needs of over three thousand patients annually, including the

coordination of chronic disease education and management for patients needing those services. In addition, the availability of timely primary care appointments will result in fewer emergency room visits for public and private hospitals located in the service area. Early detection, treatment and education regarding wellness and prevention will also help to prevent future downstream inpatient admissions.

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133355104.1.5	***1.1.1***	*N/A*	***Establish more primary care clinics: Northwest 2 ~~and Northwest 3~~ Area Health Center~~s~~***
Harris Health System			*133355104*
Related Category 3 Outcome Measure(s):	*133355104.3.5*	*IT-1.10*	*Diabetes care: HbA1c poor control (>9.0%)*
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Milestone 1 [P-X]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Metric 1 [P-X.1]: Planning documentation Goal: Produce a comprehensive implementation plan for the establishment of Northwest 2 ~~and Northwest 3~~ Area Health Center~~s~~ Data Source: Project plan Milestone 1 Estimated Incentive Payment *(maximum amount):* $8,370,608	**Milestone 2** [P-1]: Establish additional primary care clinics Metric 1 [P-1.1]: Number of additional clinics or expanded hours or space Baseline: 0 additional clinics in target area in DY2 Goal: Establish one additional clinics for the Northwest 2 ~~and Northwest 3~~ area Data Source: New primary care schedule Milestone 2 Estimated Incentive Payment *(maximum amount):* $3,043,961 **Milestone 3** [P-5]: Hire additional primary care providers and staff Metric 1 [P-5.1]: Documentation of increased number of providers and	**Milestone 5** [I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 [I-12.1]: Documentation of increased number of visits. Baseline: Established in DY3 Goal: Increase completed visits at Northwest 2 ~~and Northwest 3~~ Area Health Center~~s~~ by 3% over baseline Data Source: EHR Milestone 5 Estimated Incentive Payment *(maximum amount):* $9,158,430	**Milestone 6** [I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 [I-12.1]: Documentation of increased number of visits. Baseline: Established in DY3 Goal: Increase completed visits at Northwest 2 ~~and Northwest 3~~ Area Health Center~~s~~ by 5% over baseline Data Source: EHR Milestone 6 Estimated Incentive Payment *(maximum amount):* $7,565,660

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133355104.1.5	***1.1.1***	*N/A*	*ESTABLISH MORE PRIMARY CARE CLINICS: NORTHWEST 2 ~~AND NORTHWEST 3~~ AREA HEALTH CENTER~~S~~*
Harris Health System			*133355104*
Related Category 3 Outcome Measure(s):	*133355104.3.5*	*IT-1.10*	*Diabetes care: HbA1c poor control (>9.0%)*

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
	staff. Baseline: 0 providers and staff hired in DY2 Goal: Hire providers and support staff Data Source: Contract documentation Milestone 3 Estimated Incentive Payment: $3,043,962 **Milestone 4** [P-X2]: Establish baseline number of completed visits at Northwest 2 and Northwest 3 Area Health Centers Metric 1 [P-X2.1]: Documentation of completed visits at Northwest 2 ~~and Northwest 3~~ Area Health Center~~s~~ Baseline: 0 completed visits in DY2 Data Source: EHR		

133355104.1.5	***1.1.1***	*N/A*	*ESTABLISH MORE PRIMARY CARE CLINICS: NORTHWEST 2 ~~AND NORTHWEST 3~~ AREA HEALTH CENTER~~S~~*
Harris Health System			*133355104*
Related Category 3 Outcome Measure(s):	*133355104.3.5*	*IT-1.10*	*Diabetes care: HbA1c poor control (>9.0%)*

Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
	Milestone 4 Estimated Incentive Payment *(maximum amount):* $3,043,961		
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $8,370,608	Year 3 Estimated Milestone Bundle Amount: $9,131,884	Year 4 Estimated Milestone Bundle Amount: $9,158,430	Year 5 Estimated Milestone Bundle Amount: $7,565,660
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)**:*** $34,226,582			

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Project Option 1.1.1- Establish more primary care clinics: Southwest, Medical Center, and Northeast Same Day Access Clinics

Unique RHP Project ID: 133355104.1.6 / Pass 1
Performing Provider Name/TPI: Harris Health System / 133355104
Project Summary:
Provider:
Harris Health System is comprised of 16 community health centers, seven school-based clinics, a dental center, dialysis center, five mobile health units, one outpatient specialty services clinic, and three hospitals. With a tax base of $511.6 million, Harris Health System was able to provide more than $1.254 billion in charity care during FY 2012.

Volume Statistics - FY2012	Patient Payor Mix	Patient Demographics
Hospital admissions- 35,343 Births (babies delivered)- 6,643 Emergency visits- 173,263 Outpatient clinic visits- 1,054,770	Self-Pay- 62.6% Medicaid and CHIP- 23.4% Medicare- 8.6% Other Funding- 3.6% Commercial Insurance- 1.8%	Hispanic- 57.4% African American- 26.3% Caucasian- 9.2% Asian- 4.8% Other- 2.2% American Indian- 0.2%

Intervention(s):
Harris Health System proposes to expand the capacity of primary care by establishing adult-focused primary care clinics that offer same day visits during extended hours to meet demand that saturated existing Harris Health System health centers cannot meet.
Need for the project:
Currently, Harris Health System health centers are designated NCQA Primary Care Medical Homes with increasingly limited capacity. Health center providers are currently 95% empaneled. From March 2012-September 2012, the Harris Health System Patient Appointment Center was unable to schedule 68,247 unduplicated patients for primary care.
Target Population:
All current and potential patients seeking primary care services within the system may benefit from this project (Medicaid and CHIP-23.4% / Self-Pay- 62.6%), specifically those residing in or around the following zip codes: 77031, 77026, 77028, 77030, 77025.
Category 1 or 2 expected patient benefits:
Our goal is to increase primary care clinic completed visits at same day access clinics by 3% over baseline in DY4 and 5% over baseline in DY5. The project seeks to increase primary care completed visits by an additional 55,500 visits in DY 5 over the baseline in DY3.
Category 3 outcomes:
IT-6.1: Our goal is to increase “Ease of scheduling appointments” score by 1% above baseline in DY4 and 2% above baseline in DY5 (Press Ganey).

Project Option 1.1.1- Establish more primary care clinics: Southwest, Medical Center, and Northeast Same Day Access Clinics
Unique RHP Project ID: 133355104.1.6 / Pass 1

Performing Provider Name/TPI: Harris Health System / 133355104

Project Description:

Harris Health System proposes to expand the capacity of primary care by establishing adult-focused primary care clinics that offer same day visits during extended hours to meet demand that saturated existing Harris Health System health centers cannot meet. Same day access clinics will better accommodate the needs of the community by allowing them to receive the right care, at the right time, in the right setting.

The same day access clinics will be located in or around the following zip codes to meet the adult primary care demand surrounding the El Franco Lee and People's Health Centers, LBJ General Hospital, and Ben Taub General Hospital: 77031, 77026, 77028, 77030, and 77025. The three clinics will be approximately 1,500-3,000 square feet each of leased space. The Facilities and Planning department at the Harris Health System has confirmed that such lease space is available in or around the target zip codes. Harris Health System plans to add new providers and staff to operate the clinic for extended evening hours and weekend hours, in addition to regular weekday hours, based on demand. Point of Care lab testing will be available. If patients are in need of imaging or pharmacy services, they will be referred to the nearest facility that provides those services.

Goals and Relationship to Regional Goals:

The goals of this project are to:

- Increase capacity for same day primary care through establishment of more accessible care locations across Harris County
- Increase access to same day primary care during extended hours and weekends

Expanding the capacity of primary care through additional clinics across the county and extended operating hours to better accommodate the needs of the community will allow patients to receive the right care at the right time in the right setting.

This project meets the following Region 3 goals:

- Increase access to primary and specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their condition, regardless of where they live or their ability to pay.

The three new same day access clinics will increase access to primary care in high demand areas of underserved individuals while ensuring that patients have access to care in the

appropriate setting. Harris County residents will be treated, and care discounted, according to the Harris Health System sliding scale, with determination of eligibility for financial assistance.

Challenges and how to address:

General primary care capacity has been a challenge for the Harris Health System. The same day access clinics will provide same day access for Medical Home and non-Medical Home patients. A significant challenge for the Harris Health System has been adequate capacity to offer Medical Homes for patients who do not have a primary care provider. As patients are seen in the same day clinic setting, this will continue to be a problem for those patients who need care for chronic conditions or other specialized care. In addition, meeting the demand for intensive behavioral health care needs that will present at same day access clinics will prove to be a challenge. To address these challenges we propose to direct patients with chronic conditions into the Medical Home setting at a Harris Health System health center or refer to a primary care setting at a local FQHC. Patients with behavioral health needs will be referred to behavioral health providers.

5-Year Expected Outcome for Provider and Patients:

Over the course of the 5-Year Waiver, Harris Health System expects to realize:

- Increased adult-focused primary care capacity through same day care clinics for primary care treatable conditions

Starting Point/Baseline:

For performance purposes, the baseline will be set at 0 visits since these are new clinics that currently are not operational.

Rationale:

Reasons for selecting the project option:

Currently, Harris Health System health centers are designated NCQA Primary Care Medical Homes with increasingly limited capacity. Health center providers are currently 95% empaneled. Moreover, physicians in Harris Health System health centers carry a panel of 2,250 patients, which is higher than the industry standard of approximately 1,500 patients. Full panels lead to decreased access to primary care appointments at health centers. These health centers are approaching maximum capacity for empaneled patients. From March 2012-September 2012, the Harris Health System Patient Appointment Center was unable to schedule 68,247 unduplicated patients for primary care. For the El Franco Lee and People's health centers, there were 908 unduplicated patients for which there were no Family Practice appointments available in the

month of September 2012 alone. Within the Harris Health System, 30% of all requests received in September 2012 for Family Practice appointments that could not be scheduled were for patients living in zip codes served by the El Franco Lee and People's health centers. El Franco Lee and People's Health Centers received 145 Ask My Nurse in-basket messages per month for patients that needed same day appointments that could not be scheduled by the Patient Appointment Center. These numbers, however, do not capture the full volume of unmet demand due to the fact that some calls were dropped as patients were placed on hold and some patients who needed care did not attempt to obtain an appointment based on previous difficulties obtaining same day appointments. Based on 2012 data of incoming patient calls to the Patient Appointment Center, 4627 unduplicated patients living near the El Franco Lee and People's Health Centers were unable to get an appointment.

Ben Taub and LBJ General Hospital sees a high volume of patients that would be more appropriately treated in the same day access clinic setting The addition of same day access clinics in close proximity will result in increased access to same day care for primary care treatable conditions, a more cost effective and appropriate setting than emergency centers and a more accessible setting than saturated Medical Home health centers.

Project Components:

Not Applicable / The project option 1.1.1 do not have components

Milestones & Metrics:

- Process Milestones and Metrics- P-1 (P-1.1); P-5 (P-5.1); P-X (P-X.1); P-X2 (P-X2.1)
- Improvement Milestones and Metrics- I-12 (I-12.1)

Unique community need identification number the project addresses:

This project addresses the following community needs according to the community needs assessment:

- CN.1- Inadequate access to primary care
- CN.8- High rates of inappropriate emergency department utilization
- CN.2- Inadequate access to specialty care

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

Currently, Harris Health System does not guarantee same day care for patients who are not enrolled in a Medical Home and empaneled to a primary care physician. Thus, the same day access clinics will be a new initiative for Harris Health by providing access to same day visits regardless of Medical Home enrollment. Moreover, current health centers offer an array of ancillary services, including full service outpatient pharmacies and laboratories, in addition to various specialty and radiology services. The same day access clinics will offer limited

laboratory services and will not offer radiology or pharmacy services but will refer patients to other facilities for these services as needed.

Related Category 3 Outcome Measure(s):

OD-6 Patient Satisfaction

- IT-6.1- Percent improvement over baseline of patient satisfaction scores (standalone)
    - (1) are getting timely care, appointments, and information

Reasons/rationale for selecting the outcome measure(s):

IT- 6.1 will measure improvement in satisfaction scores over time relating to timeliness of care at the Southwest, Medical Center, and Northeast same day access clinics, specifically measuring the mean score for the Press Ganey survey question- "Ease of scheduling appointments." The same day access clinics will increase capacity for primary care visits within the Harris Health System, which will enhance access and improve the patient's experience in obtaining services. Patient satisfaction scores have been historically poor for health centers regarding timely access to care. The same day access clinics will offer an efficient venue that offers same day visits, affording patients the opportunity to seek care in a setting that is appropriate for the level of care they need and more cost effective than other alternatives.

Relationship to other Projects:

Primary Care/Ambulatory Care clinics are a top priority to Region 3 due to the acuity of the regional patient mix, population concentration, and lack of primary care access points for our patient base. The regional approach of collaboration as well as existing patient referral pattern relationships allowed our team to properly identify the community needs based on the necessity of population, uninsured, and medically underserved patient bases. This program is consistent with our region and similar to numerous initiatives in our RHP plan sharing both concepts as well as outcome measures focused to percent improvement over baseline of patient satisfaction scores, reduction of inappropriate ED utilization, and third next available appointment status. The Region 3 Initiative Grid attached as a RHP Plan addendum reflects a grid of relationship for all initiatives.

Plan for Learning Collaborative: We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system.

Project Valuation: This project addresses one of the main objectives of the 1115 Waiver; increasing access to primary care for the underserved population in this area of Harris County. The value of the project is based on the clinics' capacity to provide primary care services, including laboratory point-of-care testing, along with timely referrals for specialty care, imaging

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and other needed services within the Harris Health System network. Each of the three clinics can ultimately care for the episodic primary care needs of over six thousand patients annually, and refer new patients with chronic disease management needs to one of the NCQA certified medical home clinics that are operated by Harris Health. In addition, the availability of same day primary care appointments will result in fewer emergency room visits for public and private hospitals located in the service area. Early detection, treatment and education regarding wellness and prevention will also help to prevent future downstream inpatient admissions.

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133355104.1.6	***1.1.1***	***N/A***	***EXPAND PRIMARY CARE CAPACITY- SOUTHWEST, MEDICAL CENTER, AND NORTHEAST SAME DAY ACCESS CLINICS***
Harris Health System			*133355104*
Related Category 3 Outcome Measure(s):	*133355104.3.6*	*IT-6.1*	*Percent improvement over baseline of patient satisfaction scores*

Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Milestone 1 [P-X]: Project planning **-** engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Metric 1 [P-X.1]: Planning documentation Goal: Produce a comprehensive implementation plan for the establishment of same day access clinic Data Source: Project plan Milestone 1 Estimated Incentive Payment *(maximum amount):* $14,173,677	**Milestone 2** [P-1]: Establish additional primary care clinics Metric 1 [P-1.1]: Number of additional clinics or expanded hours or space Baseline: 0 same day access clinics in target area in DY2 Goal: Establish one same day access clinic Data Source: New primary care schedule Milestone 2 Estimated Incentive Payment *(maximum amount):* $5,154,240 **Milestone 3** [P-5]: Hire additional primary care providers and staff Metric 1 [P-5.1]: Documentation of	**Milestone 5** [I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 [I-12.1]: Documentation of increased number of visits. Baseline: Established in DY3 Goal: Increase completed visits at same day access clinics by 3% over baseline Data Source: EHR Milestone 5 Estimated Incentive Payment *(maximum amount):* $15,507,670	**Milestone 6** [I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 [I-12.1]: Documentation of increased number of visits. Baseline: Established in DY3 Goal: Increase completed visits at same day access clinics by 5% over baseline Data Source: EHR Milestone 6 Estimated Incentive Payment *(maximum amount):* $12,810,684

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133355104.1.6	*1.1.1*	*N/A*	*EXPAND PRIMARY CARE CAPACITY- SOUTHWEST, MEDICAL CENTER, AND NORTHEAST SAME DAY ACCESS CLINICS*
Harris Health System			*133355104*
Related Category 3 Outcome Measure(s):	*133355104.3.6*	*IT-6.1*	*Percent improvement over baseline of patient satisfaction scores*

Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
	increased number of providers and staff. Baseline: 0 providers and staff hired in DY2 Goal: Hire providers and support staff Data Source: Contract documentation Milestone 3 Estimated Incentive Payment*:* $5,154,240 **Milestone 4** [P-X2]: Establish baseline number of completed visits at same day access clinic Metric 1 [P-X2.1]: Documentation of completed visits at same day access clinic Baseline: 0 completed visits in DY2 Goal: Document completed visits (6 months) to create baseline		

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133355104.1.6	***1.1.1***	*N/A*	*EXPAND PRIMARY CARE CAPACITY- SOUTHWEST, MEDICAL CENTER, AND NORTHEAST SAME DAY ACCESS CLINICS*
Harris Health System			*133355104*
Related Category 3 Outcome Measure(s):	*133355104.3.6*	*IT-6.1*	*Percent improvement over baseline of patient satisfaction scores*

Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
	Data Source: EHR Milestone 4 Estimated Incentive Payment *(maximum amount):* $5,154,240		
Year 2 Estimated Milestone Bundle Amount: $14,173,677	Year 3 Estimated Milestone Bundle Amount: $ $15,462,720	Year 4 Estimated Milestone Bundle Amount: $15,507,670	Year 5 Estimated Milestone Bundle Amount: $12,810,684
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)**:*** $57,954,751			

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Project Option 1.9.3- "Other" project option: Implement other evidence-based project to expand specialty care capacity: Pre-consult evaluations to facilitate efficient specialty care.

Unique Project ID #: 133355104.1.7 / Pass 1
Performing Provider/TPI: Harris Health System/133355104
Project Summary:
Provider:
Harris Health System is comprised of 16 community health centers, seven school-based clinics, a dental center, dialysis center, five mobile health units, one outpatient specialty services clinic, and three hospitals. With a tax base of $511.6 million, Harris Health System was able to provide more than $1.254 billion in charity care during FY 2012.

Volume Statistics - FY2012	Patient Payor Mix	Patient Demographics
Hospital admissions- 35,343 Births (babies delivered)- 6,643 Emergency visits- 173,263 Outpatient visits- 1,054,770	Self-Pay- 62.6% Medicaid and CHIP- 23.4% Medicare- 8.6% Other Funding- 3.6% Commercial Insurance- 1.8%	Hispanic- 57.4% African American- 26.3% Caucasian- 9.2% Asian- 4.8% Other- 2.4%

Intervention(s):
This project will address the inefficiency of specialty clinics (focusing primarily on diabetes and rheumatology clinics) by making possible ordering best practices diagnostic algorithmic workups and eliminating the current practice of sequential ordering of individual tests which is resources and time wasteful as well as error prone. This will insure optimal testing prior to specialty consult and appropriate referral. The project will streamline the referral process and increase the productivity of both PCPs and specialists.
Need for the project:
It takes about 6 months to get a consult in the Harris Health rheumatology clinic. Similar backlogs exist for other consult services. Most patients arrive for their consult with inadequate work ups or do not have the condition in question. This number is about 50% of total number of consults in rheumatology service. The inadequacy of consultation process for diabetic patients is also illustrated by the fact that over 43% of African Americans are not aware of their diabetic kidney disease until one week prior to kidney failure and need for dialysis. We have identified several causes of the inefficiency that could be addressed by restructuring the diagnostic process.
Target Population:
All patients within the system may benefit from this project (Medicaid and CHIP-23.4% / Self-Pay- 62.6%), with a focus on those referred to diabetes and rheumatologic clinics.
Category 1 or 2 expected patient benefits:
Our goal is to decrease the rate of rejected/accepted primary care provider-initiated referrals to specialty care: decrease by 20%; 35%; 40% of baseline in DY3-DY5 in the diabetes and rheumatologic clinics. The estimated number of patients is (DY2-DY5) is about 3000.
Category 3 outcomes:
IT-1.1- Our goal is to decrease wait time from specialty referral to specialty clinic visit 20%, 30% and 40% from baseline in DY3-DY5 respectively.
IT-1.14- Diabetes care: Microalbumin/Nephropathy- Goals for DY4 and DY5 to be determined.
IT-6.1- Our goal is to increase satisfaction scores: patient's rating of doctor access to specialist- by 3% above baseline in DY4 and 5% in DY5.

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Project Option 1.9.3- "Other" project option: Implement other evidence-based project to expand specialty care capacity: Pre-consult evaluations to facilitate efficient specialty care.

Unique Project ID #: 133355104.1.7 / Pass 1
Performing Provider/TPI: Harris Health System/133355104

Project Description:
Harris Health System proposes a project that will address the opportunity for increased efficiency in the referral processes to specialty clinics. This project will focus on developing algorithms to address diabetes mellitus and rheumatology clinic.

ACOs and medical homes are designed to ensure continuity of care and facilitation of efficient use of specialty consultations. This project will address two limitations of these models: first, the limited ability of providers to keep current with the ever more complex diagnostic technologies and, second, the wasteful procedures necessary to navigate the labyrinth of operational inefficiencies. Our approach is based on the fact that pathologists through the laboratories produce around 70% of all data in medical records and are specifically trained in diagnostic medicine. The goal is to use these resources in an efficient consultative manner to improve selection and preparation of patients for specialty consultations across the entire spectrum of the Harris Health System.

Harris Health System serves Harris County, which is the 3rd largest County in the US. The system has a $1.2 billion budget, 7500 FTEs and operates 3 hospitals and an ambulatory network with over 1,000,000 visits annually, 10,000 consults / month and 10,000 calls for appointments per week. The Harris Health clinics systematically experience shortage of clinic availability for specialty consults. For example, it usually takes about 6 months to get a rheumatologist consult at the Lyndon B. Johnson rheumatology clinic. Similar backlogs exist for other consult services. This delays the initiation of the necessary treatment, negatively affects the patient's health, and produces dissatisfaction and frustration. Our analysis and discussions with clinicians revealed several causes of the backlogs that could be addressed with little capital investments by restructuring of the diagnostic process.

The current system requires physician's justification of every test on every patient. It is unreasonable to expect any practicing clinician to be familiar with the best diagnostic practices across the entire spectrum of diseases. EMRs make patient information accessible, but offer little help in either directing workups of complex conditions or managing arcane and wasteful processes of test ordering and reporting.

This project will focus primarily on diabetes mellitus (DM)/pre-diabetes and rheumatologic conditions. Our plan is to make it possible for providers to efficiently order the most appropriate best practices algorithm driven laboratory workups for particular patients. The pre-consult algorithms will be developed by pathologists in consultation with both primary care and specialist providers. They will be executed in the laboratory and reported with a concise explanation of what was done and the meaning of the results. The interpretation of algorithms will be done by pathologists during the developmental phase. As best practices become clarified, nurses or other personnel will likely be able to interpret some algorithms. However, others that require review of the medical record and a physician's judgment will continue to be done by pathologists. As the expertise and infrastructure develop, we will consider piloting similar approaches to several other specialties (Hematology and coagulation, Hepatology, etc.) that are not a part of the milestones and goals formulated for this project. The project will begin with

pre-consult evaluations for rheumatology and endocrinology and progress to the entire spectrum of diagnostic medicine.

This evaluation will be used by referral service (specially trained referral nurses interacting with clinical pathologists) to determine the need for consult, for triaging the consult requests depending on urgency and clinical condition. The approach will also ensure that the patients come to the specialty consult with the entire set of tests needed to make the diagnosis, thus eliminating/minimizing the need for additional visits. As a result, introduction of this approach will free up significant number of specialist consult spots, increase the productivity of the specialist and "unclog" the referral service by increasing the throughput without employing additional providers and major capital investments. For consult requests that are denied, referring primary care physicians will receive a detailed explanation of the reasons and alternatives to consider.

The project's final outcome will be expansion of specialty care by increasing productivity and streamlining the work of existing PCPs and specialists. It combines elements of expanding specialty care and improved access to specialty care with emphasis on improving effectiveness of existing personnel and facilities by inserting diagnostic algorithms and pathologists' pre-consults into the preparation for specialty consults. This project is intended to make better use of existing specialty services without major capital investments.

In regard to diabetes significant emphasis will be placed on certain ethnic populations (Hispanics, African Americans and Asian/Vietnamise) considering the disproportionally high prevalence of this condition and early complications in these ethnic groups. There is vast literature supporting this notion for African Americans. Disturbingly, the incidence of end stage renal disease (ESRD) due largely to diabetes continues to mount in young African Americans (J Am Soc Nephrology 18, 1038-45, 2007). African Americans make up only 13% of the US population, yet constitute 32% of patients with ESRD. The risk for developing ESRD is at least three-fold higher in African Americans. .Very troublesome that according to this study over 43% of African Americans with kidney failure were not aware of kidney disease until one week before their kidneys failed entirely and they required dialysis. Hispanic Americans also have a high prevalence of diabetes. Among all diabetics, Hispanic patients are six times more likely to develop chronic kidney disease and to advance to end-stage disease. Experience at Harris Health points also towards increased prevalence among Vietnamese. About 50% of patients served by Harris Health are Hispanic, 26% - African Americans and 5% - Asian (mainly Vietnamese). That provides an idea of involved costs and possible savings if diabetes early evaluation program (DEEP) and complications early evaluation program (CEEP) (see the goals section below) are successfully implemented.

Goals and Relationship to Regional Goals:

Project goals:

- Develop an algorithm for diabetes early evaluation program (DEEP) and for diabetes complications early evaluation program (CEEP) and implement programs in clinics. The CEEP will focus primarily on kidney complications (nephropathy); it will also require blood pressure measurements, retinal and foot examinations by PCPs as a part of the algorithm to satisfy the fast track of the referral protocol
- Introduce the algorithm-based work-ups and pre-consult evaluations for major rheumatologic conditions (total 5).

- Develop laboratory and referral center workflows and train technologists and nurses to execute them.
- Develop knowledge based systems to facilitate efficient preparation of reports that contain both the test results and an explanation of the implications for each patient.
- Work with information technology (IT) department to implement ordering and reporting of the algorithm-based work-ups.
- Assess the value of algorithmic and consultative diagnostic workups for clinicians and use their input to further improve of the effectiveness processes.

This project meets the following regional goals:

- Develop a regional approach to health care delivery that leverages and improves on existing programs and infrastructure, is responsive to patient needs throughout the entire region, and improves health care outcomes and patient satisfaction.
- Increase access to primary and specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their condition, regardless of where they live or their ability to pay.

All the regional institutions providing diagnostic and consulting services experience the same problems with shortness of slots for clinic visits and especially for consults. Thus, this project will provide a demonstration of means to improve efficiency of healthcare and patient satisfaction in the region.

Challenges:

We have found that both PCP and specialist physicians immediately understand value of this project and are anxious to participate in developing and using algorithms. The challenges lie within laboratories that must develop new workflows, with pathologists who must learn a new discipline and with information systems who must build complex new functionality.

Our approach is to use manual or pilot scale methods to introduce and refine processes. A medical technologist will manage samples in the laboratory, order tests of an algorithm, and collate results for pathologist interpretation. The interpretations will be facilitated using database that we have used for years in assisting with complex interpretations in hematopathology (http://pathology.uth.tmc.edu/faculty/pages/nguyen-nghia/decision.html). We will work with information systems continuously to determine when a process is sufficiently stable to warrant full development and then plan and execute such development. Education of nurses and medical technologists as well as pathologists is essential.

5-year expected outcome for Performing Provider and patients:

- Increase the capacity of clinics and consulting services by reducing the number of patient visits required to solve diagnostic problems.
- Reduce the need for emergency room visits and hospitalizations that result from delayed or inaccurate diagnoses in the clinics.
- Increase (with little capital investments) the throughput and productivity of the specialists consulting services by "unclogging" the Consulting System through eliminating unnecessary consults and minimizing the number of excessive visits due to incomplete pre-consult testing.
- Improve quality of care by decreasing the waiting time and eliminating unnecessary repeated visits due to incomplete pre-consult testing; enhancing patients' satisfaction.

- Make possible (or facilitate) providing quality care for expected significant influx of patients due to implementation of ACA and the 1115 Waver without major increase of numbers of providers and capital investment..

Starting Point/Baseline:
The Harris Health System has a busy centralized referral department staffed by nurses (10) and clerks. We began working with this department early in the process of developing algorithms in order obtain an illustration of the effectiveness of this approach. The focus was on systemic lupus erythematosus (SLE) referrals. The test run demonstrated that implementation of the algorithms could help greatly with workflow and result in reduction of the backlog for the rheumatology clinic by about half (from nearly 6 to about 2 1/2 months).

In review of 80 cases in the test run of the algorithm for SLE in late May, June and early July, it became clear that this might provide significant benefits if properly applied.. For example, of the 80 cases, 4 were graded as ‘URGENT, 30 were ‘APPROVED for routine consultation and 49 were ‘DENIED. Some of the denials were returned to complete the necessary laboratory work. Six patients had positive TSH or hepatitis panels, which warranted an endocrinology or gastrointestinal rather than rheumatology consultations. It has been demonstrated that proper managing of the proposed program could substantially reduce the number of inappropriate consultations and allow e patients with more severe disease to obtain early rheumatology appointments. Only 15 of the 80 patients had a urinalysis, sedimentation rate and CRP performed. Many others did not have CBCs or appropriate autoantibody measurements. Under the proposed plan, the pathologist reviewing the consult will order the indicated tests using the already collected sample. This will save time and money for the patients, nurses and physicians who would otherwise have to pass the information to several facilities to get the testing done.

Some of the cases appear to be more complex, requiring review of the medical records and physician’s judgment. Adding specialized laboratory medicine physician’s judgment at a critical point in the work-up would be far more effective and efficient than available alternatives. This is an example where specialized expertise in laboratory work-ups of patients with suspected SLE would be preferable instead of trying to educate primary care providers across the system in areas of technology they will only use occasionally. Pathologists will collate the results into a single report with a narrative explanation of what was done and the meaning of the results. Intention is to make this understandable and educational to both providers and patients.

Rationale:

A significant number of patients scheduled for specialty consults often do not have the condition in question. These patients get scheduled for consult due to PCP overload, insufficient or inappropriate laboratory testing and cumbersome delivery of laboratory results. A rough estimate shows that this number is about 50% of total number of consults in rheumatology service. PCPs need assistance in choosing the optimal tests to make the best diagnostic decisions and eliminate unnecessary consults to triage the remaining consults based on the urgency of the situation and need for specialist involvement.

Extended laboratory diagnostic work-ups commonly start after the initial visit to a specialist. Second/third visits are typically necessary for the data to be reviewed by a specialist and management decisions to be made and implemented. This process takes up a significant

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number of consult clinic openings that could be used more effectively by other patients in line and delays the implementation of treatment.

It is not uncommon that by the time laboratory testing is completed, it becomes clear that the patient did not have the condition in question. At this point, the patient may have already undergone up to 3 unnecessary specialty clinic visits. This often leads to repetition of the entire process until there is a correct diagnosis.

Laboratories produce 70% of all data in typical medical records, and placing professional expertise in the laboratory makes it possible for PCP's to order algorithmic workups and laboratory consultations. Clinical pathologists would be responsible for reviewing data and providing actionable reports for clinicians. Best practice algorithms will be made conveniently available to all providers and executed efficiently within the laboratory saving costs, time, and frustrations of unnecessary or inappropriate tests and nonproductive clinic visits.

Medical errors are significant contributors to cost and undesirable outcomes in medicine. Significant errors are reported to occur in as much as 15% of cases. (Diagnostic Errors in Acute Care , 2010) Much attention has been focused on therapeutic errors such as drug dose; however, diagnostic errors are responsible for twice as many adverse events as medication errors. (Creating a Value-Driven Laboratory:Opportunities in the New Marketplace, 2012) 44% of the diagnostic errors were failure to order, report, process or follow up on results of laboratory tests or x-rays. In addition, 70% of diagnostic errors have been attributed to data gathering, data synthesis, or clinical knowledge (Creating a Value-Driven Laboratory:Opportunities in the New Marketplace, 2012). Introduction of evidence based work-ups and use of locally developed best practices algorithms together with the expertise of specialists in diagnostic laboratory medicine will reduce errors and improve performance in each of these areas.

Project Components: Not applicable.

Milestones and Metrics: P-X1, P-X1.1; P-X2, P-X2.1, P-2, P-2.1; P-5, P-5.1; P-6, P-6.1**;** I-X1, I-X1.1; I-X2,I-X2.1; I-26, I-26.1

Unique community need identification numbers the project addresses:

- CN.2 Inadequate access to specialty care

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

This is an entirely new initiative for Harris Health System. Some institutions such as Partners in Boston, use pre-consult algorithms and others like Vanderbilt, use pathologist laboratory consultations; but, we do not know of any other institution that has initiated a project that combines these elements together. In developing the programs for diabetes (DEEP and CEEP), we will use the experience of others that have successfully accomplished elsewhere. The National Kidney Foundation uses an algorithm of clinical and laboratory data in order to identify people with diabetes and/or kidney disease before they become clinically symptomatic, namely, the Kidney Early Evaluation Program (KEEP.) Another program implemented by the University of Miami screened employees of the Polk County School Board. In only two years, it produced savings in total healthcare costs of $456.44 / per covered live / per year for an ROI of 1:1.73. The savings from case finding are expected to increase further as the patients continue with chronic

care. We will work with specialist and primary care physicians in Harris Health to adapt these and other best practices to our environment and our goals.

Related Category 3 Outcome Measures:

- OD-1: Primary Care and Chronic Disease Management
  IT-1.1: Third Next Available Appointment (non-standalone)
  IT-1.14: Diabetes care: Microalbumin/Nephropathy- NQF 0062 (non-standalone)
- OD-6: Patient Satisfaction
  IT-6.1(3): Percent improvement over baseline of patient satisfaction scores: patient's rating of doctor access to specialist (stand-alone)

Reasons/rationale for selecting the outcome measures:

In an effort to increase efficiencies in the primary care setting, this project is proposing algorithms for diabetes and rheumotological conditions. We decided to measure three outcomes that are overall goals of the project. In an effort to increase efficiencies, we have chosen IT-1.1 as we aim to decrease the amount of time a patient must wait between specialty clinic referral and actual visit. Diabetes is a focus for our region, and we plan to implement an algorithm that will focus on diabetes screening. We decided that IT-1.14 is important in the success of this particular part of the project. IT-6.1(1) was chosen because Harris Health System wants to continuously provide efficient care without ever losing sight of the patient experience.

Relationship to other projects: The increase of primary care and specialty care will naturally result in additional ambulatory care encounters for our region patient base. The ambulatory initiatives cover items such as laboratory, PT/OT, social work, etc. and are a necessity of our patients to ensure a comprehensive treatment for access as well as cost avoidance. The Region 3 initiative grid in the addendum reflects all ambulatory operations initiatives.

Plan for Learning Collaborative: We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system.

Project Valuation: This project will focus primarily on diabetes mellitus (DM)/pre-diabetes and rheumatologic conditions, making it possible for providers to efficiently order the most appropriate best practices algorithm driven laboratory workups for particular patients. The value of the project is based on cost savings and efficiencies through (1) increasing the capacity of clinics and consulting services by reducing the number of patient visits required to solve diagnostic problems, (2) reducing the need for emergency room visits and hospitalizations that result from delayed or inaccurate diagnoses in the clinics. (3) increasing the throughput and productivity of the specialists consulting services by eliminating unnecessary consults, and (4) improving quality of care by decreasing the waiting time and eliminating unnecessary repeated visits due to incomplete pre-consult testing; thus enhancing patients' satisfaction. In addition, these improvements will facilitate providing quality care for expected significant influx of patients due to implementation of ACA and the 1115 Waver without a major increase in the number of providers and capital investment.

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133355104.1.7	***1.9.3***	***N/A***	***"OTHER" PROJECT OPTION: IMPLEMENT OTHER EVIDENCE-BASED PROJECT TO EXPAND SPECIALTY CARE CAPACITY IN AN INNOVATIVE MANNER NOT DESCRIBED IN THE PROJECT OPTIONS: PRE-CONSULT EVALUATIONS TO FACILITATE EFFICIENT SPECIALTY CARE***
Harris Health System			*133355104*
Related Category 3 Outcome Measure(s):	*133355104.3.7* *133355104.3.8* *133355104.3.9*	*IT-1.1* *IT-1.14* *IT-6.1(3)*	*Third Next Available Appointment (non-standalone)* *Diabetes care: Microalbumin/Nephropathy - NQF 0062(non-standalone)* *Percent improvement over baseline of patient satisfaction scores: patient's rating of doctor access to specialist (stand-alone*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-6]: Develop and implement standardized referral and work-up guidelines Metric 1 [P-6.1]: Referral and work-up guidelines. Goal: Develop algorithms for work-up, risk assessment, referral triaging for diabetes and rheumatologic conditions. Pilot the developed protocols algorithms for diabetes and (2) rheumatologic conditions. Data Source: Referral and work-up policies and procedures documents Milestone 1 Estimated Incentive Payment*:* $ 1,241,582 **Milestone 2** [P-2]: Train care providers and staff on processes, guidelines and technology for referrals and consultations into selected medical specialties Metric 1 [P-2.1]: Training of staff and providers on referral guidelines, process and technology	**Milestone 6** [I-X1]: Increase % of providers using algorithms for the diagnosis and management of diabetes conditions Metric 1 [I-X1.1]: % increase of physicians using established algorithms for diabetes conditions. Goal: 40% of total providers using algorithms Data Source: Referral management system, EHR Milestone 6 Estimated Incentive Payment: $1,693,125 **Milestone 7** [I-X2]: Increase % of providers using algorithms for rheumatologic conditions. Metric 1 [I-X2.1]: % increase of physicians using established algorithms for rheumatologic conditions. Goal: 45% increase above baseline Data Source: Referral management system, EHR	**Milestone 10** [I-X1]: Increase % of providers using algorithms for the diagnosis and management of diabetes conditions Metric 1 [I-X1.1]: % increase of physicians using established algorithms for diabetes conditions. Goal: 50% of total providers using algorithms Data Source: Referral management system, EHR Milestone 10 Estimated Incentive Payment: $ 1,698,047 **Milestone 11** [I-X2]: Increase % of providers using algorithms for rheumatologic conditions. Metric 1 [I-X2.1]: % increase of physicians using established algorithms for rheumatologic conditions. Goal: 55% increase above baseline Data Source: Referral management system, EHR	**Milestone 14** [I-X1]: Increase % of providers using algorithms for the diagnosis and management of diabetes conditions Metric 1 [I-X1.1]: % increase of physicians using established algorithms for diabetes conditions. Goal: 60% of total providers using algorithms Data Source: Referral management system, EHR Milestone 14 Estimated Incentive Payment: $1,402,734 **Milestone 15** [I-X2]: Increase % of providers using algorithms for rheumatologic conditions. Metric 1 [I-X2.1]: % increase of physicians using established algorithms for rheumatologic conditions. Goal: 65% increase above baseline Data Source: Referral management system, EHR

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133355104.1.7	***1.9.3***	***N/A***	***"OTHER" PROJECT OPTION: IMPLEMENT OTHER EVIDENCE-BASED PROJECT TO EXPAND SPECIALTY CARE CAPACITY IN AN INNOVATIVE MANNER NOT DESCRIBED IN THE PROJECT OPTIONS: PRE-CONSULT EVALUATIONS TO FACILITATE EFFICIENT SPECIALTY CARE***
Harris Health System			*133355104*
Related Category 3 Outcome Measure(s):	*133355104.3.7* *133355104.3.8* *133355104.3.9*	*IT-1.1* *IT-1.14* *IT-6.1(3)*	*Third Next Available Appointment (non-standalone)* *Diabetes care: Microalbumin/Nephropathy - NQF 0062(non-standalone)* *Percent improvement over baseline of patient satisfaction scores: patient's rating of doctor access to specialist (stand-alone*
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Baseline: will be established Goal: Pilot to include 5% of providers Data Source: EMR; Log of staff trained and training curriculum Milestone 2 Estimated Incentive Payment: $1,241,582 **Milestone 3** [P-X1]: Establish baselines for rate of inappropriate or rejected referrals in diabetes conditions. Metric 1 [P-X1.1]: Determine the rate of inappropriate or rejected referrals in diabetes conditions. Goal: establish % of inappropriate or rejected referrals Data Source: EMR Milestone 3 Estimated Incentive Payment : $1,241,582 **Milestone 4** [P-X2]: Establish baselines for rate of inappropriate or rejected referrals in rheumatologic conditions.	Milestone 7 Estimated Incentive Payment: $ 1,693,125 **Milestone 8** [I-26]: Reduce the rate of inappropriate or rejected referrals Metric 1 [I-26.1]: Rate of Rejected/Accepted Primary Care Provider-Initiated Referrals to Specialty Care. This rate will be calculated on a quarterly basis and reported for most recent quarter. Goal: 20% decrease of rejected referrals from baseline for diabetes clinics Data Source: eReferral or other referrals system Milestone 8 Estimated Incentive Payment: $ 1,693,125 **Milestone 9** [I-26]: Reduce the rate of inappropriate or rejected referrals Metric 1 [I-26.1]: Rate of Rejected/Accepted Primary Care Provider-Initiated Referrals to Specialty Care. This rate will be calculated on a quarterly basis and	Milestone 11 Estimated Incentive Payment: $ 1,698,047 **Milestone 12** [I-26]: Reduce the rate of inappropriate or rejected referrals Metric 1 [I-26.1]: Rate of Rejected/Accepted Primary Care Provider-Initiated Referrals to Specialty Care. This rate will be calculated on a quarterly basis and reported for most recent quarter. Goal: 35% decrease of rejected referrals from baseline for diabetes clinics Data Source: eReferral or other referrals system Milestone 12 Estimated Incentive Payment: $1,698,047 **Milestone 13** [I-26]: Reduce the rate of inappropriate or rejected referrals Metric 1 [I-26.1]: Rate of Rejected/Accepted Primary Care Provider-Initiated Referrals to Specialty Care. This rate will be	Milestone 15 Estimated Incentive Payment: $1,402,734 **Milestone 16** [I-26]: Reduce the rate of inappropriate or rejected referrals Metric 1 [I-26.1]: Rate of Rejected/Accepted Primary Care Provider-Initiated Referrals to Specialty Care. This rate will be calculated on a quarterly basis and reported for most recent quarter. Goal: 40% decrease of rejected referrals from baseline for diabetes clinics Data Source: eReferral or other referrals system Milestone 16 Estimated Incentive Payment: $1,402,734 **Milestone 17** [I-26]: Reduce the rate of inappropriate or rejected referrals Metric 1 [I-26.1]: Rate of Rejected/Accepted Primary Care Provider-Initiated Referrals to Specialty Care. This rate will be calculated on a quarterly basis and

133355104.1.7	***1.9.3***	***N/A***	***"OTHER" PROJECT OPTION: IMPLEMENT OTHER EVIDENCE-BASED PROJECT TO EXPAND SPECIALTY CARE CAPACITY IN AN INNOVATIVE MANNER NOT DESCRIBED IN THE PROJECT OPTIONS: PRE-CONSULT EVALUATIONS TO FACILITATE EFFICIENT SPECIALTY CARE***
Harris Health System			*133355104*
Related Category 3 Outcome Measure(s):	*133355104.3.7* *133355104.3.8* *133355104.3.9*	*IT-1.1* *IT-1.14* *IT-6.1(3)*	*Third Next Available Appointment (non-standalone)* *Diabetes care: Microalbumin/Nephropathy - NQF 0062(non-standalone)* *Percent improvement over baseline of patient satisfaction scores: patient's rating of doctor access to specialist (stand-alone*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Metric 1 [P-X2.1]: Determine the rate of inappropriate or rejected referrals in rheumatologic conditions. Goal: Establish % of inappropriate or rejected referrals Data Source: EMR Milestone 4 Estimated Incentive Payment : $1,241,582 **Milestone 5** [P-5]: Provide reports on wait time from receipt of referral to actual referral appointment Metric 1 [P-5.1]: Generate and provide reports on average referral process time and/or time to appointment Goal: Establish baseline for average referral process time and/or time to appointment for diabetes and rheumatologic conditions Data Source: EHR, referral management system, administrative records Milestone 5 Estimated Incentive	reported for most recent quarter. Goal: 20% decrease of rejected referrals from baseline for rheumatologic clinics Data Source: eReferral or other referrals system Milestone 9 Estimated Incentive Payment: $ 1,693,125	calculated on a quarterly basis and reported for most recent quarter. Goal: 35% decrease of rejected referrals from baseline for rheumatologic clinics Data Source: eReferral or other referrals system Milestone 13 Estimated Incentive Payment: $ 1,698,047	reported for most recent quarter. Goal: 40% decrease of rejected referrals from baseline for rheumatologic clinics Data Source: eReferral or other referrals system Milestone 17 Estimated Incentive Payment: $ 1,402,734

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133355104.1.7	***1.9.3***	***N/A***	***“OTHER” PROJECT OPTION: IMPLEMENT OTHER EVIDENCE-BASED PROJECT TO EXPAND SPECIALTY CARE CAPACITY IN AN INNOVATIVE MANNER NOT DESCRIBED IN THE PROJECT OPTIONS: PRE-CONSULT EVALUATIONS TO FACILITATE EFFICIENT SPECIALTY CARE***
Harris Health System			*133355104*
Related Category 3 Outcome Measure(s):	*133355104.3.7* *133355104.3.8* *133355104.3.9*	*IT-1.1* *IT-1.14* *IT-6.1(3)*	*Third Next Available Appointment (non-standalone)* *Diabetes care: Microalbumin/Nephropathy - NQF 0062(non-standalone)* *Percent improvement over baseline of patient satisfaction scores: patient’s rating of doctor access to specialist (stand-alone*
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Payment: $ 1,241,582			
Year 2 Estimated Milestone Bundle Amount: $ 6,207,912	Year 3 Estimated Milestone Bundle Amount: $ 6,772,498	Year 4 Estimated Milestone Bundle Amount: $ 6,792,186	Year 5 Estimated Milestone Bundle Amount: $ 5,610,936
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:** $ 25,383,532			

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Project Option- 1.1.2 Expand Existing Primary Care Capacity: Referrals to FQHCs
Unique RHP Project ID: 133355104.1.8 / Pass 1
Performing Provider Name/TPI: Harris Health System / 133355104
Project Summary:
Provider:
Harris Health System is comprised of 16 community health centers, seven school-based clinics, a dental center, dialysis center, five mobile health units, one outpatient specialty services clinic, and three hospitals. With a tax base of $511.6 million, Harris Health System was able to provide more than $1.254 billion in charity care during FY 2012.

Volume Statistics - FY2012	Patient Payor Mix	Patient Demographics
Hospital admissions- 35,343 Births (babies delivered)- 6,643 Emergency visits- 173,263 Outpatient clinic visits- 1,054,770	Self-Pay- 62.6% Medicaid and CHIP- 23.4% Medicare- 8.6% Other Funding- 3.6% Commercial Insurance- 1.8%	Hispanic- 57.4% African American- 26.3% Caucasian- 9.2% Asian- 4.8% Other- 2.2% American Indian- 0.2%

Intervention(s):
Harris Health System proposes to collaborate with FQHCs by adding additional providers and nursing support staff to targeted FQHCs, as well as develop a seamless referral process by which Harris Health can refer primary care patients to FQHCs, as necessary. The additional providers will result in an additional 25,000 visits by DY5.
Need for the project:
Currently, FQHCs throughout Harris County serve high demand, underserved areas. However, many have underutilized clinic space that can accommodate additional providers and expand existing primary care capacity.
Target Population:
All current and potential patients seeking primary care services within the system and at FQHCs may benefit from this project (Overall Payor Mix: Medicaid and CHIP-23.4% / Self-Pay-62.6%).
Category 1 or 2 expected patient benefits:
Our goal is to increase primary care clinic completed visits by additional primary care providers by 3% over baseline in DY4 and 5% in DY5. An additional 25,000 visits over baseline are expected by DY5.
Category 3 outcomes:
IT-6.1: Our goal is to increase satisfaction scores overall by 1% above baseline (for FQHCs that added providers in DY 3) in DY4 and Increase satisfaction scores overall by 2% above baseline (for FQHCs that added providers in DY 3) and increase satisfaction scores for 1% overall for FQHCs that added providers in DY 4) in DY5.

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Project Option- 1.1.2 Expand Existing Primary Care Capacity: Referrals to FQHCs

Unique RHP Project ID: 133355104.1.8 / Pass 1

Performing Provider Name/TPI: Harris Health System / 133355104

Project Description:

Harris Health System proposes to expand the capacity of primary care by adding additional primary care providers and staff to local Federally Qualified Health Centers in order to meet the demand that saturated existing Harris Health System health centers cannot meet.

Currently, FQHCs throughout Harris County serve high demand, underserved areas. However, many have underutilized clinic space that can accommodate additional providers and expand existing primary care capacity. Thus, Harris Health System proposes to collaborate with FQHCs by adding additional providers and nursing support staff to targeted FQHCs, as well as develop a seamless referral process by which Harris Health can refer primary care patients to FQHCs, as necessary. The additional providers will result in an additional 25,000 visits by DY5. Each FQHC differs in size, location, and target population, but many are located proximate to a Harris Health System health center, allowing for easy referrals and convenient locations for many patients. Partner FQHCs include: Central Care Community Health Center, El Centro de Corazon; Good Neighbor Healthcare Center; Healthcare for the Homeless – Houston; Houston Area Community Services (HACS); HOPE Clinic; Independence Heights Community Health Center; Legacy Community Health Services; Pasadena Health Center; Spring Branch Community Health Center; and Vecino Health Centers (Denver Harbor Family Clinic and Airline Children's Clinic). Target zip codes are listed below according to FQHC partner. Healthcare for the Homeless-Houston serves all zip codes.

Legacy- Montrose	**Legacy- Baytown**	**Good Neighbor / HACS / Independence Heights / Spring Branch**		**Pasadena**
77001	77520	77018	77092	77034
77002	77521	77024	77098	77058
77003	77522	77043	77265	77059
77006	77530	77046	77090	77062
77019	77532	77055	77022	77089
77098	77562	77079	77076	77209
Legacy- Southwest / Hope Clinic		77080	77091	77501
77027	77071	77037	77088	77502
77036	77074	77008	77014	77505
77056	77081	77038	77086	77506
77057	77096	77040	77041	77507
77063	77099	77064	77065	77536
77031	77072	77066	77067	77546
77082	77077	77068	77069	77547
77083		77070	77095	77571 & 77598
Legacy- 5th Ward / Denver Harbor		**El Centro de Corazon**		**Central Care**
77013		77011		77004
77015		77012		77033

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77016	77017	
77020	77023	
77026	77029	
77028	77061	
77044	77075	
77049	77087	
77078		

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

The goals of this project are to:

- Increase capacity for primary care by adding providers and nursing support staff to existing, underutilized clinic space

Expanding the capacity of primary care through additional providers at FQHCs will better accommodate the needs of the community and allow patients to receive the right care at the right time in the right setting.

This project meets the following Region 3 goals:

- Increase access to primary and specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their condition, regardless of where they live or their ability to pay.

This project will increase access to primary care in high-demand areas of underserved individuals while ensuring that patients have access to care in the appropriate setting, regardless of their ability to pay.

Challenges:

General primary care capacity has been a challenge for the Harris Health System. A significant challenge for the Harris Health System has been adequate capacity to offer Medical Homes for patients who do not have a primary care provider. The Referrals to FQHCs project will expand capacity for primary care and connect patients to care in a timely fashion that would otherwise not be possible. There will be an additional challenge to develop a referral system for patients who seek an appointment at the Harris Health System for whom the demand cannot be met, as well as a referral system for patients who seek care for primary care treatable conditions in the Harris Health Emergency Centers. A seamless system will be developed so that patients are referred to the FQHCs for establishment of a Medical Home.

The nature of the partnerships required by this project adds complexity to successful implementation. While the project requires additional contract procurement for the subcontracting of services, the Legal and Compliance departments at Harris Health System have significant experience in this area and Harris Health currently subcontracts for a number of services. Monitoring provider and staff recruitment activities, provider performance, and adherence to standardized referral guidelines will also be a challenge. The development of

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standardized processes and procedures relating to the aforementioned areas of concern will be a focus of the planning period in DY2.

5-Year Expected Outcome for Provider and Patients:

Over the course of the 5-Year Waiver, Harris Health System expects to realize:

- Increased adult-focused primary care capacity (25,000 additional visits) through additional providers at FQHCs and a smooth referral process.

In DY 5, Harris Health hopes to have 25,000 completed visits through the referral and new providers.

Starting Point/Baseline:

For performance purposes, the baseline will be set at 0 additional visits at targeted FQHCs.

Rationale:

Currently, Harris Health System health centers are designated NCQA Primary Care Medical Homes with increasingly limited capacity. Health center providers are currently 95% empaneled. Moreover, physicians in Harris Health System health centers carry a panel of 2,250 patients, plus an additional 500 patients for each midlevel provider who works with them to manage their patient panel. These panel sizes are higher than the industry standard of approximately 1,500 patients. Full panels lead to decreased access to primary care appointments at health centers. These health centers are approaching maximum capacity for empaneled patients. From March 2012-September 2012, the Harris Health System Patient Appointment Center was unable to schedule 68,247 unduplicated patients for primary care. This volume, however, does not capture the full volume of unmet demand. Without access to primary care, patients are more likely to seek care in Emergency Centers, which is a higher cost and not convenient for patient. Care is better coordinated in a Medical Home, leading to better management of chronic disease, improved patient satisfaction, and better outcomes

The addition of providers at local FQHCs will result in increased access to primary care.

Project Components:

a) Expand primary care clinic space
b) Expand primary care clinic hours
c) Expand primary care clinic staffing- (P-5) Additional providers and staff will be hired at FQHCs.

This project will not directly address components a) or b). At targeted FQHCs, there is significant space that is currently underutilized. Moreover, expanded hours are already offered at select FQHCs. Thus, this project aims to maximize space by adding primary care staffing to the current infrastructure and operating hours.

Milestones & (Metrics):

- Process Milestones and Metrics- P-5 (P-5.1); P-X (P-X.1)
- Improvement Milestones and Metrics- I-12 (I-12.1)

Unique community need identification number the project addresses:

This project addresses the following community needs according to the community needs assessment:

- CN.1- Inadequate access to primary care

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

While Harris Health System has collaborated with local FQHCs in various ways, a project aimed at increasing providers and developing a formalized referral process for primary care has not been explored. The project will promote true collaboration through a mutual, patient-centered goal that will refer patients to a primary care location that is appropriate and convenient by leveraging the ability of the Harris Health System to secure and fund additional providers. This project to refer patients to the FQHCs complements the project to establish same day access clinics (133355104.1.1; 133355104.1.2 133355104.1.6).

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

OD-6 Patient Satisfaction

- IT-6.1- Percent improvement over baseline of patient satisfaction scores (standalone)
  - (1) are getting timely care, appointments, and information

Reasons/rationale for selecting the outcome measure(s):

From March 2012-September 2012, the Harris Health System Patient Appointment Center was unable to schedule 68,247 unduplicated patients for primary care. According survey results for the last 12 months as reported by Press Ganey, the patient satisfaction score for all Harris Health primary care Medical Home health centers regarding standard Access to Care survey questions is 76.8. Without access to primary care, patients are more likely to seek care in Emergency Centers, where they will wait longer and their care is not coordinated. If patients are satisfied with the care they receive at their Medical Home, they are more likely to seek care promptly when needed in the appropriate setting, more adherent to provider recommendations for disease management, and more satisfied with the care they receive. We have selected IT-6.1 because it is an effective tool for assessing improvement in access to care and for the targeted development of process improvement needs. Harris Health System wishes to ensure a positive patient experience internally and in the area at partner FQHC facilities.

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Relationship to other Projects:

Primary Care/Ambulatory Care clinics are a top priority to Region 3 due to the acuity of the regional patient mix, population concentration, and lack of primary care access points for our patient base. The regional approach of collaboration as well as existing patient referral pattern relationships allowed our team to properly identify the community needs based on the necessity of population, uninsured, and medically underserved patient bases. This program is consistent with our region and similar to numerous initiatives in our RHP plan sharing both concepts as well as outcome measures focused to percent improvement over baseline of patient satisfaction scores, reduction of inappropriate ED utilization, and third next available appointment status. The Region 3 Initiative Grid attached as a RHP Plan addendum reflects a grid of relationship for all initiatives.

Plan for Learning Collaborative: We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system.

Project Valuation: This project addresses one of the main objectives of the 1115 Waiver; increasing access to primary care for the underserved/uninsured population in Harris County. It will expand capacity for primary care medical homes and connect patients to care in a timely fashion that might not otherwise be possible. A referral system will be developed for patients who seek an appointment at the Harris Health System for whom the demand cannot be met in a timely manner, as well as for patients who seek care for primary care treatable conditions in the Harris Health Emergency Centers. The value of the project is based on the incremental capacity to provide primary care services at the community FQHCs, along with timely referrals for specialty care and other needed services within the Harris Health System network. This expansion can ultimately care for the primary care needs of over eight thousand patients annually. In addition, the availability of incremental primary care appointments will result in fewer emergency room visits for public and private hospitals located in the service area. Early detection, treatment and education regarding wellness and prevention will also help to prevent future downstream inpatient admissions.

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133355104.1.8	*1.1.2*	*C*	*EXPAND PRIMARY CARE CAPACITY- REFERRALS TO FQHCS*
Harris Health System			*133355104*
Related Category 3 Outcome Measure(s):	*133355104.3.8*	*IT-6.1*	*Percent improvement over baseline of patient satisfaction scores*

Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Milestone 1 [P-X]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Metric 1 [P-X.1]: Planning documentation Goal: Produce a comprehensive implementation plan for referrals to FQHCs Data Source: Project plan Milestone 1 Estimated Incentive Payment *(maximum amount):* $4,893,329	**Milestone 2** [P-5]: Hire additional primary care providers and staff Metric 1 [P-5.1]: Documentation of increased number of providers and staff. Baseline: 0 providers and staff hired in DY2. Goal: Hire providers and support staff Data Source: Contract documentation Milestone 2 Estimated Incentive Payment *(maximum amount):* $2,669,180 **Milestone 3** [P-X2]: Establish baseline number of completed visits by additional primary care providers Metric 1 [P-X2.1]: Documentation of completed visits by additional primary care providers	**Milestone 4** [I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 [I-12.1]: Documentation of increased number of visits. Baseline: Established in DY3 Goal: Increase completed visits by additional primary care providers by 3% over baseline Data Source: HER Milestone 4 Estimated Incentive Payment *(maximum amount):* $5,353,877	**Milestone 5** [I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 [I-12.1]: Documentation of increased number of visits. Baseline: Established in DY3 Goal: Increase completed visits by additional primary care providers by 5% over baseline Data Source: HER Milestone 5 Estimated Incentive Payment *(maximum amount):* $4,422,768

133355104.1.8	***1.1.2***	***C***	***EXPAND PRIMARY CARE CAPACITY- REFERRALS TO FQHCS***
Harris Health System			*133355104*
Related Category 3 Outcome Measure(s):	*133355104.3.8*	*IT-6.1*	*Percent improvement over baseline of patient satisfaction scores*

Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
	Baseline: 0 completed visits in DY2 Goal: Document established baseline of completed visits by additional primary care providers Data Source: EHR Milestone 3 Estimated Incentive Payment *(maximum amount):* $2,669,179		
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $4,893,329	Year 3 Estimated Milestone Bundle Amount: $5,338,359	Year 4 Estimated Milestone Bundle Amount: $5,353,877	Year 5 Estimated Milestone Bundle Amount: $4,422,768
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)**:*** $20,008,333			

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

Unique RHP Project Identification Number: 133355104.1.9 / Pass 1
Performing Provider Name/TPI: Harris Health System/TPI 133355104
Project Summary:
Provider:
Harris Health System is comprised of 16 community health centers, seven school-based clinics, a dental center, dialysis center, five mobile health units, one outpatient specialty services clinic, and three hospitals. With a tax base of $511.6 million, Harris Health System was able to provide more than $1.254 billion in charity care during FY 2012.

Volume Statistics - FY2012	Patient Payor Mix	Patient Demographics
Hospital admissions- 35,343 Births (babies delivered)- 6,643 Emergency visits- 173,263 Outpatient clinic visits- 1,054,770	Self-Pay- 62.6% Medicaid and CHIP- 23.4% Medicare- 8.6% Other Funding- 3.6% Commercial Insurance- 1.8%	Hispanic- 57.4% African American- 26.3% Caucasian- 9.2% Asian- 4.8% Other- 2.2% American Indian- 0.2%

Intervention(s):
This project will address the shortage of pediatric and adolescent behavioral health services by implementing and expanding these services across eight facilities within the system. We propose to expand psychiatry to 5.0 FTEs and expand behavioral therapy to 11 FTEs.
Need for the project:
Currently, Harris Health System offers pediatric and adolescent behavioral health services at five of its facilities with a total of 1.3 psychiatry FTEs and 3.4 behavioral therapy FTEs.
Target Population:
This project specifically targets patients in the following zip codes and surrounding areas of Harris County seeking behavioral health services: 77009, 77099, 77547, 77039, 77520, 77504, 77084, and 77070. Data from FY2012 shows that 60% of all pediatric visits in Harris Health System were funded.
Category 1 or 2 expected patient benefits:
Our DY3 goal is to increase the number of visits from baseline by 25%. In DY4, we aim to increase by 70% from DY3 completed visits and in DY5 we aim to increase by 90% from DY4 completed visits. We estimate that we will provide an additional 20,000 visits by DY5.
Category 3 outcomes:
IT-6.1: Our goal is to increase patient satisfaction scores (patients are getting timely care, appointments, and information) by 1.5% in DY4 and 2% in DY5.

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

Unique RHP Project Identification Number: 133355104.1.9 / Pass 1

Performing Provider Name/TPI: Harris Health System/TPI 133355104

Project Description:
Harris Health System will address Project Option 1.12.2 related to the shortage of pediatric and adolescent behavioral health services by implementing and expanding these services across eight facilities within the system.

Currently, Harris Health System offers pediatric and adolescent behavioral health services at five of its facilities. The scope of this project is to increase access to these services in areas of high need in the community, specifically to serve the following zip codes and surrounding areas of Harris County: 77009, 77099, 77547, 77039, 77520, 77504, 77084, and 77070.

Goals and Regional Goals:

Project Goals:

- Increase psychiatry and behavioral therapy staffing at existing locations within Harris Health System. We propose to expand psychiatry to 5.0 FTEs (currently 1.3 FTEs) and expand behavioral therapy to 11 FTEs (currently 3.4 FTEs). We will also hire 5.0 additional FTEs of support staff. The additional workforce will increase access to behavioral health services for the pediatric population of Harris County.
- Increase capacity in underserved areas.
- Treat children and adolescents in appropriate outpatient setting for potential decrease in need for inpatient behavioral health services.

Regional goals addressed with the project:

- Increase access to primary and specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their condition.
    - This project addresses this regional goal by focusing on areas with high numbers of low-income families who may otherwise not have adequate access to appropriate levels of outpatient behavioral health services for children and adolescents.
- Develop a regional approach to health care delivery that leverages and improves on existing programs and infrastructure, is responsive to patient needs throughout the entire region, and improves health care outcomes and patient satisfaction
    - This project addresses the growing need for behavioral health services for the state of Texas. Expansion of services will help address this need at an earlier stage in life, which is vital for a successful outcome.

Challenges:
There are an inadequate number of behavioral health providers in the region and across the state of Texas, which includes a shortage of child psychiatrists. Harris Health System faces an even greater challenge, as much of our patient population served is primarily Spanish speaking, making it more difficult to find behavioral health professionals who can communicate effectively in the patient's language of choice. Harris Health System plans to actively recruit, hire, and train behavioral health providers to address these challenges in DY2.

- Inpatient behavioral health services have been reduced in Harris County. One of the area's major inpatient psychiatric hospitals was closed due to loss of its Medicaid/Medicare certification. The lack of inpatient beds for pediatric and adolescent behavioral health patients is a challenge for Harris Health System, the region, and Texas as a whole. Behavioral health needs may lead to school failure, behavioral conflicts, and substance abuse; if left untreated, these problems may become more difficult and costly to treat. Expanding pediatric and adolescent behavioral health services through projects as proposed, has the potential to help decrease the need for inpatient behavioral health beds by addressing issues at earlier stages in life.

5-Year Expected Outcome for Performing Provider and Patients:
By addressing the challenges for the region and Harris Health System as performing provider, we expect to achieve the overarching goal of increasing availability to pediatric and adolescent behavioral health services to underserved areas of Harris County. In reaching these goals, we expect to maintain high levels of patient satisfaction as evident by our survey scores reported throughout the latter demonstration years of the waiver.

Starting Point/Baseline:
Volume: In FY12, there were approximately 3,867 pediatric psychiatry and behavioral health therapy visits and 44,800 primary care pediatric visits. For FY13, we estimate 6,000 pediatric psychiatry and behavioral health therapy visits.

FTEs: In FY12, there were 0.9 psychiatry FTEs and 2.4 behavioral therapy FTEs.

These metrics will serve as baselines for the expected increase in volume per year and required workforce beginning in DY3.

Rationale:
Studies have shown that at least 1 in 5 children and adolescents have a mental health disorder in the United States, with 1 in 10 children suffering a disorder so severe that it disrupts daily living (SAMHSA'S National Mental Health Information Center, 2003). Texas children are not receiving adequate behavioral health care services (Children's Mental Health in Texas: A State of the State Report, 2006).

Current challenges for adequate delivery of pediatric behavioral health delivery include funding, insurance limitations, limited providers, language and cultural barriers between providers and patients, growing need, social stigma, and a lack of parental and early intervention services. Currently, Texas ranks 49th in the nation in behavioral health expenditures per capita (National Association of State Mental Health Program Directors Research Institute, Inc.). Due to limited funding, state agencies focus on severe crisis treatment. There are 1.4 million children without health insurance in Texas (Children's Defense Fund, 2006), and behavioral health services available to these children are limited.

Project Components:

This project option does not have required components.

Milestones and Metrics:

Harris Health System has chosen project option 1.12.2: Enhance service availability (i.e., hours, locations, transportation, mobile clinics) of appropriate levels of behavioral health care to best fit the scope and goals of this project.

- Process Milestones and Metrics:
  - P-4, P-4.1
  - P-6, P-6.1
  - P-10, P-10.1
- Improvement Milestones and Metrics:
  - I-11, I-11.1

Unique Community Need Identification Numbers:

The scope and goals of this project specifically address three of the identified community needs from the regional needs assessment. The project focuses on CN.3 and CN.18 by increasing access for pediatric and adolescent patients to behavioral health services. This aligns with CN.6 by addressing the importance of adequate access and behavioral health treatment for children and potential long term benefits.

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

This is not a new initiative for Harris Health System, however, this is an expansion of an existing service. This initiative will greatly enhance the services offered to this underserved population.

<u>**Related Category 3 Outcome Measure:**</u>

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

Reasons/rationale for selecting the outcome measure:

This measure focuses on patient satisfaction outcomes to ensure patients are receiving care and appointments in a timely manner for behavioral health services regardless of ability to pay. Harris Health System highly values our patients and will continuously work on opportunities for improvement. This outcome measure allows Harris Health to focus on improvements that value the patient as a whole and not only based on clinical indicators. We will begin to measure in DY4.

Relationship to other Projects:

The behavioral health crisis in Region 3 is considerable and the proposed initiatives in our RHP plan will only imply a small impression into the overall community need for treatment, but is a good start. The outpatient focus of many RHP Plan initiatives will help numerous facilities focus to treating the patients in an ambulatory setting as well as continued navigation of services with a focus to keeping patients from the inpatient unit. This initiative is similar to many others in the sense of the category of behavioral health. The Region 3 Initiative Grid attached in the addendum will show the relationship to other programs.

Plan for Learning Collaborative:

As performing provider, Harris Health System plans to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system.

Project Valuation:

The goal of this project is to increase psychiatry and behavioral therapy staffing at existing pediatric locations within Harris Health System. Expanding pediatric and adolescent behavioral health services has the potential to help decrease the future need for inpatient behavioral health beds by addressing issues at earlier stages in life. Untreated behavioral health needs may lead to school failure, behavioral conflicts, and substance abuse; the longer the issues are left untreated, the more difficult and costly it is to provide effective treatment. The increase in provider staffing throughout the existing pediatric services network can ultimately meet the behavioral care needs of an additional eight thousand patients annually.

133355104.1.9	1.12.2	N/A	*Enhance service availability of appropriate levels of behavioral health care: Expansion of Pediatric Behavioral Health Services*
Harris Health System			*133355104*

Related Category 3 Outcome Measure(s):	*133355104.3.11*	*IT-6.1 (1)*	*Percent improvement over baseline of patient satisfaction scores Improve utilization rates of clinical preventive services (testing, preventive services, treatment) in target population with identified disparity*

Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Milestone 1 [P-4]: Hire and train staff to operate and manage projects selected Metric 1 [P-4.1]: Number of staff secured and trained Baseline: 1.3 FTEs Psychiatrist 3.4 FTEs Behavioral Therapy 0 FTEs support staff Goal: Additional 1.0 FTEs Psychiatrist for a total of 4.4 FTEs Additional 1.0 FTEs Behavioral Therapy for a total of 4.4 FTEs 1.0 FTEs support staff Data Source: Staffing plan Milestone 1 Estimated Incentive Payment (maximum amount):	**Milestone 2** [P-6]: Establish behavioral health services in new community-based settings in underserved areas Metric 1 [P-6.1]: Number of new community-based settings where behavioral health services are delivered Baseline: Currently offering pediatric behavioral health services at 5 sites Goal: Expansion to 1 additional site for a total expansion of services at 6 sites Data Source: Business Plan Milestone 2 Estimated Incentive Payment: $1,640,546.67 **Milestone 3** [P-4]: Hire and train staff	**Milestone 5** [P-6]: Establish behavioral health services in new community-based settings in underserved areas Metric 1 [P-6.1]: Number of new community-based settings where behavioral health services are delivered Baseline: Currently offering pediatric behavioral health services at 5 sites Goal: Expansion to 2 additional site for a total expansion of services at 8 sites Data Source: Business Plan Milestone 5 Estimated Incentive Payment: $1,233,986.75 **Milestone 6** [P-10]: Participate in	**Milestone 9** [P-10]: Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements. Metric 1 [P-10.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP Baseline/Goal: TBD Data Source: Meeting

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$4,511,350	to operate and manage projects selected Metric 1 [P-4.1]: Number of staff secured and trained Baseline: 1.3 FTEs Psychiatrist 3.4 FTEs Behavioral Therapy 0 FTEs support staff Goal: Additional 1.5 FTEs Psychiatrist for a total of 3.8 FTEs Additional 3.0 FTEs Behavioral Therapy for a total of 7.4 FTEs Additional 2 FTEs support staff for a total of 3.0 FTEs Milestone 3 Estimated Incentive Payment: $1,640,546.67 **Milestone 4** [I-11]: Increased utilization of community behavioral healthcare Metric 1 [P-11.1]: Percent utilization of community behavioral healthcare services Baseline: approximately 6,000 visits for FY13 Goal: Increase number of visits from baseline by 25% Data Source: EMR	face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements. Metric 1 [P-10.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP Baseline/Goal: TBD Data Source: Meeting documentation; learning collaborative Milestone 6 Estimated Incentive Payment: $1,233,986.75 **Milestone 7** [P-4]: Hire and train staff to operate and manage projects selected Metric 1 [P-4.1]: Number of staff secured and trained Baseline:	Documentation; learning collaborative Milestone 9 Estimated Incentive Payment: $2,038,761 **Milestone 10** [I-11]: Increased utilization of community behavioral healthcare Metric 1 [P-11.1]: Percent utilization of community behavioral healthcare services Goal: increase number of visits from DY4 by 90% Data Source: EMR Milestone 10 Estimated Incentive Payment: $2,038,761

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	Milestone 4 Estimated Incentive Payment: $1,640,546.67	1.3 FTEs Psychiatrist 3.4 FTEs Behavioral Therapy 0 FTEs support staff Goal: Additional 1.2 FTEs Psychiatrist for a total of 5 FTEs Additional 3.6 FTEs Behavioral Therapy for a total of 11.0 FTEs Additional 2 FTEs support staff for a total of 5.0 FTEs Milestone 7 Estimated Incentive Payment: $1,233,986.75 **Milestone 8** [I-11]: Increased utilization of community behavioral healthcare Metric 1 [I-11.1]: Percent utilization of community behavioral healthcare services Goal: Increase number of visits from DY3 by 70% Data Source: EMR Milestone 8 Estimated Incentive Payment: $1,233,986.75	
Year 2 Estimated Milestone Bundle Amount: $4,511,350	Year 3 Estimated Milestone Bundle Amount: $4,921,640	Year 4 Estimated Milestone Bundle Amount: $4,935,947	Year 5 Estimated Milestone Bundle Amount: $4,077,522
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $18,446,459			

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Project Option 1.12.4- Other- Enhance service availability of appropriate levels of behavioral health care: Expansion of Ambulatory Mental Health Services

Unique RHP Project ID: 133355104.1.10 / Pass 1
Performing Provider Name/TPI: Harris Health System / 133355104
Project Summary:
Provider:
Harris Health System is comprised of 16 community health centers, seven school-based clinics, a dental center, dialysis center, five mobile health units, one outpatient specialty services clinic, and three hospitals. With a tax base of $511.6 million, Harris Health System was able to provide more than $1.254 billion in charity care during FY 2012.

Volume Statistics - FY2012	Patient Payor Mix	Patient Demographics
Hospital admissions- 35,343 Births (babies delivered)- 6,643 Emergency visits- 173,263 Outpatient clinic visits- 1,054,770	Self-Pay- 62.6% Medicaid and CHIP- 23.4% Medicare- 8.6% Other Funding- 3.6% Commercial Insurance- 1.8%	Hispanic- 57.4% African American- 26.3% Caucasian- 9.2% Asian- 4.8% Other- 2.2% American Indian- 0.2%

Intervention(s):
This project will to enhance service availability of appropriate levels of behavioral health care by expanding mental health services in the ambulatory care setting. Therapists and psychiatrists will be added (4.5 Psychiatry FTEs and 24 Therapy FTEs) to existing Harris Health System health centers across Harris County.
Need for the project:
Hours and appointment availability is currently limited. There are only 4.5 Psychiatry FTEs and 12.6 Therapy FTEs in the health centers.
Target Population:
All patients within the system seeking behavioral health services may benefit from this project (Overall Payor Mix: Medicaid and CHIP-23.4% / Self-Pay- 62.6%). .
Category 1 or 2 expected patient benefits:
Our goal is to increase the number of unique patients with a primary diagnosis of mental illness treated in the primary care setting by 3% over baseline in DY3, 5% in DY4 and 8% in DY5..
Category 3 outcomes:
IT- 1.20: Our goal is to increase the percent of patients diagnosed with major depression that are adherent to prescribed medication treatment plan. Adherence will be 15% of the identified patient population in DY4 and 20% in DY5.

Project Option 1.12.4- Other- Enhance service availability of appropriate levels of behavioral health care: Expansion of Ambulatory Mental Health Services

Unique RHP Project ID: 133355104.1.10 / Pass 1

Performing Provider Name/TPI: Harris Health System / 133355104

Project Description:

Harris Health System proposes to enhance service availability of appropriate levels of behavioral health care by expanding mental health services in the ambulatory care setting. Therapists and psychiatrists will be added to existing Harris Health System health centers across Harris County. Currently, each of the targeted health centers offers mental services, but with limited hours and appointment availability. Mental health provider FTEs will be added to each of the health centers below, in existing underutilized space. Appointment availability and service hours within the boundaries of normal operating hours will be expanded.

Facility	Psychiatry			Therapy		
	Current FTE	Expansion FTE	Total Proposed FTE	Current FTE	Expansion FTE	Total Proposed FTE
Health Centers						
Acres Home Health Center	0.4	1.6	2.0	1.0	2.0	3.0
Aldine Health Center	0.4	0.6	1.0	1.0	1.0	2.0
Baytown Health Center	0.2	0.8	1.0	1.0	1.0	2.0
Casa de Amigos Health Center	0.3	0.7	1.0	1.3	0.7	2.0
E.A. Squatty Lyons Health Center	0.2	0.8	1.0	0.4	1.6	2.0
El Franco Health Center	0.5	1.0	1.5	1.0	2.0	3.0
Gulfgate Health Center	0.2	0.8	1.0	1.0	1.0	2.0
Martin Luther King Jr. Health Center	0.3	0.7	1.0	1.0	1.0	2.0
Northwest Health Center	0.2	0.8	1.0	1.0	1.0	2.0
People's Health Center	0.6	0.4	1.0	2.0	0.0	2.0
Quentin Mease Hospital	0.0	0.4	0.4	0.0	0.6	0.6
Settegast Health Center	0.2	0.8	1.0	0.7	1.3	2.0

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Strawberry Health Center	0.4	0.6	1.0	1.2	0.8	2.0
HCHP	0.2	0.8	1.0	0.0	2.0	2.0
Thomas Street Health Center	0.4	0.6	1.0	0.0	2.0	2.0
Smith Clinic	0.0	1.0	1.0	0.0	2.0	2.0
LBJ Specialty Clinic	0.0	1.0	1.0	0.0	2.0	2.0
Total Health Centers FTE	**4.5**	**13.4**	**17.9**	**12.6**	**24.0**	**36.6**

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Goals and Relationship to Regional Goals:

The goals of this project are to:

- Increase access to and capacity for mental health services in the ambulatory care setting
- Develop a mechanism for the identification of the mentally ill population within Harris Health community centers
- Improve medication adherence by monitoring pharmacy utilization
- Enhanced access to mental health services and the ability to track and monitor medication adherence promote a decrease in acute care and emergency center visit utilization and thereby lowers overall cost of care per patient

This project meets the following Region 3 goals:

- Increase access to primary and specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their condition, regardless of where they live or their ability to pay.

Additional provider FTEs will increase access to a high-demand specialty care service in high-demand areas of underserved individuals. The health center is the appropriate setting for outpatient mental health needs. Harris Health System ensures that Harris County residents will receive care regardless of their ability to pay.

Challenges:

This project possesses challenges relative to the patient population and the data collection of medication adherence.

1. Initial identification of primary diagnosed patients with major depression
2. Cultural nuances and family dynamics that impact seeking treatment for mental health/major depression concerns
3. Retrieval of data relative to pharmacy utilization and patient medication adherence
4. Recruitment of sufficient psychiatrist to optimize patient capacity
5. Recruitment of mental health professionals to complement the psychiatrists' case load for behavioral intervention and counseling services

Challenges will be addressed by working collaboratively with Harris Health's academic partners and residency programs to secure psychiatrists for the mental health primary care expansion. Providing a clinical setting for residents will aid in securing future psychiatrists to sustain the program as attrition occurs. Recruitment of mental health professionals will be enhanced by internal and external recruitment efforts and in collaboration with the region's academic partners.

An initial internal data retrieval of all patient encounters across the continuum for Harris Health patients, with a primary diagnosis of major depression or a diagnosis of another mental health concern (in accordance with DSM 1V) will be conducted. Following identification of the patient population, a culturally sensitive program for patient contact and monitoring will be established in collaboration with the mental health team of professionals. A plan for retrieval of pharmacy utilization will be developed in conjunction with the Chief of Pharmacy and community health center staff pharmacists to ascertain medication for tracking and capacity and timeframes for reporting. Language barriers will be mitigated by the use of bilingual psychiatrists, mental health professionals, and ready access to patient interpretive services either on-site or telephonically.

5-Year Expected Outcome for Provider and Patients:

Over the course of the 5-Year Waiver, Harris Health System expects to realize:

- Increased access to mental health services in the ambulatory care setting.
- Increase the number of adults enrolled in a Harris Health Medical Home with a diagnosis of major depression or dysthymia and an initial PHQ-9 score greater than nine who achieve remission at twelve months
- Patients with a primary diagnosis of major depression will demonstrate improved adherence to medication management

Starting Point/Baseline:

To be established in DY2.

Current Status: Provider FTEs

Facility	Psychiatry	Therapy
	Current FTE	Current FTE
Health Centers		
Acres Home Health Center	0.4	1.0
Aldine Health Center	0.4	1.0

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Baytown Health Center	0.2	1.0
Casa de Amigos Health Center	0.3	1.3
E.A. Squatty Lyons Health Center	0.2	0.4
El Franco Health Center	0.5	1.0
Gulfgate Health Center	0.2	1.0
Martin Luther King Jr. Health Center	0.3	1.0
Northwest Health Center	0.2	1.0
People's Health Center	0.6	2.0
Quentin Mease Hospital	0.0	0.0
Settegast Health Center	0.2	0.7
Strawberry Health Center	0.4	1.2
HCHP	0.2	0.0
Thomas Street Health Center	0.4	0.0
Smith Clinic	0.0	0.0
LBJ Specialty Clinic	0.0	0.0
Total Health Centers FTE	**4.5**	**12.6**

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Rationale:

Mental health concerns are attributed to 25 % of the population in the US, and 50 % will be treated for such at least once in a lifetime (CDC , 2011).Mental health, specifically major depression, bipolar disorder and dysthymia, are the most common mental health disorders treated in the ambulatory care setting at Harris Health. Major depression is proven to be a concurrent disorder as a result of a chronic disease, and as an example, Harris Health has 47, 000 patients with diabetes and Harris County has 9% of its 4 million residents with a diagnosis of diabetes (CDC, 2011).

Formulary dispensing includes serotonin specific reuptake inhibitors (SSRI) as part of the top 6 medications prescribed for mental health. Psychiatric assessment with associated medication and stabilization are essential, but therapists are required in order to provide counseling and education relative to coping skills, problem solving, and management of behavioral symptomatology. Psychiatric and mental health professional services are interdependent and relative to successful patient outcomes. Ready access to providers and therapists is crucial to permit timely de-escalation, clinical interventions, and promotion of

mental health. Harris Health has geriatric treatment centers and mental health concerns in Texas according to the CDC (2008) accounts for as much as 14 % in residents over the age of 50.

While Harris Health System offers mental health services, hours and appointment availability is currently limited. There are only 4.5 Psychiatry FTEs and 12.6 Therapy FTEs in the health centers.

Project Components:

The chosen project option does not have any required core components.

Milestones & Metrics:

- Process Milestones and Metrics- P-10 (P-10.1); P-X1 (P-X.1); P-X2 (P-X2.1)
- Improvement Milestones and Metrics- I-X1 (I-X1.1)

Unique community need identification number the project addresses:

This project addresses the following community needs according to the community needs assessment:

- CN.2- Inadequate access to specialty care
- CN.3- Inadequate access to behavioral health care

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

Currently, Harris Health System offers limited mental health service availability in health centers. This project enhances the expansion of pediatric behavioral health services as well. In addition, it provides the ambulatory care providers that will support an expanded inpatient capacity and hospital-based service capacity at Harris Health System hospitals: Ben Taub General Hospital and LBJ General Hospital. Additionally this initiative will track, monitor, and report on medication adherence for patients with a primary diagnosis of major depression.

Related Category 3 Outcome Measure(s):

OD-1 Primary Care and Chronic Disease Management

- IT- 1.20 Other outcome target: Percent of patients diagnosed with major depression that are adherent to prescribed medication treatment plan

Reasons/rationale for selecting the outcome measure(s):

Mental health, specifically major depression, bipolar disorder and dysthymia, are the most common mental health disorders treated in the ambulatory care setting at Harris Health. Major depression is proven to be a concurrent disorder as a result of a chronic disease, and as an

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example, Harris Health has 47, 000 patients with diabetes and Harris County has 9% of its 4 million residents with a diagnosis of diabetes (CDC, 2011).

Relationship to other Projects:

The Harris Health projects of implementing a disease registry will aid in the identification of patients with a mental health diagnosis, predict utilization and cost, and also track medications prescribed and filled.

Relationship to Other Performing Providers' Projects in the RHP:

The behavioral health crisis in Region 3 is considerable and the proposed initiatives in our RHP plan will only imply a small impression into the overall community need for treatment, but is a good start. The outpatient focus of many RHP Plan initiatives will help numerous facilities focus to treating the patients in an ambulatory setting as well as continued navigation of services with a focus to keeping patients from the inpatient unit. This initiative is similar to many others in the sense of the category of behavioral health. The Region 3 Initiative Grid attached in the addendum will show the relationship to other programs.

The cohabitation of primary care and behavioral health is an important focus of our region in order to treat the patient base with comprehensive physical and behavioral healthcare issues. There are multiple initiatives in our RHP plan that address this need and all can be found on the Region 3 Initiative Grid in the addendums. The outcome measures focused to screening measures and access of the patient base.

Plan for Learning Collaborative: We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system.

Project Valuation:

The goal of this project is to increase psychiatry and behavioral therapy staffing at current medical home primary care clinics, in existing underutilized space. All of the targeted health centers offer behavioral services; however the hours and appointment availability are limited. Service hours and appointment capacity will be expanded within each of the clinics. Enhanced access to mental health services and the ability to track and monitor medication adherence will promote a decrease in acute care and emergency center visit utilization, as well as potentially decrease the need for additional inpatient psychiatric beds, thereby lowering the overall cost of care. The increase in provider staffing throughout the existing primary care services network can ultimately meet the behavioral care needs of an additional seven thousand patients annually.

Centers for Disease Control and Prevention. (2008).The state of mental health and aging in America.
Available from http://www.cdc.gov/aging/pdf/mental_health.pdf
Centers for Disease Control and Prevention. (2011).CDC mental illness surveillance. Available from
http://www.cdc.gov/mentalhealthsurveillance/fact_sheet.html
Centers for Disease Control and Prevention. (2011). National diabetes fact sheet: national estimates and
general information on diabetes and prediabetes in the United States. Available from http://apps.nccd.cdc.gov/DDTSTRS/FactSheet.aspx

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133355104.1.10	***1.12.4***	***N/A***	***ENHANCE SERVICE AVAILABILITY OF APPROPRIATE LEVELS OF BEHAVIORAL HEALTH CARE- EXPANSION OF AMBULATORY MENTAL HEALTH SERVICES***
Harris Health System			*133355104*
Related Category 3 Outcome Measure(s):	*133355104.3.12*	*IT-1.20*	*Other outcome target: Percent of patients diagnosed with major depression that are adherent to prescribed medication treatment plan*

Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Milestone 1 [P-X1]: Expand capacity by adding mental health providers in primary care settings <u>Metric 1</u> [P-X1.1]: Number of staff secured and trained Baseline: 0 staff hired in DY1 Goal: Hire 1.1 Psychiatry FTEs and 1.8 Therapy FTEs Data Source: Project records Milestone 1 Estimated Incentive Payment *(maximum amount):* $2,646,392 **Milestone 2** [P-X2]: Establish baseline number of unique patients with a primary diagnosis of mental illness treated in the primary care setting <u>Metric 1</u> [P-X2.1]: Documentation of number of unique patients with a primary diagnosis of mental illness	**Milestone 3** [P-X1]: Expand capacity by adding mental health providers in primary care settings <u>Metric 1</u> [P-X1.1]: Number of staff secured and trained Goal: Hire 5.6 Psychiatry FTEs and 10.2 Therapy FTEs for a total of 6.7 Psychiatry FTEs and 12.0 Therapy FTEs Data Source: Project records Milestone 3 Estimated Incentive Payment*:* $2,887,071.50 **Milestone 4** [I-X1]: Increase the number of unique patients with a primary diagnosis of mental illness treated in the primary care setting. <u>Metric 1</u> [I-X1.1]: Number of patients with a primary diagnosis of mental illness treated in the primary care setting.	**Milestone 5** [P-X1]: Expand capacity by adding mental health providers in primary care settings <u>Metric 1</u> [P-X1.1]: Number of staff secured and trained Goal: Hire 4.4 Psychiatry FTEs and 7.4 Therapy FTEs for a total of 10.1 Psychiatry FTEs and 16.4 Therapy FTEs Data Source: Project records Milestone 5 Estimated Incentive Payment*:* $1,930,309.67 **Milestone 6** [I-X1]: Increase the number of unique patients with a primary diagnosis of mental illness treated in the primary care setting. <u>Metric 1</u> [I-X1.1]: Number of patients with a primary diagnosis of mental illness treated in the primary care setting.	**Milestone 8** [P-X1]: Expand capacity by adding mental health providers in primary care settings <u>Metric 1</u> [P-X1.1]: Number of staff secured and trained Goal: Hire 2.3 Psychiatry FTEs and 4.6 Therapy FTEs for a total of 13.4 Psychiatry FTEs and 24.0 Therapy FTEs Data Source: Project records Milestone 8 Estimated Incentive Payment*:* $1,594,603.67 **Milestone 9** [I-X1]: Increase the number of patients with a primary diagnosis of mental illness treated in the primary care setting. <u>Metric 1</u> [I-X1.1]: Number of patients with a primary diagnosis of mental illness treated in the primary care setting.

133355104.1.10	1.12.4	N/A	ENHANCE SERVICE AVAILABILITY OF APPROPRIATE LEVELS OF BEHAVIORAL HEALTH CARE- EXPANSION OF AMBULATORY MENTAL HEALTH SERVICES
Harris Health System			133355104
Related Category 3 Outcome Measure(s):	133355104.3.12	IT-1.20	Other outcome target: Percent of patients diagnosed with major depression that are adherent to prescribed medication treatment plan

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
treated in the primary care setting Goal: Provide baseline documentation Data Source: Project records Milestone 2 Estimated Incentive Payment: $2,646,392	Goal: Increase number of unique patients with a primary diagnosis of mental illness treated in the primary care setting 3% over baseline Data Source: EHR Milestone 4 Estimated Incentive Payment: $2,887,071.50	Goal: Increase number of unique patients with a primary diagnosis of mental illness treated in the primary care setting 5% over baseline Data Source: EHR Milestone 6 Estimated Incentive Payment: $1,930,309.67 **Milestone 7** [P-10]: Participate in face-to-face learning at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. Metric 1 [P-10.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: Participate in all semi-annual face-to-face meetings or seminars Data Source: Documentation of semiannual meetings including	Goal: Increase number of unique patients with a primary diagnosis of mental illness treated in the primary care setting 8% over baseline Data Source: EHR Milestone 9 Estimated Incentive Payment: $1,594,603.67 **Milestone 10** [P-10]: Participate in face-to-face learning at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. Metric 1 [P-10.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: Participate in all semi-annual

DRAFT

133355104.1.10	*1.12.4*	*N/A*	***Enhance Service Availability of Appropriate Levels of Behavioral Health Care- Expansion of Ambulatory Mental Health Services***
Harris Health System			*133355104*
Related Category 3 Outcome Measure(s):	*133355104.3.12*	*IT-1.20*	*Other outcome target: Percent of patients diagnosed with major depression that are adherent to prescribed medication treatment plan*

Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
		meeting agendas, slides from presentations, and/or meeting notes. Milestone 7 Estimated Incentive Payment*:* $1,930,309.67	face-to-face meetings or seminars Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Milestone 10 Estimated Incentive Payment*:* $1,594,603.67
Year 2 Estimated Milestone Bundle Amount: $5,292,784	Year 3 Estimated Milestone Bundle Amount: $5,774,143	Year 4 Estimated Milestone Bundle Amount: $5,790,929	Year 5 Estimated Milestone Bundle Amount: $4,783,811
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)**:*** $21,641,667			

Project Option 1.3.1- Implement/Enhance and Use Chronic Disease Management Registry Functionalities: Implement a Chronic Disease Management Registry

Unique RHP Project ID: 133355104.1.11 / Pass 1
Performing Provider Name/TPI: Harris Health System / 133355104

Project Summary:

Provider:
Harris Health System is comprised of 16 community health centers, seven school-based clinics, a dental center, dialysis center, five mobile health units, one outpatient specialty services clinic, and three hospitals. With a tax base of $511.6 million, Harris Health System was able to provide more than $1.254 billion in charity care during FY 2012.

Volume Statistics - FY2012	Patient Payor Mix	Patient Demographics
Hospital admissions- 35,343 Births (babies delivered)- 6,643 Emergency visits- 173,263 Outpatient clinic visits- 1,054,770	Self-Pay- 62.6% Medicaid and CHIP- 23.4% Medicare- 8.6% Other Funding- 3.6% Commercial Insurance- 1.8%	Hispanic- 57.4% African American- 26.3% Caucasian- 9.2% Asian- 4.8% Other- 2.2% American Indian- 0.2%

Intervention(s):
This project will develop a chronic disease management registry to use system-wide to ensure providers and clinical staff has access to determine patient status and identify physical, psychosocial and emotional needs of the chronically ill patient.

Need for the project:
The purpose is to provide the ability to identify patients at risk based on chronic disease states and associated utilization patterns. When patients' needs are identified then are educated and empowered to self-manage, quality improves, inappropriate utilization decreases, and the cost per capita declines.

Target Population:
All patients within the system with may benefit from this project (Medicaid and CHIP-23.4% / Self-Pay- 62.6%), specifically those with chronic diseases to include diabetes, COPD, asthma, heart failure, and obesity.

Category 1 or 2 expected patient benefits:
Our DY4 goal is to improve upon DY2 baseline of patient identification in registry by 30%. Our DY5 goal is for 50% of patients in registry have at least 1 contact in the prior year period. The estimated total number of patients that would be managed within the registry would be > 10,000 patients.

Category 3 outcomes:
IT-3.2: Our goal is to reduce congestive heart failure 30 day readmission rates by 3% of baseline in DY4 and 5% of baseline in DY5

Project Option 1.3.1- Implement/Enhance and Use Chronic Disease Management Registry Functionalities: Implement a Chronic Disease Management Registry

Unique RHP Project ID: 133355104.1.11 / Pass 1
Performing Provider Name/TPI: Harris Health System / 133355104

Project Description:

Harris Health System will develop a chronic disease management registry to use system-wide to ensure providers and clinical staff has access to determine patient status and identify physical, psychosocial and emotional needs of the chronically ill patient. Electronic information sharing will promote a continuum of awareness of adherence to treatment plans, pharmacy, and primary and secondary care utilization. The purpose of the implementation of a disease registry is to provide the ability to identify patients at risk based on chronic disease states and associated utilization patterns that will facilitate the ability to identify gaps in service and deficits in patient understanding and self-management of their disease. When patients' needs are identified then are educated and empowered to self-manage quality improves inappropriate utilization decrease and the cost per capita declines. The project will utilize the existing electronic medical record and enhance the capabilities to implement a comprehensive disease registry.

Goal(s) and Relationship to Regional Goals:

The goals of this project are to:

- Identification of Harris Health patients at risk based on chronic disease process and severity of illness established by utilization of emergency center visits, acute care admissions and readmissions
- Identification of Harris Health patients who are at risk for decline in their respective chronic disease processes based on evidence relative to individual patient pharmacy utilization as indicative of adherence to treatment plan and ascertain barriers to adherence
- Stratify patients based on need relative to utilization indicating a deficit in education, instruction or support both financial and emotional
- Electronic reporting on ambulatory care sensitive conditions will delineate patient need for case management services to promote self- management

This project meets the following Region 3 goals:

- Transform health care delivery from a disease-focused model of episodic care to a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary or duplicative services, and builds on the accomplishments of our existing health care system, and
- Develop a culture of ongoing transformation and innovation that maximizes the use of technology and best-practices, facilitates regional collaboration and sharing, and engages patients, providers, and other stakeholders in the planning, implementation, and evaluation processes.

Challenges or Issues:

Population served by Harris Health has a literacy level averaging 5th grade

- Culturally diverse population to include Hispanics and African American who are predisposed to diabetes, hypertension, and obesity (Harris Health System Fact Sheet 2012)
    - Hispanic 57.4%
    - African American 26.3%
    - Caucasian 9.2%
    - Asian 4.8%
    - Other 2.2%
    - American Indian 0.2%
- Inability to identify patients proactively based on lack of cohort data specific to individual patients, disease processes and respective utilization

The project will address the above challenges by capture of individual demographic data in a searchable database that will be aligned with utilization, cohorted to a disease process (s) and associated with NDC (pharmacy) utilization. Evaluation of the data will depict the penetration of chronic disease demographically and permit the specific patient centered programs for self-management and financial assistance to be availed to promote self-management and early intervention. Individual identification of need based on utilization and specific disease process will permit the development of patient specific intervention to address psychosocial barriers to care delivery.

5-year Expected Outcome for Provider and Patient:

Patients with chronic illness will have improved health, via management, the cost per patient is decreased due to decreased acute care and emergency visit utilization, and quality is improved via the proactive identification of patient need and access to same is available.

Starting Point/Baseline:

Because the disease registry project is a new endeavor, the baseline for this project is currently 0 patients enrolled in the registry. A baseline for patients registered will be established in DY 3 and will serve as the basis of our improvement targets for DY 4 and DY5.

Current status:

Harris Health per internal data has 47,000 patients in the served population and the top 5 diagnoses of chronic disease are heart failure, hypertension, obesity, depression, and chronic respiratory to include Chronic Obstructive Pulmonary Disease and asthma (October 2011-September 2012). Without a disease registry it is difficult to establish the incidence and prevalence.

Rationale:

Project option 1.3.1 is selected based on the need to implement a searchable comprehensive registry that will electronically be capable of reporting data to efficiently identify, and evaluate patients with chronic disease, and their associated utilization. Additionally the disease registry will provide data to analyze to address the reasons for emergency and visits and readmissions to acute care based on a deficit in the patient's ability to self-manage their disease process. A disease registry also will promote the adaptation of existing or implementation of new programs based on demographic data retrieved specific to chronic disease and the ambulatory case sensitive conditions.

Project components:

a) Enter patient data into unique chronic disease registry. The patient clinical information to include laboratory values, diagnostic testing and procedural interventions will be extrapolated and electronically captured from the electronic medical record which will interface with the disease registry software. Patient data will be captured utilizing predetermined inclusion criteria, and entered into discrete data fields which will provide the structure for entry into the disease registry. Based on data collected and retrieved the patients will be identified based on place of service and provider. As a result each patient's unique data will be collected from any access point across the continuum so as to ascertain management of the chronic disease and associated professional and patient interventions and outcomes.
b) Use registry data to proactively contact, educate, and track patients by disease status, risk status, self-management status, community and family need.
c) Use registry reports to develop and implement targeted QI plan. Reports will be electronically produced as part of key performance indicator dashboard and will be reviewed at a minimum by the Ambulatory Care Committee, the Quality Governance Council, and as applicable the Board of Managers.
d) Conduct quality improvement for project using methods such as rapid cycle improvement. Activities may include, but are not limited to, identifying project impacts, identifying "lessons learned," opportunities to scale all or part of the project to a broader patient population, and identifying key challenges associated with expansion of the project, including special considerations for safety-net populations.

Unique community need identification numbers the project addresses:

- CN .8 –High rates of inappropriate emergency department utilization
- CN.9- High rates of preventable hospital readmissions
- CN.10- High rates of preventable hospital admissions
- CN.11 – High rates of chronic disease and inadequate access to treatment programs and services for illnesses associated with chronic disease including:
    - Asthma
    - Diabetes
    - Obesity
    - Cardiovascular
    - Aids/HIV
    - Cancer

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

The project is a new initiative for Harris Health and does not exist today in any form. The current electronic health record does not capture data in patient categories or cohort data that is electronically available to the end user to drive decision making, to meet the needs of the community with chronic illness.

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

OD-3 Potentially Preventable Re-Admissions- 30 day Readmission Rates

- IT- 3.2 Congestive Heart Failure Admission rate (CHF)- PQI #8

Category 3 outcome measures are related to primary care, management of chronic disease and cost. The rationale for selecting IT 3.2 is relevant to the high volume of patients at Harris Health diagnosed with ambulatory care sensitive conditions pertinent to chronic disease such as COPD, asthma, Hypertension, diabetes and heart failure. An active disease registry will promote the management of patients via their identification in the population, patterns of utilization and their ability to self-manage thereby preventing inappropriate admissions or readmissions for the ambulatory care sensitive condition.

Relationship to other Projects:

The sheer volume of population, as well as the complexity of patient conditions, dictates the need of numerous disease registries in our region to properly identify and manage chronic conditions. The concept is utilized consistently throughout our region in order to help achieve milestones and outcomes specific to patient conditions. All disease registries presented have a similarity in concept but are unique in the sense of condition or patient population focus. The Region 3 initiative grid in the addendum reflects direct relations between all projects.

Plan for Learning Collaborative:

We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system.

Project Valuation:

The purpose of the implementation of a disease registry is to provide the ability to identify patients at risk based on chronic disease states and associated utilization patterns that will facilitate the ability to identify gaps in service and deficits in patient understanding and self-management of their disease. Patients with chronic illness will have improved health, via education and case management, the cost per patient is decreased due to decreased acute care and emergency visit utilization, and the patient's quality of life is improved. Harris Health internal data for the most recent year has 47,000 patients with one or more of the top 5 diagnoses of chronic disease – heart failure, hypertension, obesity, depression, and chronic respiratory. With a disease registry allowing us to establish clear incidence and prevalence data, the cost saving opportunity related to the potential improved management of these conditions is substantial.

133355104.1.11	1.3.1	A-D	IMPLEMENT/ENHANCE AND USE CHRONIC DISEASE MANAGEMENT REGISTRY FUNCTIONALITIES: IMPLEMENT A CHRONIC DISEASE MANAGEMENT REGISTRY
Harris Health			133355104
Related Category 3 Outcome Measure(s):	133355104.3.13	IT-3.2	Congestive Heart Failure 30 Day Readmission Rate

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-1]: 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). Metric 1 [P-1.1]: Documentation of patients to be entered into the registry Goal: Provide documentation of patients to patients appropriate for registry Data source: performing providers records/documentation Milestone 1 estimated Incentive Payment : $4,825,421	**Milestone 2** [P-2]: Review current registry capability and assess future needs. Metric 1 [P-2.1]: Metric: Documentation of review of current registry capability and assessment of future registry needs Baseline/Goal: Registry reports Data Source: Registry Milestone 2 Estimated Incentive Payment: $1,316,069 **Milestone 3** [P-4]: 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 Metric 1 [P-4.1]: Documentation of registry automated report Goal: Produce registry automated report Data Source: Registry Milestone 3 Estimated Incentive Payment: $1,316,069 **Milestone 4** [P-6]: Conduct staff training on populating	**Milestone 6** [I-15]: Increase the percentage of patients enrolled in the registry. Metric 1 [I-15.1]: Percentage of patients in the registry Baseline: Established in DY3 Goal: Improve upon DY2 baseline of patient identification by 30% Data Source: Registry or EHR Milestone 6 Estimated Incentive Payment: $5,279,579	**Milestone 7** [I-16]: Increase the number of patient contacts recorded in the registry relative to baseline rate. Metric 1 [16.1]: Total number of in-person and virtual (including email, phone and web-based) visits, either absolute or divided by denominator. Goal: For 50% of patients in registry have at least 1 contact in the prior year period. Data source: Internal clinic or hospital records/documentation Milestone 7 Estimated Incentive Payment: $4,361,391

133355104.1.11	*1.3.1*	*A-D*	*IMPLEMENT/ENHANCE AND USE CHRONIC DISEASE MANAGEMENT REGISTRY FUNCTIONALITIES: IMPLEMENT A CHRONIC DISEASE MANAGEMENT REGISTRY*
Harris Health			*133355104*
Related Category 3 Outcome Measure(s):	*133355104.3.13*	*IT-3.2*	*Congestive Heart Failure 30 Day Readmission Rate*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	and using registry functions. <u>Metric 1</u> [P-6.1]: Documentation of training programs and list of staff members trained, or other similar documentation Baseline: Zero documentation Goal: 100% documentation of training for relevant clinicians Data Source: Human Resources or training program materials Milestone 4 Estimated Incentive Payment: $1,316,069 **Milestone 5** [P-X]: Establish baseline number of patients enrolled in the registry <u>Metric 1</u> [P-X.1]: Documentation of number of patients enrolled in the registry Baseline: 0 patients enrolled in DY2 Goal: Provide documentation of number of patients enrolled in the registry Data Source: EHR Milestone 5 Estimated Incentive Payment: $1,316,069		

<table>
<tr><td>***133355104.1.11***</td><td colspan="2">***1.3.1***</td><td colspan="2">***A-D***</td><td colspan="2">***IMPLEMENT/ENHANCE AND USE CHRONIC DISEASE MANAGEMENT REGISTRY FUNCTIONALITIES: IMPLEMENT A CHRONIC DISEASE MANAGEMENT REGISTRY***</td></tr>
<tr><td colspan="6">*Harris Health*</td><td>*133355104*</td></tr>
<tr><td>***Related Category 3 Outcome Measure(s):***</td><td colspan="2">*133355104.3.13*</td><td colspan="2">*IT-3.2*</td><td colspan="2">*Congestive Heart Failure 30 Day Readmission Rate*</td></tr>
<tr><td colspan="2">**Year 2
(10/1/2012 – 9/30/2013)**</td><td colspan="2">**Year 3
(10/1/2013 – 9/30/2014)**</td><td colspan="2">**Year 4
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(10/1/2015 – 9/30/2016)**</td></tr>
<tr><td colspan="2">Year 2 Estimated Milestone Bundle Amount: $4,825,421</td><td colspan="2">Year 3 Estimated Milestone Bundle Amount: $5,264,276</td><td colspan="2">Year 4 Estimated Milestone Bundle Amount: $5,279,579</td><td>Year 5 Estimated Milestone Bundle Amount: $4,361,391</td></tr>
<tr><td colspan="7">**TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD** *(add milestone bundle amounts over Years 2-5)***:** $19,730,667</td></tr>
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Project Option 1.10.4- Implement other evidence-based project to enhance performance improvement and reporting capacity: Center of Innovation

Unique RHP Project ID: 133355104.1.12 / Pass 1

Performing Provider Name/TPI: Harris Health System / 133355104

Project Summary:

Provider:
Harris Health System is comprised of 16 community health centers, seven school-based clinics, a dental center, dialysis center, five mobile health units, one outpatient specialty services clinic, and three hospitals. With a tax base of $511.6 million, Harris Health System was able to provide more than $1.254 billion in charity care during FY 2012.

Volume Statistics - FY2012	Patient Payor Mix	Patient Demographics
Hospital admissions- 35,343 Births (babies delivered)- 6,643 Emergency visits- 173,263 Outpatient clinic visits- 1,054,770	Self-Pay- 62.6% Medicaid and CHIP- 23.4% Medicare- 8.6% Other Funding- 3.6% Commercial Insurance- 1.8%	Hispanic- 57.4% African American- 26.3% Caucasian- 9.2% Asian- 4.8% Other- 2.2% American Indian- 0.2%

Intervention(s):
This project will establish a Center of Innovation 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.
Need for the project:
There is strong rationale and evidence to suggest that a comprehensive Center for Innovation in Healthcare would increase the value of healthcare (best care with lower cost).
Target Population:
Specifically, CLABSI patients will initially be targeted; however, the target population will change as new performance activities develop. (Overall Payor Mix: Medicaid and CHIP-23.4% / Self-Pay- 62.6%).
Category 1 or 2 expected patient benefits:
The project seeks to demonstrate ≥2 performance activities in DY 4 and ≥5 in DY5 that were designed and implemented based on the data in the reports and efforts of the Center of Innovation. This project would target an estimated 1000+ patients.
Category 3 outcomes:
IT-4.2: Our goal is to decrease the number of cases of CLABSI as designated by IQR criteria at Harris Health System by 20% of baseline in DY4 and 30% of baseline in DY5.

Project Option 1.10.4- Implement other evidence-based project to enhance performance improvement and reporting capacity: Center of Innovation

<u>Unique RHP Project ID:</u> 133355104.1.12 / Pass 1

<u>Performing Provider Name/TPI:</u> Harris Health System / 133355104

<u>Project Description:</u>

Harris Health System proposes to establish a Center of Innovation 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.

In order to respond to the rapidly changing industry, innovation must be at the center of care delivery redesign, competitive strategy, and the development of internal resources. The Center of Innovation in Healthcare will serve as a platform for transformational change to create better value in healthcare. The innovations resulting from Harris Health System's Center of Innovation will be centered around patients in the hospital, in outpatient settings, and with partners in the community. The implementation activities entail redesign of healthcare delivery processes, team building, care coordination, physician and nursing training and education of stakeholders.

Central staff at the institute comprised of healthcare leaders with expertise in the science of healthcare delivery, innovation, public health, systems engineers, information technology, community leaders and patients, will be created to innovate, collaborate and assist in delivering concepts to transform the delivery of care in our region and share nationally. The implementation activities would require support of the center design team of 15-20 experts in the science of healthcare delivery, patient safety, systems engineering, information technology, public health, and social services among others. The center would also require a facility for the core design team and 4-6 meeting rooms for team meetings. Administrative staff will be needed for coordination of activities. The first 12 months would also involve training of key physician and nursing leaders in the core concepts of patient safety and quality improvement to build a culture receptive to innovation. Additional support may include transportation for patient and community members to the facility; travel costs to learn from successful sustained programs with high impact; additional training for team members. The existing physician and nursing expertise would serve as a foundation for the initial design and implementation teams.

The center will define high impact opportunities in patient safety, clinical effectiveness of evidence based best practices, population health, care coordination and unmet patient needs in Medicaid and uninsured patients. The center design team will partner with healthcare providers, patients and other stakeholders to innovate and pilot the implementation. The innovation will require rapid assessment and modification cycles, clear metrics and local support for change through partnership between the local and center design team. A comprehensive evaluation of

the innovation by the center will drive the continuous PDSA cycles until the impact is sustained. Replication of the successful innovation will be carried out throughout the organization. The science of innovation will be amplified by dissemination of the new knowledge.

This initiative is most suited to be initiated in Harris County because of: (a) the local expertise in the science of healthcare delivery, public health, information technology in reducing patient errors, and healthcare systems engineering (b) high rate of uninsured and Medicaid patients in the county (c) the international expertise at UT Health (via the Academy of Patient Safety and Clinical Effectiveness and the Center for Healthcare Quality and Safety, (d) long history of partnerships with national organizations (IHI, UHC, AHRQ, NQF) (e) the potential for rapid dissemination and implementation of the program throughout the country and nationally.

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

The goals of this project are to:

- Establish a Center of Innovation to leverage information technology, financial data, clinical knowledge, and human resources to implement performance improvement activities and promote a culture of innovation across the Harris Health System.
- Hire and train Center of Innovation quality improvement staff in well-proven quality and efficiency improvement principles, tools and processes.
- Enhance performance improvement and reporting capacity across the Harris Health System.
- Improve central line-associated bloodstream infections (CLABSI) rates at Harris Health System.

This project meets the following Region 3 goals:

- Develop a culture of ongoing transformation and innovation that maximizes the use of technology and best-practices, facilitates regional collaboration and sharing, and engages patients, providers, and other stakeholders in the planning, implementation, and evaluation processes.

The Center of Innovation will work to develop and instill a culture of transformation and innovation within the Harris Health System through promotion of creativity and facilitation of collaboration, calculated risk-taking, and problem solving. The efficient and effective use of IT and clinical best practices will be ensured by staff to be hired and trained in quality and efficiency improvement principles, such as Lean/Six Sigma. Best practices will be shared at face-to-face meetings within the region and the Center of Innovation will participate in learning events with the possibility of presenting findings.

Challenges and how we will address them:

The primary challenges will be:

a) Creating a culture for rapid implementation and sustainability

b) Integrating data with national benchmarking programs in patient safety, mortality, and hospital costs
c) Obtaining accurate, real-time data to evaluate the effectiveness of the program

Harris Health System will create a culture for rapid implementation and sustainability through, dedicated, highly-skilled resources and support from executive leadership. Data will be integrated with currently used benchmarking programs at Harris Health, while the organization continuously seeks opportunities to move toward the most relevant benchmarking programs for the organization. Data needs will be met by the dedicated efforts of the internal information technology department to achieving accurate, timely data.

5-Year Expected Outcome for Provider and Patients:

Over the course of the 5-Year Waiver, Harris Health System expects to realize:

- A culture of ongoing transformation and innovation that is supported by a Center of Innovation staffed by highly-skilled healthcare workers capable of impacting clinical and operational outcomes in a way that aligns with the strategic goals of the organization.

Starting Point/Baseline:

The Center for Innovation is a new initiative for Harris Health System; thus, the baseline will be 0 for all milestones and metrics.

Rationale:

Reasons for selecting the project option:

There is strong rationale and evidence to suggest that a comprehensive Center for Innovation in Healthcare would increase the value of healthcare (best care with lower cost).

Centers of healthcare innovation at Cincinnati Children's Hospital, UCLA Medical Center, Geisinger Health System and the programs such as UT Health's program for chronically ill children piloted by Dr. Tyson are excellent references. The success of these programs demonstrates high reliability organizations in patient safety, clinical effectiveness, cost of care and integration of nontraditional community resources to improve health. These centers have reduced patient harm, improved mortality, reduced patient readmissions and emergency room visits, improved patient satisfaction and reduced disparities in healthcare delivery.

Project Components:

Not applicable / Project option 1.10.4 does not have components.

Milestones & (Metrics):

- Process Milestones and Metrics- P-1 (P-1.1); P-2 (P-2.1); P-4 (P-4.1); P-6 (P-6.1; P-6.2); P-9 (P-9.1)
- Improvement Milestones and Metrics- I-10 (I-10.2)

Unique community need identification number the project addresses:

This project addresses the following community needs according to the community needs assessment:

- CN.9- High rates of preventable hospital readmissions
- CN.10-High rates of preventable hospital admissions

How the project represents a new initiative for the Performing Provider or significantly enhances an existing delivery system reform initiative:
The Harris Health System currently does not have a Center of Innovation or another similar initiative.

Related Category 3 Outcome Measure(s):

OD- Potentially Preventable Complications and Healthcare Acquired Conditions

- IT-4.2 Central line-associated bloodstream infections (CLABSI) rates

Reasons/rationale for selecting the outcome measure(s):

Central line infections are common preventable complications and can be substantially reduced through design of systems processes and interdisciplinary care models. Sustained reduction and elimination of healthcare associated infections will require healthcare redesign.

Relationship to other Projects:

Innovation is key to the transformation of healthcare in our community. The consistency of innovation in our region allows for increased improvements based on research trends, patient need, and provider availability. The waiver funding allows for innovation in specific areas and all innovative projects included in the plan are similar in the fact of program redesigns for historic treatments, and focus to chronic condition outcome measures such as central line infections. The Region 3 initiative grid in the addendum can provide a side by side comparison of all projects that directly relate to innovation.

Plan for Learning Collaborative: We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system.

Project Valuation:

The goal of the center is to define high impact opportunities in patient safety, clinical effectiveness of evidence based best practices, population health, care coordination and unmet patient needs in Medicaid and uninsured patients. The center design team will partner with

healthcare providers, patients and other stakeholders to develop innovation strategies and plans, and pilot the implementation. As noted earlier, centers of healthcare innovation at other prominent healthcare organizations are excellent references. The success of these programs demonstrates high reliability organizations in patient safety, clinical effectiveness, cost of care and integration of nontraditional community resources to improve health. These centers have reduced patient harm, improved mortality, reduced patient admissions, readmissions and emergency room visits, improved patient satisfaction and reduced disparities in healthcare delivery.

133355104.1.12	*1.10.4*	*N/A*	*IMPLEMENT OTHER EVIDENCE-BASED PROJECT TO ENHANCE PERFORMANCE IMPROVEMENT AND REPORTING CAPACITY: CENTER FOR INNOVATION*
Harris Health System			*133355104*
Related Category 3 Outcome Measure(s):	*133355104.3.14*	*IT-4.2*	*Central line-associated bloodstream infections (CLABSI) rates*

Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 09/30/2016)**
Milestone 1 [P-1]: Establish a performance improvement office to collect, analyze, and manage real-time data and to monitor the improvement trajectory and improvement activities across the Performing Provider's delivery system Metric 1 [P-1.1]: Documentation of the establishment of performance improvement office Baseline: Center of Innovation does not exist at Harris Health System Goal: Establish the Center of Innovation at Harris Health System and provide documentation of plant for staffing and functional capabilities	**Milestone 2** [P-6]: Hire/train quality improvement staff in well-proven quality and efficiency improvement principles, tools and processes, such as rapid cycle improvement and/or data and analytics staff for reporting purposes (e.g., to measure improvement and trends) Metric 1 [P-6.1]: Increase number of staff trained in quality and efficiency improvement principles Baseline: 0 staff hired and trained in DY2 Goal: Hire and train Center of Innovation staff in quality and efficiency improvement principles Data Source: HR, training programs	**Milestone 4** [I-10]: Enhance performance improvement and reporting capacity. Metric 1 [P-10.2]: Demonstrate how quality reports are used to drive performance improvement. Goal: Demonstrate ≥2 performance activities that were designed and implemented based on the data in the reports and efforts of the Center of Innovation Data Source: HR, training program materials (including documentation of the number of hours of training required). Milestone 4 Estimated Incentive Payment: $3,261,494.67	**Milestone 7** [I-10]: Enhance performance improvement and reporting capacity. Metric 1 [P-10.2]: Demonstrate how quality reports are used to drive performance improvement. Goal: Demonstrate ≥5 performance activities that were designed and implemented based on the data in the reports and efforts of the Center of Innovation Data Source: HR, training program materials (including documentation of the number of hours of training required). Milestone 7 Estimated Incentive Payment: $2,694,278.33

133355104.1.12	***1.10.4***	***N/A***	***IMPLEMENT OTHER EVIDENCE-BASED PROJECT TO ENHANCE PERFORMANCE IMPROVEMENT AND REPORTING CAPACITY: CENTER FOR INNOVATION***
Harris Health System			*133355104*
Related Category 3 Outcome Measure(s):	*133355104.3.14*	*IT-4.2*	*Central line-associated bloodstream infections (CLABSI) rates*
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 09/30/2016)**
Data Source: HR documents, office policies and procedures Milestone 1 Estimated Incentive Payment *(maximum amount):* $8,942,808	<u>Metric 2</u> [P-6.2]: Increase number of data analysts hired who are responsible for collecting and analyzing real-time data to measure improvement and trends and to drive rapid-cycle performance improvement. Baseline: 0 data analysts hired in DY3 Goal: Hire data analysts for Center of Innovation Data Source: HR, job descriptions Milestone 2 Estimated Incentive Payment*:* $4,878,061.50 **Milestone 3** [P-2]: Establish a program for trained experts on process improvements to mentor and	**Milestone 5** [P-6]: Hire/train quality improvement staff in well-proven quality and efficiency improvement principles, tools and processes, such as rapid cycle improvement and/or data and analytics staff for reporting purposes (e.g., to measure improvement and trends) <u>Metric 1</u> [P-6.1]: Increase number of staff trained in quality and efficiency improvement principles Baseline: Staff hired and trained in DY3 Goal: Hire and train Center of Innovation staff in quality and efficiency improvement principles Data Source: HR, training	**Milestone 8** [P-6]: Hire/train quality improvement staff in well-proven quality and efficiency improvement principles, tools and processes, such as rapid cycle improvement and/or data and analytics staff for reporting purposes (e.g., to measure improvement and trends)We <u>Metric 1</u> [P-6.1]: Increase number of staff trained in quality and efficiency improvement principles Baseline: Staff hired and trained in DY4 Goal: Hire and train Center of Innovation staff in quality and efficiency improvement principles Data Source: HR, training

133355104.1.12	*1.10.4*	*N/A*	*IMPLEMENT OTHER EVIDENCE-BASED PROJECT TO ENHANCE PERFORMANCE IMPROVEMENT AND REPORTING CAPACITY: CENTER FOR INNOVATION*
Harris Health System			*133355104*
Related Category 3 Outcome Measure(s):	*133355104.3.14*	*IT-4.2*	*Central line-associated bloodstream infections (CLABSI) rates*

Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 09/30/2016)**
	train other staff, including front-line staff, for safety and quality care improvement. All staff trained in this program should be required to lead an improvement project in their department within 6 months of completing their training. Metric 1 [P-2.1]: Train the trainer program established Baseline: Train the trainer program not established in DY2 Goal: Establish program and provide documentation Data Source: HR, training program materials (including documentation of the number of hours of training required). Milestone 3 Estimated Incentive Payment*:* $4,878,061.50	programs Metric 2 [P-6.2]: Increase number of data analysts hired who are responsible for collecting and analyzing real-time data to measure improvement and trends and to drive rapid-cycle performance improvement. Baseline: Data analysts hired in DY3 Goal: Hire data analysts for Center of Innovation Data Source: HR, job descriptions Milestone 5 Estimated Incentive Payment*:* $3,261,494.67 **Milestone 6** [P-9]: Participate in face-to-face learning at least twice\ per year with other providers and the RHP to promote collaborative learning around shared or similar projects.	programs Milestone 8 Estimated Incentive Payment*:* $2,694,278.33 **Milestone 9** [P-4]: Participate in/present to quality/performance improvement conferences, webinars, learning sessions or other venues Metric 1 [P-4.1]: Number of learning events attended and number of learning events at which a presentation was delivered summarizing the provider's improvement activities and results Goal: Attend and present at learning events; Provide documentation Data Source: Learning events' agendas, abstracts or materials related to provider's presentation

133355104.1.12	***1.10.4***	***N/A***	***IMPLEMENT OTHER EVIDENCE-BASED PROJECT TO ENHANCE PERFORMANCE IMPROVEMENT AND REPORTING CAPACITY: CENTER FOR INNOVATION***
Harris Health System			*133355104*
Related Category 3 Outcome Measure(s):	*133355104.3.14*	*IT-4.2*	*Central line-associated bloodstream infections (CLABSI) rates*

Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 09/30/2016)**
		Metric 1 [P-9.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Baseline: No participation in DY3 Goal: Participate at least twice per year Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Milestone 6 Estimated Incentive Payment: $3,261,494.67	Milestone 9 Estimated Incentive Payment*:* $2,694,278.33
Year 2 Estimated Milestone Bundle Amount*:* $8,942,808	Year 3 Estimated Milestone Bundle Amount: $9,756,123	Year 4 Estimated Milestone Bundle Amount: $9,784,484	Year 5 Estimated Milestone Bundle Amount: $8,082,835
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:** $36,566,250			

Harris County Hospital District Ben Taub General Hospital

Pass 2

DRAFT

Project Option 1.9.2-Improve access to specialty care: Increase access to outpatient Physical and Occupational Therapy specialty services

Unique RHP Project ID: 133355104.1.13 / Pass 2
Performing Provider Name/TPI: Harris Health System / 133355104

Project Summary:

Provider:
Harris Health System is comprised of 16 community health centers, seven school-based clinics, a dental center, dialysis center, five mobile health units, one outpatient specialty services clinic, and three hospitals. With a tax base of $511.6 million, Harris Health System was able to provide more than $1.254 billion in charity care during FY 2012.

Volume Statistics - FY2012	Patient Payor Mix	Patient Demographics
Hospital admissions- 35,343 Births (babies delivered)- 6,643 Emergency visits- 173,263 Outpatient clinic visits- 1,054,770	Self-Pay- 62.6% Medicaid and CHIP- 23.4% Medicare- 8.6% Other Funding- 3.6% Commercial Insurance- 1.8%	Hispanic- 57.4% African American- 26.3% Caucasian- 9.2% Asian- 4.8% Other- 2.2% American Indian- 0.2%

Intervention(s):
This project will increase the number of outpatient physical and occupational therapy providers in order to improve access and meet unmet demand for patients who are being referred for services from NCQA medical homes and specialty clinics.

Need for the project:
With current staffing 1040 new patients per month on average are appointed and seen. This is compared to the total number of referrals received which is 2487. Based on the current average monthly referral volume and the Physical and Occupational Therapy provider panel capacity it was determined that an additional 23 FTE's are required to meet demand.

Target Population:
Any patient appropriate for outpatient physical and/or occupational therapy within the system may benefit from this project (Overall payor mix: Medicaid and CHIP-23.4% / Self-Pay- 62.6%).

Category 1 or 2 expected patient benefits:
Our goals are to increase the number of patients seen per month by specialty Physical and Occupational Therapy services by 1,320 and increase the number of FTEs by 23.

Category 3 outcomes:
IT-10.1: Our goal is to improve quality of life (QOL) scores to greater than 50 at discharge from therapy for at least 10% of the patients seen in DY4 and for at least 20% of the patients seen in DY5.

Project Option 1.9.2-Improve access to specialty care: Increase access to outpatient Physical and Occupational Therapy specialty services

Unique RHP Project ID: 133355104.1.13 / Pass 2

Performing Provider Name/TPI: Harris Health System / 133355104

Project Description:
Harris Health System Rehabilitation Services proposes to increase the number of outpatient physical and occupational therapy providers in order to improve access and meet unmet demand for patients who are being referred for services from NCQA medical homes and specialty clinics.

This project will increase the capacity to provide outpatient physical and occupational therapy services and the availability of therapy providers to meet the current unmet demand from referring primary care providers to the underserved areas of Harris County, primarily low-income, uninsured and Medicaid populations. Outpatient Physical Therapy and Occupational Therapy (PT and OT) services are targeted to populations who are at risk for impairments in activities of daily living resulting from a lack of access to specialty care. The project will improve access and expand current outpatient physical and occupational therapy services that would result in improved quality of life by persons served.

The Harris Health System Rehabilitation Services and Child Life Department serves 13 community health clinics (Medical Homes) and the specialty clinics at Ben Taub General Hospital, Lyndon B. General Hospital, and Quentin Mease Community Hospital. With current staffing 1040 new patients per month on average are appointed and seen. This is compared to the total number of referrals received which is 2487. The average monthly referral volume by discipline is as follows:

- Medical Home Average Monthly referrals
  - Physical Therapy: 1592
  - Occupational Therapy: 285
  - Total: 1877
- Specialty Clinic Average Monthly referrals
  - Physical Therapy: 412
  - Occupational Therapy: 198
  - Total: 610
- Total number of patients seeking therapy per month:
  - 2487
- Total number of patients currently seen per month:
  - 1040
- Total number of patients who are unable to receive services per month:
  - 1447
- Additional patients to be served per month with additional FTE's:
  - 1320

Based on the current average monthly referral volume and the Physical and Occupational Therapy provider panel capacity it was determined that an additional 23 FTE's are required to

meet demand. The department currently has 30.5 funded FTE's as compared to a need for 53.42 FTE's required to provide services referred to by a primary care physician's order.

A six-month pilot was conducted from January 16, 2012 to July 16, 2012 to conduct a gap analysis for services provided and to formally define the role of physical and occupational therapists in the medical home. The results of the pilot are as follows:

1. PT's and OT's are integral part of the medical home patient care team as evidenced by their role in management of musculoskeletal and neuromuscular disorders.
2. New business model of care should be implemented to support NCQA Standards.
3. Access to care was identified as the major barrier to improved patient outcomes.

Successful completion of the pilot resulted in approval from Harris Health Leadership to adopt new medical home business model so that all referred patients have access and NCQA Standards can be adhered to. It was determined that access to specialty care (PT and OT) needs to be addressed to improve the quality of life of persons served.

The project will improve access to specialty care by providing an additional 23 PT and OT providers to the Rehabilitation Services department and by adding additional outpatient therapy treatment space near the referring clinics.

Target Zip Codes:

77030	77088	77009	77018	77056
77026	77039	77012	77074	77099
77004	77520	77047	77028	77338

Goals and Relationship to Regional Goals:

The goal of this project is to use physical therapists, physical therapist assistants, and occupational therapists to provide specialty care to patients who have impaired functional mobility and activities of daily living due to decreased quality of life. Once referred from a primary care physician, patients will have access to qualified rehabilitation professionals who will provide an individualized treatment plan based on the diagnosis and impairments identified from an evaluation. Early intervention and appropriate access to care will result in improved health outcomes because treatment can be delivered in an acute phase of the patient's disorder as opposed to the chronic state that often occurs because of delayed access.

Project Goals:

- Increase the number of patients seen per month by specialty Physical and Occupational Therapy services by 1,320.
- Improve the health outcomes of referred patients through improved access to specialty Physical and Occupational Therapy services.
- Decrease barriers to access to specialty Physical and Occupational Therapy services by placing additional staff and clinics in underserved areas of Harris County

This project meets the following regional goals:

- Transform healthcare delivery from a tertiary care model of episodic care to a primary/secondary model of patient-centered, coordinated care model of care by integrating Physical and Occupational therapy services within the medical home model. This will improve health outcomes, and reduce health care costs by increasing access to specialty care services.

- Build on a regional approach to health care delivery that leverages and improves on existing programs and infrastructure, is responsive to patient needs throughout the entire region, and improves health care outcomes and patient satisfaction.
- Increase access to primary and specialty care services, with a focus on underserved populations to ensure patients receive the most appropriate care for their condition, regardless of where they live or their ability to pay.

Increasing the number of Physical and Occupational therapy staff will not only increase access to our patients who are in need of these specialty services, but it will also increase access to our medical home leadership and staff for improved communication, education and population management.

Challenges:

- Highly competitive hiring market, creating challenges in finding staff to fill the newly created positions.
- Finding innovative ways to mentor and integrate new staff into the larger health system due to geographical separation.
- Lack of education to physicians and specialty care providers about how to assess and refer patients to Physical and Occupational Therapy services.

Harris Health's Rehabilitation Services department has an excellent reputation in the city and state for staff that are highly trained and specialized providers. This attracts therapists from several educational institutions that seek employment with Harris Health to be mentored and to serve a diverse patient population. In addition, the department has an active student program that allows individuals to be trained within our system which further attracts recent graduates to seek employment with our department. Currently there are no vacant positions in the outpatient rehabilitation services department. Due to the additional locations being separate from the current staff, a mentoring program will be developed. This mentoring program will involve experienced therapists to rotate initially to the location for orientation and mentoring. Then a rotation of staff will occur annually for ongoing mentoring and development. In addition the rehabilitation services department has a well-established education program for its entire staff that occurs throughout the year. With this program, each of the referring clinics will be assigned a lead contact therapist to oversee the needs of the clinic and its physicians. This lead therapist will attend physician meetings and work closely with the physicians to provide ongoing education on the specific population seen at each clinic. In addition, the physicians will have direct contact with the lead therapist assigned to the clinic via phone or electronic communication at all times. With these strategies, the challenges identified can be overcome.

5-Year Expected Outcome for Provider and Patients:

Harris Health System Outpatient Rehabilitation Services expects to improve access to care for patients referred to specialty Physical and Occupational therapy care. Barriers to access to care will be reduced through geographically located clinics in underserved areas. Additionally, it is expected that patients seeking specialty Physical and Occupational Therapy services will have an increased quality of life through earlier intervention. Expected outcomes will relate to the project goals described above.

Starting Point/Baseline:

With the current 30.5 funded FTE's the physical therapy and occupational therapy services are able to provide care for approximately 776 individual's seeking physical therapy and 264 individual's seeking occupational therapy per month for a total of 1,040 individuals served per month. The current number of referrals per month from primary care physicians total 2,487, this leaves a disparity of 1,447 individuals not having access to the specialty care of physical therapy and occupational therapy. In addition, the physical therapy and occupational therapy services are provided at two locations at LBJ General Hospital and Quentin Mease Hospital limiting access to patients that live in the western part of the Harris County due to a variety of barriers, including, but not limited to transportation. To serve the individuals not currently able to access services an additional 23 FTE's will be needed, including 12 physical therapists, 3 physical therapist assistants, 6 occupational therapists, 1 wellness program manager, and 1 program operations manager. The total acquisition of these additional FTE's would occur over a 3 year period. The program operations manager would be hired year two and the wellness program manager would be hired year four for program analysis, staff education, development and strategic planning.

Rationale:

A large number of patients, who are enrolled in Medicaid, are uninsured or underinsured in Harris County are not receiving Physical therapy and Occupational Therapy services due to limited access. Currently there are only two outpatient therapy clinics in the Harris Health System and both are more centrally located. This leaves much of the county without local therapy services. The proposed clinic locations will be located in underserved areas of Harris County where access to specialty Physical and Occupational Therapy services is limited.

Project Components:

a) Increase service availability with extended hours: The clinics would operate similarly to the current clinics which have extended hours from 7 am to 5:30 pm.
b) Increase number of specialty clinic locations: This program would offer two additional locations located in underserved areas of the county either in existing community health clinics or in a local existing commercial structure. Additional staff will be hired to operate these clinics.
c) Implement transparent, standardized referrals across the system: Due to the integrated electronic medical record system all referring providers would refer patients to the specialty services of physical therapy and occupational therapy in a standardized format for all providers and everyone in the system will be able to see the referral and when the individual's appointment is made.
d) Conduct quality improvement projects: With this program a wellness program coordinator and program operations manager will provide ongoing evaluation of the program. These personnel will identify barriers to access and create solutions to circumvent these obstacles. They will continually measure and analyze the difference between number of total referrals for the system and the number patients served to determine availability of services. In addition, they will evaluate the improvement that therapy services make on the individual's served quality of life and adjust services as needed to best serve the population for optimal outcomes. Finally, further evaluation of the population served will be conducted to determine continual changes to the program to

improve the overall health of the population through therapy services with increased access. Plan Do Study Act cycles will be implemented to continually evaluate process improvements throughout the project.

Unique community need identification numbers the project addresses:

- CN.2- Inadequate access to specialty care
- CN.6- Inadequate access to treatment and services designed for special needs populations, including disabled, homeless, children and elderly
- CN.11- High rates of chronic disease and inadequate access to treatment programs and services for illnesses associated with chronic disease, including
  - Cancer
  - Diabetes
  - Obesity
  - Cardiovascular disease
  - Asthma
  - AIDS/HIV

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

Currently the Harris Health System Outpatient Rehabilitation Services department is serving medical home patients in two centrally located outpatient facilities. Additionally, current staffing is not adequate to meet the demand for specialty Physical and Occupational Therapy services. This project will enhance the ability to serve more patients, that is, improve access to these services, while at the same time improve health outcomes and quality of life for the patients served. By locating new clinics in underserved areas and adding additional staff this project will reduce barriers to accessing specialty therapy services and further integrating these services into the medical home model.

Related Category 3 Outcome Measure(s):

OD- 10 Quality of Life/Functional Status:

- IT-10.1 Quality of Life
  a. *Demonstrate improvement in quality (QOL) scores, as measured by evidence based and validated assessment tool, for the target population.* Patients will complete the Short Form Health Survey (SF-36) upon initial evaluation and upon discharge from Physical or Occupational Therapy to measure the patient's perceived quality of life before and after therapy intervention. This tool is evidence based and validated for a wide range of diagnostic groups that are routinely seen in outpatient services.
  b. *Data source:* The SF-36 was developed by the RAND Corporation as part of the multi-year Medical Outcomes Study to explain variations in patient outcomes. The SF-36 is a multipurpose, 36-item survey that measures eight domains of health: physical functioning, role limitations due to physical health, bodily pain, general health perceptions, vitality, social functioning, role limitations due to emotional problems, and mental health. It yields scale scores for each of these eight health domains, and two summary measures of physical and mental health: the Physical Component Summary (PCS) and Mental Component Summary (MCS). A copy of this form will be provided as needed.

Reasons/rationale for selecting the outcome measure:

Lack of access to specialty Physical and Occupational Therapy services results in decreased quality of life. Earlier intervention and improved access for acute neuro and musculoskeletal deficiencies result in less impairment, improved quality of life, and ultimately decreased health care costs. The SF-36 will allow therapists to track patients' self-reported perceived quality of life to help manage treatment programs and produce improved health outcomes.

This outcome measure was selected because it is able to be used on individuals from a wide range of age groups and treatment groups with a variety of diseases and conditions. In addition, this outcome measure is available in over 140 translations. This tool is evidence based and validated for a wide range of diagnostic groups that are routinely seen in outpatient services.

Relationship to other Projects and Other Performing Providers Projects in the RHP:

This project will work in conjunction with Harris Health System Casa de Amigos Same Day Access Clinic and Southwest Area Same Day Access Clinic. This project will support the expansion of primary care physician services projects by accommodating the likely rise in referrals to specialty Physical and Occupational therapy services in the increase in staffing levels.

The increased access to primary care visits will naturally generate additional need of specialty care visits based on the condition and acuity of the patients served. Understanding that the patient base targeted through this initiative will generate significant specialty care visits due to chronic conditions and lack of previous treatments, this initiative and similar initiatives will focus to 30-day readmission rate reductions, improvement for patient satisfaction scores, and admission rates specific to chronic conditions. Numerous initiatives have been included in the RHP plan and the addendum of the Initiative Grid can directly tie all specialty care projects together by category.

Plan for Learning Collaborative:

We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system.

Project Valuation:

This project will increase the capacity to provide outpatient physical and occupational therapy services to the underserved areas of Harris County, primarily low-income, uninsured and Medicaid populations. The expanded Outpatient Physical Therapy and Occupational Therapy (PT and OT) services will be targeted to populations who are at risk for impairments in activities of daily living resulting from a lack of access to specialty care. The project will improve access by providing an additional 23 PT and OT providers to the Rehabilitation Services department and by adding additional outpatient therapy treatment space near the referring clinics, facilitating an increase in the number of patients seen per month by specialty Physical and Occupational Therapy services of 1,320 patients. The project will result in improved quality of life by persons served, measured by a standard health survey.

133355104.1.13	*1.9.2*	*1.9.2 A)-D)*	*IMPROVE ACCESS TO SPECIALTY CARE: INCREASE ACCESS TO OUTPATIENT PHYSICAL AND OCCUPATIONAL THERAPY SPECIALTY SERVICES*
Harris Health System			*133355104*
Related Category 3 Outcome Measure(s):	*133355104.3.18*	*IT- 10.1*	*Quality of Life*

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1 [P-X]: To Hire personnel to support and manage the project. Metric 1 [P-X.2]: Documentation of hired personnel. Baseline: 0 program operations managers hired for the project Goal: Hire 1 program operations manager. Data Source: human resources reports Milestone 1 Estimated Incentive Payment*:* $1,752,311 **Milestone 2** [P-X2]: Project planning-engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Metric 1 [P-X2.1]: Planning documentation Goal: Produce a comprehensive implementation plan for onboarding additional FTE's Data Source: project plan Milestone 2 Estimated Incentive Payment*:* $1,752,311	**Milestone 3** [I-22]: Increase the number of specialist providers for the high impact/most impacted medical specialties Metric 1 [I-22.1] Increase number of specialist providers Baseline: 30.5 FTEs in DY2 Goal: Hire 4 specialists (2 Physical Therapists, 1 Physical Therapist Assistant, and 1 Occupational Therapists) Data Source: human resources reports Milestone 3 Estimated Incentive Payment*:* $1,312,606 **Milestone 4** [P-2]: Train care providers and staff on processes, guidelines and technology for referrals and consultations into selected medical specialties. Metric 1 [P-2.1] Training of staff and providers working in specialty care and medical specialty clinics Baseline: 0 providers trained Goal: Train all specialty providers Data Source: Training curriculum and materials and Documentation of training attendance	**Milestone 6** [I-22]: Increase the number of specialist providers for the high impact/most impacted medical specialties Metric 1 [I-22.1]: Increase number of specialist providers Baseline: 34.5 FTEs in DY3 Goal: Hire 7 specialists (4 Physical Therapists, 1 Physical Therapist Assistant, and 2 Occupational Therapists) Data Source: human resources reports Milestone 6 Estimated Incentive Payment: $1,314,716 **Milestone 7** [I-23]: Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services Metric 1 [I-23.1]: Documentation of increased number of unique patients. Demonstrate improvement over prior reporting period (baseline for DY3). Baseline: 1260 Goal: 440 additional new patients seen per month. Data Source: EHR Milestone 7 Estimated Incentive	**Milestone 9** [I-22]: Increase the number of specialist providers for the high impact/most impacted medical specialties Metric 1 [I-22.1]: Increase number of specialist providers Baseline: 41.5FTEs Goal: Hire 10 specialists (6 Physical Therapists, 1 Physical Therapist Assistant, and 3 Occupational Therapists) Data Source: human resources reports Milestone 9 Estimated Incentive Payment*:* $814,462 **Milestone 10** [I-23]: Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services Metric 1 [I-23.1]: Documentation of increased number of unique patients. Demonstrate improvement over prior reporting period (baseline for DY4). Baseline: 1700 Goal: 660 additional new patients seen per month. Data Source: EHR Milestone 10 Estimated Incentive

133355104.1.13	***1.9.2***	***1.9.2 A)-D)***	***IMPROVE ACCESS TO SPECIALTY CARE: INCREASE ACCESS TO OUTPATIENT PHYSICAL AND OCCUPATIONAL THERAPY SPECIALTY SERVICES***
Harris Health System			*133355104*
Related Category 3 Outcome Measure(s):	*133355104.3.18*	*IT- 10.1*	*Quality of Life*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	Milestone 4 Estimated Incentive Payment*:* $1,312,607 **Milestone 5** [I-23]: Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services Metric 1 [I-23.2]: Documentation of increased number of unique patients. Demonstrate improvement over prior reporting period (baseline for DY2). Baseline: 1040 patients seen per month Goal: 220 additional new patients seen per month. Data Source: EHR Milestone 5 Estimated Incentive Payment*:* $1,312,606	Payment*:* $1,314,716 **Milestone 8** [P-X]: To Hire personnel to support and manage the project. Metric 1 [P-X.1]: Documentation of hired personnel. Baseline: 1 program operations manager hired in DY2 Goal: Hire 1 wellness program operations manager. Data Source: human resources reports Milestone 8 Estimated Incentive Payment*:* $1,314,717	Payment*:* $814,462 **Milestone 11** [I-X]: To improve wellness interventions and education integrated in care Metric1 [I-X.1]: Documentation of wellness intervention or education completed. Goal: To have documented wellness intervention or education completed >50% of patients Data source: EHR Milestone 11 Estimated Incentive Payment*:* $814,461 **Milestone 12** [P-1]: Conduct a new gap assessment based on the community need. Metric 1 [P-1.1] Documentation of gap assessment Goal: Improve access based on referral data and make changes to clinic model as indicated by new gap assessment. Data source: complete needs assessment report Milestone 12 Estimated Incentive Payment*:* $814,462

133355104.1.13	***1.9.2***	***1.9.2 A)-D)***	***IMPROVE ACCESS TO SPECIALTY CARE: INCREASE ACCESS TO OUTPATIENT PHYSICAL AND OCCUPATIONAL THERAPY SPECIALTY SERVICES***
Harris Health System			*133355104*
Related Category 3 Outcome Measure(s):	*133355104.3.18*	*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)**
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $3,504,622	Year 3 Estimated Milestone Bundle Amount: $3,937,819	Year 4 Estimated Milestone Bundle Amount: $3,944,149	Year 5 Estimated Milestone Bundle Amount: $3,257,847
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:** $14,644,436			

Project Option 1.1.1- Establish more primary care clinics: Casa de Amigos Same Day Access Clinic

Unique RHP Project ID: 133355104.1.14 / Pass 2

Performing Provider Name/TPI: Harris Health System / 133355104

Project Summary:

Provider:

Harris Health System is comprised of 16 community health centers, seven school-based clinics, a dental center, dialysis center, five mobile health units, one outpatient specialty services clinic, and three hospitals. With a tax base of $511.6 million, Harris Health System was able to provide more than $1.254 billion in charity care during FY 2012.

Volume Statistics - FY2012	Patient Payor Mix	Patient Demographics
Hospital admissions- 35,343 Births (babies delivered)- 6,643 Emergency visits- 173,263 Outpatient clinic visits- 1,054,770	Self-Pay- 62.6% Medicaid and CHIP- 23.4% Medicare- 8.6% Other Funding- 3.6% Commercial Insurance- 1.8%	Hispanic- 57.4% African American- 26.3% Caucasian- 9.2% Asian- 4.8% Other- 2.2% American Indian- 0.2%

Intervention(s):

This project will expand the capacity of primary care by establishing an adult-focused primary care clinic near the current Casa de Amigos Health Center that offers same day visits during extended hours to meet demand that saturated existing Harris Health System health centers cannot meet.

Need for the project:

Currently, Harris Health System health centers are designated NCQA Primary Care Medical Homes with increasingly limited capacity. Health center providers are currently 95% empaneled. For the Casa de Amigos health center, there were 107 unduplicated patients for which there were no Family Practice appointments available in the month of September 2012 alone.

Target Population:

Any patient seeking primary care within the system may benefit from this project (Medicaid and CHIP-23.4% / Self-Pay- 62.6%).

Category 1 or 2 expected patient benefits:

Our goals are to increase completed visits at same day access clinic by 3% over baseline in DY4 and 5% in DY5. The project seeks to increase completed visits for same day access by 31,000 visits by DY5 over the baseline established in DY3.

Category 3 outcomes:

IT-6.1: Our goal is to increase “Ease of scheduling appointments” score by 1% above baseline in DY4 and 2% in DY5.

Project Option 1.1.1- Establish more primary care clinics: Casa de Amigos Same Day Access Clinic

Unique RHP Project ID: 133355104.1.14 / Pass 2

Performing Provider Name/TPI: Harris Health System / 133355104

Project Description:

Harris Health System proposes to expand the capacity of primary care by establishing adult-focused primary care clinics that offer same day visits during extended hours to meet demand that saturated existing Harris Health System health centers cannot meet. Same day access clinics will better accommodate the needs of the community by allowing them to receive the right care, at the right time, in the right setting.

A same day access clinic will ideally be located in or around the following zip code to meet the adult primary care demand surrounding the Casa de Amigos Health Center (Casa): 77009. The clinic will be approximately 3,000-4,000 square feet of leased space. The Facilities and Planning department at the Harris Health System has confirmed that such lease space is available in or around the target zip code. Harris Health System plans to add new providers and staff to operate the clinic for extended evening hours and weekend hours, in addition to regular weekday hours, based on demand. Point of Care lab testing will be available. If patients are in need of imaging or pharmacy services, they will be referred to the nearest health center that provides those services.

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

The goals of this project are to:

- Increase capacity for same day primary care through establishment of more accessible care locations across Harris County
- Increase access to same day primary care during extended hours and weekends

Expanding the capacity of primary care through additional clinics across the county and extended operating hours to better accommodate the needs of the community will allow patients to receive the right care at the right time in the right setting.

This project meets the following Region 3 goals:

- Increase access to primary and specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their condition, regardless of where they live or their ability to pay.

The Casa de Amigos same day access clinic will increase access to primary care in a high-demand area of underserved individuals while ensuring that patients have access to care in the

appropriate setting. Harris County residents will be treated, and care discounted, according to Harris Health's sliding fee scale, with determination of eligibility for financial assistance.

Challenges and how to address:

General primary care capacity has been a challenge for the Harris Health System. The same day access clinic will provide same day access for Medical Home and non-Medical Home patients. A significant challenge for the Harris Health System has been adequate capacity to offer Medical Homes for patients who do not have a primary care provider. As patients are seen in the same day access clinic setting, this will continue to be a problem for those patients who need care for chronic conditions or other specialized care. In addition, meeting the demand for intensive behavioral health care needs that will present at same day clinics will prove to be a challenge. To address these challenges we propose to direct patients with chronic conditions into the Medical Home setting at a Harris Health System health center or refer to a primary care setting at a local FQHC. Patients with behavioral health needs will be referred to behavioral health providers.

5-Year Expected Outcome for Provider and Patients:

Over the course of the 5-Year Waiver, Harris Health System expects to realize:

- Increased adult-focused primary care capacity through same day care clinics for primary care treatable conditions

Starting Point/Baseline:

For performance purposes, the baseline will be set at 0 visits since this is a new clinic that currently is not operational.

Rationale:

Reasons for selecting the project option:

Currently, Harris Health System health centers are designated NCQA Primary Care Medical Homes with increasingly limited capacity. Health center providers are currently 95% empaneled. Moreover, physicians in Harris Health System health centers carry a panel of 2,250 patients, which is higher than the industry standard of approximately 1,500 patients. Full panels lead to decreased access to primary care appointments at health centers. These health centers are approaching maximum capacity for empaneled patients. From March 2012-September 2012, the Harris Health System Patient Appointment Center was unable to schedule 68,247 unduplicated patients for primary care. For the Casa de Amigos Health Center, there were 107 unduplicated patients for which there were no Family Practice appointments available in the month of September 2012 alone. Casa de Amigos received 49 Ask My Nurse in-basket messages per month for patients that needed same day appointments that could not be scheduled by the Patient Appointment Center. These numbers, however, do not capture the full volume of unmet demand

due to the fact that some calls were dropped as patients were placed on hold and some patients who needed care did not attempt to obtain an appointment based on previous difficulties obtaining same day appointments. Based on 2012 data of incoming patient calls to the Patient Appointment Center, 4627 unduplicated patients living near Casa de Amigos Health Center were unable to get an appointment.

The addition of same day access clinics will result in increased access to same day care for primary care treatable conditions, a more cost effective and appropriate setting than emergency centers and a more accessible setting than saturated Medical Home health centers.

Project Components:

Not Applicable / The project option 1.1.1 do not have components

Milestones & Metrics:

- Process Milestones and Metrics- P-1 (P-1.1); P-5 (P-5.1); P-X (P-X.1); P-X2 (P-X2.1)
- Improvement Milestones and Metrics- I-12 (I-12.1)

Unique community need identification number the project addresses:

This project addresses the following community needs according to the community needs assessment:

- CN.1- Inadequate access to primary care
- CN.8- High rates of inappropriate emergency department utilization
- CN.2- Inadequate access to specialty care

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

Currently, Harris Health System does not guarantee same day care for patients who are not enrolled in a Medical Home and empaneled to a primary care physician. Thus, the same day access clinic will be a new initiative for Harris Health by providing access to same day visits regardless of Medical Home enrollment. Moreover, current health centers offer an array of ancillary services, including full service outpatient pharmacies and laboratories, in addition to various specialty and radiology services. The same day access clinic will offer limited laboratory services and will not offer radiology or pharmacy services but will refer patients to other facilities for these services as needed.

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

OD-6 Patient Satisfaction

- IT-6.1- Percent improvement over baseline of patient satisfaction scores (standalone)
  - (1) are getting timely care, appointments, and information

Reasons/rationale for selecting the outcome measure(s):

IT- 6.1 will measure improvement in satisfaction scores over time relating to timeliness of care at the Casa de Amigos (Casa) same day access clinic, specifically measuring the mean score for the Press Ganey survey question- "Ease of scheduling appointments." The same day access clinic will increase capacity for primary care visits within the Harris Health System, which will enhance access and improve the patient's experience in obtaining services. Patient satisfaction scores have been historically poor for health centers regarding timely access to care. The same day access clinic will offer an efficient venue that offers same day visits, affording patients the opportunity to seek care in a high-satisfaction setting that is appropriate for the level of care they need and more cost effective than other alternatives.

Relationship to other Projects and Other Performing Providers' Projects in the RHP: Primary Care/Ambulatory Care clinics are a top priority to Region 3 due to the acuity of the regional patient mix, population concentration, and lack of primary care access points for our patient base. The regional approach of collaboration as well as existing patient referral pattern relationships allowed our team to properly identify the community needs based on the necessity of population, uninsured, and medically underserved patient bases. This program is consistent with our region and similar to numerous initiatives in our RHP plan sharing both concepts as well as outcome measures focused to percent improvement over baseline of patient satisfaction scores, reduction of inappropriate ED utilization, and third next available appointment status. The Region 3 Initiative Grid attached as a RHP Plan addendum reflects a grid of relationship for all initiatives.

Plan for Learning Collaborative: We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system.

Project Valuation: This project addresses one of the main objectives of the 1115 Waiver; increasing access to primary care for the underserved population in this area of Harris County. The value of the project is based on the clinic's capacity to provide primary care services, including laboratory point-of-care testing, along with timely referrals for specialty care, imaging and other needed services within the Harris Health System network. The clinic can ultimately care for the episodic primary care needs of over ten thousand patients annually, and refer new patients with chronic disease management needs to one of the NCQA certified medical home clinics that are operated by Harris Health. In addition, the availability of same day primary care appointments will result in fewer emergency room visits for public and private hospitals located in the service area. Early detection, treatment and education regarding wellness and prevention will also help to prevent future downstream inpatient admissions.

133355104.1.14	*1.1.1*	*N/A*	***Expand Primary Care Capacity- Casa de Amigos Same Day Access Clinic***
Harris Health System			*133355104*
Related Category 3 Outcome Measure(s):	*133355104.3.19*	*IT-6.1*	*Percent improvement over baseline of patient satisfaction scores*

Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Milestone 1 [P-X]: Project planning **-** engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Metric 1 [P-X.1]: Planning documentation Goal: Produce a comprehensive implementation plan for the establishment of same day access clinic Data Source: Project plan Milestone 1 Estimated Incentive Payment *(maximum amount):* $6,996,473	**Milestone 2** [P-1]: Establish additional primary care clinics Metric 1 [P-1.1]: Number of additional clinics or expanded hours or space Baseline: 0 same day access clinics in target area in DY2 Goal: Establish one same day access clinic Data Source: New primary care schedule Milestone 2 Estimated Incentive Payment *(maximum amount):* $2,582,414 **Milestone 3** [P-5]: Hire additional primary care providers and staff Metric 1 [P-5.1]: Documentation of increased number of providers and	**Milestone 5** [I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 [I-12.1]: Documentation of increased number of visits. Baseline: Established in DY3 Goal: Increase completed visits at same day access clinic by 3% over baseline Data Source: EHR Milestone 5 Estimated Incentive Payment *(maximum amount):* $7,764,645	**Milestone 6** [I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 [I-12.1]: Documentation of increased number of visits. Baseline: Established in DY3 Goal: Increase completed visits at same day access clinic by 5% over baseline Data Source: EHR Milestone 6 Estimated Incentive Payment *(maximum amount):* $6,413,909

133355104.1.14	***1.1.1***	***N/A***	***EXPAND PRIMARY CARE CAPACITY- CASA DE AMIGOS SAME DAY ACCESS CLINIC***	
Harris Health System				*133355104*
Related Category 3 Outcome Measure(s):	*133355104.3.19*	*IT-6.1*	*Percent improvement over baseline of patient satisfaction scores*	

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
	staff. Baseline: 0 providers and staff hired in DY2 Goal: Hire providers and support staff Data Source: Contract documentation Milestone 3 Estimated Incentive Payment *(maximum amount):* $2,582,414 **Milestone 4** [P-X2]: Establish baseline number of completed visits at same day access clinic Metric 1 [P-X2.1]: Documentation of completed visits at same day access clinic Baseline: 0 completed visits in DY2 Goal: Document completed visits (6 months) to create baseline		

133355104.1.14	***1.1.1***	***N/A***	***EXPAND PRIMARY CARE CAPACITY- CASA DE AMIGOS SAME DAY ACCESS CLINIC***
Harris Health System			*133355104*
Related Category 3 Outcome Measure(s):	*133355104.3.19*	*IT-6.1*	*Percent improvement over baseline of patient satisfaction scores*

Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
	Data Source: EHR Milestone 4 Estimated Incentive Payment *(maximum amount):* $2,582,415		
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $6,996,473	Year 3 Estimated Milestone Bundle Amount: $7,747,243	Year 4 Estimated Milestone Bundle Amount: $7,764,645	Year 5 Estimated Milestone Bundle Amount: $6,413,909
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:** $28,922,270			

Project Option 1.8.6 - The expansion of existing dental clinics, the establishment of additional dental clinics, or the expansion of dental clinic hours: Increase, Expand, and Enhance Oral Health Services: Expansion of Adult Dental Services

Unique RHP Project ID: 133355104.1.15 / Pass 2
Performing Provider Name/TPI: Harris Health System/133355104

Project Summary:

Provider:
Harris Health System is comprised of 16 community health centers, seven school-based clinics, a dental center, dialysis center, five mobile health units, one outpatient specialty services clinic, and three hospitals. With a tax base of $511.6 million, Harris Health System was able to provide more than $1.254 billion in charity care during FY 2012.

Volume Statistics - FY2012	Patient Payor Mix	Patient Demographics
Hospital admissions- 35,343 Births (babies delivered)- 6,643 Emergency visits- 173,263 Outpatient clinic visits- 1,054,770	Self-Pay- 62.6% Medicaid and CHIP- 23.4% Medicare- 8.6% Other Funding- 3.6% Commercial Insurance- 1.8%	Hispanic- 57.4% African American- 26.3% Caucasian- 9.2% Asian- 4.8% Other- 2.2% American Indian- 0.2%

Intervention(s):
This project will expand adult dental services by establishing additional sites and expanding services at current sites. Services will be added or expanded at 7 health centers.

Need for the project:
Health System offers adult dental services at 8 community health centers. A stand-alone dental center provides urgent care, oral surgery, and dentures. However, current access is not sufficient. Bad oral health care increases the risk of heart disease, diabetes and stroke.

Target Population:
Any adult patient within the system who seeks dental care may benefit from this project (Medicaid and CHIP-23.4% / Self-Pay- 62.6%).

Category 1 or 2 expected patient benefits:
Our goals are to increase completed visits at new dental clinics by 20% above baseline in DY4 and 40% in DY5. We estimate an additional 25,000 dental visits by DY5.

Category 3 outcomes:
IT-7.8: Our goal is to increase the percentage of patients with diabetes accessing dental services following referral by their medical provider. We will increase by 5% over baseline in DY4 and 7% in DY5.

Project Option 1.8.6 - The expansion of existing dental clinics, the establishment of additional dental clinics, or the expansion of dental clinic hours: Increase, Expand, and Enhance Oral Health Services: Expansion of Adult Dental Services

Unique RHP Project ID: 133355104.1.15 / Pass 2
Performing Provider Name/TPI: Harris Health System/133355104

Project Description:
Harris Health System proposes to expand adult dental services by establishing additional sites and expanding services at current sites.

Dental services will be added or expanded at 7 health centers. Currently the Harris Health System offers adult dental services at 8 community health centers. A stand-alone dental center provides urgent care, oral surgery, and dentures. We are one of the few public health systems in the nation that offers oral health services to its patient population.

Harris Health System proposes to establish additional adult-focused primary care centers to meet the demand that saturated existing Harris Health System health centers cannot meet. Current and new sites will be assessed for dental services to include 1 FTE dentist and 1 FTE dental assistant.

Goals:
Project Goals:
- Establish and expand adult oral health services at 7 health centers.
- Increase number of adults receiving oral health services.

Regional goals addressed with project:
- Increase access to primary and specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their condition, regardless of where they live or their ability to pay.
    - Vulnerable and underserved populations face numerous barriers to accessing oral health care. Access to oral care is critical for overall health for all stages of life. The impact of untreated oral health has been linked to diabetes, heart disease, and stroke. Additionally, poor oral health can affect appearance, self-esteem, and one's ability to chew and digest food properly. This proposal will focus on areas of low-income families who may otherwise not have adequate access to oral health care.

Challenges:
- Harris Health System currently has a waitlist for adult oral health services.
- Our current facilities have space restrictions to expand oral health services.

5-year expected outcome for Performing Provider and patients:
By addressing the challenges for Harris Health System as performing provider, we expect to achieve the overarching goal of increasing access to oral health services in the underserved areas of Harris County.

Starting Point/Baseline:
In FY12 Harris Health System provided 67,144 oral health care visits.. To date for fiscal year 2013, we have provided 38,606 visits. From January 2012-September 2012, the Harris Health System Patient Appointment Center was unable to schedule 30,632 unduplicated patients for oral health care. However, these numbers do not capture the full volume of unmet demand due to the fact that some calls were dropped as patients were placed on hold and some patients who needed care did not attempt to obtain an appointment based on previous difficulties obtaining same day appointments.

Based on historical data, the baseline will be 10 patients per day per provider. By DY5, we plan to reach our goal of 14 patients per day per provider.

Rationale:

There are significant disparities in oral health care between some population groups, including, but not limited to, the uninsured, children, minorities, publically insured, elderly, and low income individuals. Improving access to these vulnerable populations is the first step in reducing disparities and improving oral health care.

Adequate oral health services are a vital and basic component for overall health. Health risks from lack of good dental care reach further than just cavities and gum disease. Bad oral health care increases the risk of heart disease, diabetes and stroke. By adding and expanding dental services to seven sites, we will be increasing access to oral health services for the underserved in Harris County, and thereby helping to reduce disparities.

Project Components:
This project option does not have required project components.

Milestones & Metrics:
Harris Health System has chosen project option 1.8.6: The expansion of existing dental clinics, the establishment of additional dental clinics, or the expansion of dental clinic hours to best fit the scope and goal of this project.

- Process Milestones and Metrics: P-4, P-4.1; P-X1, P-X1.1; P-X2 , P-X2.1; P-X3, P-X3.1
- Improvement Milestones and Metrics: I-X1, I-X1.1

Unique Community Need Identification Numbers:

- CN.1: Inadequate access to primary care
- CN.4: Inadequate access to dental care
- CN.11: High rates of chronic disease and inadequate access to treatment programs and services for illnesses associated with chronic disease, including: Cancer, Diabetes, Obesity, Cardiovascular disease, Asthma, AIDS/HIV

The scope and goals of this project specifically address three of the identified community needs from the regional needs assessment. The project focuses on CN.1, CN.4, and CN.11 by increasing access to oral health services. This aligns with CN.11 by addressing the importance of adequate access for our patients with chronic diseases.

How the project represents a new initiative for Performing Provider or significantly enhances an existing delivery system reform initiative:
There is limited access for oral health, particularly for the low-income, uninsured, and Medicaid populations. Oral health is vital in disease prevention. This project will allow Harris Health System to increase access to the underserved populations through additional facilities. Treating

cavities and other oral health problems has potential cost savings by preventing other chronic diseases.

Related Category 3 Outcome Measure(s):

OD-7 Oral Health

Improvement Target(s):

- IT-7.8 Chronic Disease Patients Accessing Dental Services
  Harris Health System plans to increase oral health access of our adult patients with diabetes following a referral from their provider. We will begin to measure and report in DY4.

Reasons/rationale for selecting the outcome measure(s):

We chose to measure the percentage of patients with diabetes who access our dental services following a referral. It is especially important that diabetic patients receive appropriate oral health services, as high blood sugar has been linked to tooth decay and gum disease.

Relationship to other Projects and Other Performing Providers' Projects in the RHP:

Dental services for both adult and children is a service that is currently underfunded and incomplete in access for the targeted patient base. The dental initiatives represented in the RHP plan are specific to community need and location of the patient to ensure strong access to treatment. The outcome measures focus to the reduction of emergency room utilization, patient satisfaction, as well as increase access to the service line. The Region 3 initiative grid in the addendum directly reflects all relationships of dental initiatives.

Plan for Learning Collaborative:

As performing provider, Harris Health System plans to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system.

Project Valuation:

There is limited access for oral health, particularly for the low-income, uninsured, and Medicaid populations. Oral health is vital in disease prevention. Bad oral health care increases the risk of heart disease, diabetes and stroke. By adding and expanding dental services to seven sites, we will be increasing access to oral health services for the underserved in Harris County, and thereby helping to reduce disparities. The expanded services in Harris Health clinics can ultimately address the routine dental care needs of over ten thousand patients, or 25,000 additional visits, annually. Treating cavities and other oral health problems will assist in providing healthcare cost savings by preventing or mitigating the effects of other chronic diseases, with a specific focus on the diabetic population.

133355104.1.15	*1.8.6*	*N/A*	**Increase, Expand, and Enhance Oral Health Services: Expansion of Adult Dental Services**
Harris Health System			*133355104*
Related Category 3 Outcome Measure(s):	*133355104.3.20*	*IT-7.8*	*IT-7.8 Chronic Disease Patients Accessing Dental Services*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-X1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Metric 1 [P-X1.1]: Planning documentation Goal: Produce a comprehensive implementation plan for the establishment and expansion of dental clinics. Data Source: Project plan Milestone 1 Estimated Incentive Payment *(maximum amount):* $6,365,521	**Milestone 2** [P-4]: Establish and expand additional dental care clinics. Metric 1 [P-4.1]: Number of additional clinics or expanded hours or space Baseline: Dental services at 8 sites Goal: Establish and expand dental services in 6 additional health centers and 1 existing health center Data Source: New dental schedule Milestone 2 Estimated Incentive Payment *(maximum amount):* $2,353,005 **Milestone 3** [P-X2]: Hire additional dental staff Metric 1 [P-X2.2]: Documentation of increased number of dental staff Baseline: 19 FTE Dentist and 50 FTE Dental Assistants Goal: Hire 7 additional FTE Dentists and 7 additional FTE Dental Assistants Data Source: Contract documentation Milestone 3 Estimated Incentive Payment *(maximum amount):* $2,353,005	**Milestone 5** [I-X]: Increase number of adult patients who access Harris Health oral health services. Metric 1 [I-X.1]: Increase the number of adults accessing oral health services. Goal: Increase completed visits at new dental clinics by 20% above baseline Data Source: EHR Milestone 5 Estimated Incentive Payment *(maximum amount):* $7,074,419	**Milestone 6** [I-X]: Increase number of adult patients who access Harris Health oral health services. Metric 1 [I-X.1]: Increase the number of adults accessing oral health services. Goal: Increase completed visits at new dental clinics by 40% above baseline Data Source: EHR Milestone 6 Estimated Incentive Payment *(maximum amount):* $5,843,722

133355104.1.15	***1.8.6***	***N/A***	**Increase, Expand, and Enhance Oral Health Services: Expansion of Adult Dental Services**	
Harris Health System				*133355104*
Related Category 3 Outcome Measure(s):	*133355104.3.20*	*IT-7.8*	*IT-7.8 Chronic Disease Patients Accessing Dental Services*	

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	Milestone 4 [P-X3]: Establish baseline number of completed visits Metric 1 [P-X3.1]: Documentation of completed visits Baseline: To be established at new sites Goal: 10 visits per provider per day Data Source: EHR Milestone 4 Estimated Incentive Payment *(maximum amount):* $2,353,006		
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $6,365,521	Year 3 Estimated Milestone Bundle Amount: $7,059,016	Year 4 Estimated Milestone Bundle Amount: $7,074,419	Year 5 Estimated Milestone Bundle Amount: $5,843,722
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)**:*** $26,342,678			

Harris County Hospital District Ben Taub General Hospital

Pass 3

Project Option-1.1.4 “Other”: Implement other evidence-based project to expand primary care capacity: House Calls Program

Unique RHP Project Identification Number: 133355104.1.16/ Pass 3
Performing Provider Name/TPI: Harris Health System / 133355104

Project Summary:

Provider:
Harris Health System is comprised of 16 community health centers, seven school-based clinics, a dental center, dialysis center, five mobile health units, one outpatient specialty services clinic, and three hospitals. With a tax base of $511.6 million, Harris Health System was able to provide more than $1.254 billion in charity care during FY 2012.

Volume Statistics - FY2012	Patient Payor Mix	Patient Demographics
Hospital admissions- 35,343 Births (babies delivered)- 6,643 Emergency visits- 173,263 Outpatient clinic visits- 1,054,770	Self-Pay- 62.6% Medicaid and CHIP- 23.4% Medicare- 8.6% Other Funding- 3.6% Commercial Insurance- 1.8%	Hispanic- 57.4% African American- 26.3% Caucasian- 9.2% Asian- 4.8% Other- 2.2% American Indian- 0.2%

Intervention(s):
This project will expand the House Calls Program in order to improve access, maximize independence, and realize cost savings by providing comprehensive, coordinated, multidisciplinary primary care at home to a population of patients that are homebound or have difficulties getting to clinic visits.

Need for the project:
Many Texans with multiple chronic illnesses are housebound, too ill or disabled to easily visit their physician’s office. Instead, they go to the Emergency Center (EC) or hospital, often by ambulance ($600/ Round Trip), for routine care.

Target Population:
The target population for these goals includes any patient who is homebound or has extreme difficulties getting to clinic visits due to their health status. (Medicaid and CHIP-23.4% / Self-Pay- 62.6%).

Category 1 or 2 expected patient benefits:
Our goal is to increase number of homebound patients seen to a total of 1850 patients in DY5.

Category 3 outcomes:
IT-6.1: Our goal is to increase “Patients are getting timely care, appointments, and information” score by 5% above baseline in DY3, 10% in DY4, and 15% in DY5.

Project Option-1.1.4 "Other": Implement other evidence-based project to expand primary care capacity: House Calls Program

Unique RHP Project Identification Number: / Pass 3
Performing Provider Name/TPI: Harris Health System / 133355104

Project Description:
Harris Health System proposes to expand the House Calls Program in order to improve access, maximize independence, and realize cost savings by providing comprehensive, coordinated, multidisciplinary primary care at home to a population of patients that are homebound or have difficulties getting to clinic visits. Many Texans with multiple chronic illnesses (heart disease, strokes, dementia) are housebound, too ill or disabled to easily visit their physician's office for needed care. Instead, they go to the Emergency Center (EC) or hospital, often by ambulance ($600/ Round Trip), for routine care. These patients make up a small percentage of the patient population, but the cost to treat them is disproportionately high. House calls are our proposed solution to help these high-cost, debilitated, home-limited patients get access to care. In Harris Health, the average EC visit cost is $832, so avoiding one EC visit provides a huge cost savings. Savings are even greater for avoided hospitalizations ($12,000/admission). Most importantly, the continuity and quality of care and patient and family satisfaction is markedly increased with house calls. Harris County, the population served by Harris Health System, will be divided into quadrants and established teams distributed through these quadrants to provide home care. Homebound patient's access to care requires ambulance transport and often the EC is used for primary care. We will use house calls to increase access to primary care throughout Harris County by removing obstacles to it and bring primary care to the patient. The geographical challenges of the region will be addressed by a logistics approach using regional cohorting, and the house calls model will create patient-centered, coordinated primary care delivery that improves patient satisfaction and health outcomes, reduces unnecessary services, and builds on the accomplishments of our existing health care system. Care coordination services, across all treatment settings, will be furnished by a physician/nurse practitioner-directed team of health care professionals who are available 24/7 (typically by telephone) to carry out individualized plans of care[9].

We will grow our existing program (0.6 MD FTE and 0.9 NP FTE following 180 patients) to create four full multidisciplinary teams (each team 1.5 MD and 3 NP plus SW, Pharm, etc.); each will have a census of 500 patients, make 2,500 house calls per year, have an active call center to triage and treat to prevent unneeded EC visits and subsequent hospital admissions, and attain an estimable level of patient and caregiver satisfaction. We conservatively estimate from our current experience and the literature that this house calls team will prevent 1 EC visit per year per enrolled patient, 5 round trip non-emergent ambulance rides for routine care per patient per year, 0.3 hospitalizations per year per enrolled patient, and one emergent ambulance ride per patient per year. Even with these conservative estimates, the prevention of these expensive episodes gives significant value of the house calls program. The ultimate impact will be 10,000-12,000 fewer ambulance rides, 2000 fewer EC visits, 670 fewer admissions which adds up to $17 million in cost avoidance and over $10 million in realized savings.

There will also be a significant training mission to fulfill unmet needs. Two thirds of physicians treating patients with multiple chronic conditions believe that their training did not adequately prepare them to coordinate in-home and community health services. Even fewer have

significant experience performing house calls; many have never performed a single house call[15]. While these comments are applicable to physicians (and trainees), they are also broadly applicable to pharmacists, nurse practitioners and all the other members of the health care team managing these complicated house call patients[15]. We will address this issue with technology and training. Active learners will include trainees at Baylor College of Medicine as well as Geriatrics fellows in the Baylor Geriatrics fellowship program and pharmacy students at University of Houston School of Pharmacy (ongoing programs).

Patients will retain freedom of choice and the ability to opt out of the house calls program and enrollment in the program does not force them to forego any existing benefit. Improved technologies and innovation are revolutionizing house calls. We already use point-of-care devices to get blood tests at the bedside. Monitoring and more sophisticated assessment can be performed using various technologies in the patient's home[16], but that is not the focus of this proposal.

Goals and Relationship to Regional Goals:

Project Goals:

- Improve Access
- Maximize independence
- Realize cost savings

The target population for these goals is patients who are homebound or have extreme difficulties getting to clinic visits due to their health status. Right now their access to care requires ambulance transport and often the EC is used for primary care. We will use house calls to improve access to primary care by removing obstacles and bringing the primary care provider to the patient. We will increase independence by working to modify the home environment and realize cost savings by decreasing ambulance use, EC use, and hospitalizations.

This project meets the following regional goals:

- Develop a regional approach to health care delivery that leverages and improves on existing programs and infrastructure, is responsive to patient needs throughout the entire region, and improves health care outcomes and patient satisfaction.
- Increase access to primary and specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their condition, regardless of where they live or their ability to pay.
- Transform health care delivery from a disease-focused model of episodic care to a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary or duplicative services, and builds on the accomplishments of our existing health care system

Challenges:

- Geography: The region we hope to serve is over 1,700 square miles. Without logistic support, the time spent driving from one visit to the next can be frustrating. We will utilize computer based models to optimize the scheduling of visits to minimize miles driven and time spent out of patient's homes.
- Insufficient physician training: Professional training in providing care in patient homes is almost non-existent. We will grow our learning relationships to involve medical students and residents (Baylor College of Medicine), pharmacy students (University of Houston),

and nursing students (University of St. Thomas). We will also augment the experiences of our Geriatric fellows to train them to be our next wave of providers.

- Personal safety concerns: Going alone to some of the homes can be harrowing. We plan to diminish risk by having more than one clinician go to the sites.

5-Year Expected Outcome for Provider and Patients:

Our present house calls team is very modest, delivering care to 180 housebound patients. At the end of this proposal, the four interdisciplinary teams including physicians, nurse practitioners, social workers, pharmacists, therapists, and integrated call center and support team will be managing close 2,000 patients in their homes and making 10,000 house calls in the year. The expected impact will be 10,000-12,000 fewer ambulance rides, 2,000 fewer EC visits, 670 fewer admissions, $17 million in cost avoidance and over $10 million in realized savings.

Starting Point/Baseline:

Harris Health System currently has an active house call team headquartered at Quentin Mease Hospital consisting of 2 part-time physicians (total 0.6 FTE) and 2 part-time nurse practitioners (total 0.9 FTE) that cares for 180 housebound patients for a total of 900 house calls in 12 months ending 12/11. Currently, there is capability to perform point of care laboratory studies with the newest technology, (ISTAT-1) and the team is consistently writing progress notes into electronic medical record (EPIC) using the internet.

Rationale:

It has been proven that house call based primary care for home-bound individuals works [1]. For example, the Virginia Commonwealth Medical Center house calls program reduced hospital costs by 60% [2]. Call Doctor Medical Group in San Diego reduced ER visits by 59%[1]. In New York, Mount Sinai Visiting Doctors reduced hospitalizations by 66% [3].

In addition to Home-based programs' potential to save on the most expensive patients, these programs decrease mortality of frail elderly[6] and prevent nursing home placement. House calls slow the progression of disability[7], improve medication management [8] and decrease medication- associated adverse events[9]. House calls identify new medical and safety problems before they cause clinical harm [10], decrease caregiver burden and enhance quality of life for patient and caregiver [9]. House calls improve end-of-life care for patients and have proven to increase physician satisfaction as well[9].

In 2003, the U.S. Department of Transportation reported [12] that, "More than 3.5 million people in this country never leave their homes." While 20% of those over 85 are housebound [13], by calculation almost 1% of those between 25 and 65 also do not leave their homes. Therefore, there is a huge potential population from which to target [14]. Because of our focus and mission, other priority patient populations will be targeted including frequent EC users, especially those using "911" transportation, and those referred from the inpatient units, at high risk for readmission after discharge [8]. Thus, a significant number of our new patient house calls will be "immediately" post-discharge visits[8].

Project Components:

This project option does not include any required core project components. However, we will increase our capacity to provide primary care to more individuals, by: a) adding additional primary care providers, b) adding social workers/case managers, c) adding a logistics expert, and

d) forming multidisciplinary care teams. Additionally, we will use performance improvement principles to modify the selection criteria to increase the efficacy of the house calls intervention. We will compare the resource utilization for the three months prior to enrollment in the house calls program to the months after the house calls begin to start to assess the effects of this effort on resource utilization.

Milestones and Metrics:

Process:

P-5 Milestone: Train/hire additional primary care providers and staff and/or increase the number of primary care clinics for existing providers
P-5.1 Metric: Documentation of increased number of providers and staff and/or clinic sites.
P-X1 Milestone: Establish care management protocols.
P-X1.1 Metric: Documentation of protocols.
P-X2 Milestone: Establish baseline of housebound patients.
P-X2.1 Metric: Establish new baseline from current patients seen
P-X3 Milestone: Establish central call center to provide logistic support to house calls team.
P-X3.1 Metric: Documentation of implementation.

Improvement:

I-X1 Recruit homebound patients to house calls program.
I-X1.1 Increase number of homebound patients seen
I-11 Milestone: Patient satisfaction with primary care services.
I-11.5 Metric: Patient satisfaction scores: Average reported patient satisfaction scores, specific ranges and items to be determined by assessment tool scores. Demonstrate improvement over prior reporting period.

Unique community need identification numbers the project addresses:

CN.1-Inadequate access to primary care; CN.6-Inadequate access to treatment and services designed for special needs populations, including disabled, homeless, children, elderly; CN.7-Insufficient access to care coordination practice management and integrated care treatment programs; CN.8-High rates of inappropriate emergency department utilization; CN.9-High rates of preventable hospital readmissions; CN.10-High rates of preventable hospital admissions; and CN.11-High rates of chronic disease and inadequate access to treatment programs and services for illnesses associated with chronic disease.

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

This project will significantly enhance an already successful program by increasing it size, reach and scope of patient. Our 180 patients are mostly elderly and live within Beltway 8, but there are unmet needs in all adult age groups throughout Harris County including rural areas. Additionally, the multidisciplinary team is critical to the best outcomes for the patients and that is less available for the present House Calls program. With the goal to ultimately provide 2,000 of the most challenging patients with improved care that will more closely meet their needs and at a reduced cost, this project will greatly enhance the care delivery in Harris County.

Related Category 3 Outcome Measures:

OD-6

IT-6.1(1) Percent improvement over baseline of patient satisfaction scores

Reasons/rationale for selecting the outcome measures: It would be no challenge to save money by reducing services, and therefore reducing satisfaction. Therefore, while saving money it is critical to assess satisfaction to insure that the patients are not "suffering" from these interventions. This is why the house calls program has chosen to measure patient satisfaction in Category 3.

Relationship to other projects and other performing providers' projects: A primary focus of the waiver as well as our region is ensuring appropriate emergency department utilization for our patient base. The lack of primary care, specialty care, and behavioral health treatment currently creates congestion in the emergency departments thus increasing cost and comprehensive treatment of patients with chronic conditions. The ED initiatives focus to outcomes of readmission rates, appropriate ED utilization, and patient satisfaction and all initiative relationships can be found on the Region 3 initiative grid in the addendum.

Plan for learning collaborative: As performing provider, Harris Health System plans to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system.

Project Valuation: This project will expand the House Calls Program in order to improve access, maximize independence, and realize cost savings by providing comprehensive, coordinated, multidisciplinary primary care at home to a population of patients that are homebound or have difficulties getting to clinic visits. The geographical challenges of the region will be addressed by a logistics approach using regional cohorting, and the house calls model will create patient-centered, coordinated primary care delivery that improves patient satisfaction and health outcomes, reduces unnecessary services, and builds on the accomplishments of our existing health care system. The present house calls team is very modest, delivering care to 180 housebound patients. By the end of the demonstration period, the four interdisciplinary teams including physicians, nurse practitioners, social workers, pharmacists, therapists, and integrated call center and support team are expecting to manage close 2,000 patients in their homes and make approximately 10,000 house calls in the year. The expected impact will be several thousand fewer ambulance rides, 2,000 fewer EC visits, 670 fewer admissions, resulting in millions of dollars in cost avoidance and realized savings.

133355104.1.16	*1.1.4*	*N/A*	*"OTHER": IMPLEMENT OTHER EVIDENCE-BASED PROJECT TO IMPLEMENT USE OF PALLIATIVE CARE PROGRAMS: PALLIATIVE HOUSE CALLS PROGRAM*	
Harris Health System				*133355104*
Related Category 3 Outcome Measure(s):	*133355104.3.21*	*IT-6.1(1)*	*Percent improvement over baseline of patient satisfaction scores*	

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-5]: Train/hire additional primary care providers and staff Metric 1 [P-5.1]: Documentation of increased number of providers and staff Baseline: Current team consisting of 0.6 MD FTEs and 0.9 NP FTEs Goal: Grow existing team to total of 1.5 MD FTEs and 3 NP FTEs Data Source: Hospital or other Performing Provider report, policy, contract or other documentation Milestone 1 Estimated Incentive Payment : $482,444 **Milestone 2** [P-X1]: Establish care management protocols. Metric 1 [P-X1.1] Documentation of protocols. Baseline: None presently used Goal: Establish care management protocols Data Source: Protocols book Milestone 2 Estimated Incentive Payment : $482,444	**Milestone 5** [P-5]: Train/hire additional primary care providers and staff Metric 1 [P-5.1]: Documentation of increased number of providers and staff Baseline: Currently one team consisting of 1.5 MD FTEs and 3 NP FTEs Goal: Establish one additional team consisting of 1.5 MD FTEs and 3 NP FTEs for a total of 2 teams (3 MD FTEs; 6 NP FTEs) Data Source: Hospital or other Performing Provider report, policy, contract or other documentation Milestone 5 Estimated Incentive Payment : $ 1,616,427 **Milestone 6** [I-X1]: Recruit homebound patients to house calls program. Metric 1[I-X1.1]: Increase number of homebound patients seen Goal: Census of 500 pts/team per established team (1) and 350 pts/team on new team for total of 850 patients in DY3 Data Source: Internal Rosters	**Milestone 7** [P-5]: Train/hire additional primary care providers and staff Metric 1 [P-5.1]: Documentation of increased number of providers and staff Baseline: Currently two teams consisting of 1.5 MD FTEs and 3 NP FTEs each Goal: Establish one additional team consisting of 1.5 MD FTEs and 3 NP FTEs for a total of 3 teams (4.5 MD FTEs; 9 NP FTEs) Data Source: Hospital or other Performing Provider report, policy, contract or other documentation Milestone 7 Estimated Incentive Payment : $1,656,901 **Milestone 8** [I-X1]: Recruit homebound patients to house calls program. Metric 1 [I-X1.1]:]: Increase number of homebound patients seen Goal: Census of 500 pts/team by year's end per established team (2) and 350 pts/team on new team for total of 1350 patients in DY4 Data Source: Internal Rosters	**Milestone 9** [P-5]: Train/hire additional primary care providers and staff Metric 1 [P-5.1]: Documentation of increased number of providers and staff Baseline: Currently two teams consisting of 1.5 MD FTEs and 3 NP FTEs each Goal: Establish one additional team consisting of 1.5 MD FTEs and 3 NP FTEs for a total of 4 teams (6 MD FTEs; 12 NP FTEs) Data Source: Hospital or other Performing Provider report, policy, contract or other documentation Milestone 9 Estimated Incentive Payment: $1,370,440 **Milestone 10** [I-X1]: Recruit homebound patients to house calls program. Metric 1 [I-X1.1]: Increase number of homebound patients seen Goal: Census of 500 pts/team by year's end per established team (3) and 350 pts/team on new team for total of 1850 patients in DY5 Milestone 10 Estimated Incentive

133355104.1.16	***1.1.4***	***N/A***	***"OTHER": IMPLEMENT OTHER EVIDENCE-BASED PROJECT TO IMPLEMENT USE OF PALLIATIVE CARE PROGRAMS: PALLIATIVE HOUSE CALLS PROGRAM***
Harris Health System			*133355104*
Related Category 3 Outcome Measure(s):	*133355104.3.21*	*IT-6.1(1)*	*Percent improvement over baseline of patient satisfaction scores*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 3 [P-X2]: Establish baseline of housebound patients. Metric 1 [P-X2.1] Establish new baseline from current patients seen Baseline: 180 pts enrolled with current team Goal: Census of 350 pts/team for 1 teams Data Source: Internal Rosters Milestone 3 Estimated Incentive Payment: $482,444 **Milestone 4** [P-X3]: Establish central call center to provide logistic support to house calls team. Metric 1 [P-X3.1]: Documentation of implementation. Goal: Establish central call center to provide logistic support to house calls team. Data source: Hiring records Milestone 4 Estimated Incentive Payment : $482,443	Milestone 6 Estimated Incentive Payment : $ 1,616,427	Milestone 8 Estimated Incentive Payment : $1,656,901	Payment : $1,370,441
Year 2 Estimated Milestone Bundle Amount: $1,929,775	Year 3 Estimated Milestone Bundle Amount: $3,232,854	Year 4 Estimated Milestone Bundle Amount: $3,313,802	Year 5 Estimated Milestone Bundle Amount: $2,740,881
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over DYs 2-5)****:*** $11,217,312			

Project Option 1.8.6- The expansion of existing dental clinics, the establishment of additional dental clinics, or the expansion of dental clinic hours: Expansion of Pediatric Dental Services

Unique ID #: 133355104.1.17/Pass 3
Performing Provider/TPI: Harris Health System/133355104

Project Summary:
Provider:
Harris Health System is comprised of 16 community health centers, seven school-based clinics, a dental center, dialysis center, five mobile health units, one outpatient specialty services clinic, and three hospitals. With a tax base of $511.6 million, Harris Health System was able to provide more than $1.254 billion in charity care during FY 2012.

Volume Statistics - FY2012	Patient Payor Mix	Patient Demographics
Hospital admissions- 35,343 Births (babies delivered)- 6,643 Emergency visits- 173,263 Outpatient clinic visits- 1,054,770	Self-Pay- 62.6% Medicaid and CHIP- 23.4% Medicare- 8.6% Other Funding- 3.6% Commercial Insurance- 1.8%	Hispanic- 57.4% African American- 26.3% Caucasian- 9.2% Asian- 4.8% Other- 2.2% American Indian- 0.2%

Intervention(s):
This project will address the growing need for pediatric oral health services by implementing these services across three facilities within our system.
Need for the project:
Currently, Harris Health System only offers adult oral health care at some of our centers. In fiscal year 2011, fewer than half of the 3.5 million Texas children eligible for dental services through Medicaid received preventive dental treatments. More than 1.38 million children did not receive any dental treatments at all.
Target Population:
Any pediatric patient within the system who seeks dental care may benefit from this project. Data from FY2012 shows that 60% of all pediatric visits in Harris Health System were funded.
Category 1 or 2 expected patient benefits:
Our goal is to increase the number of children accessing dental services. Our DY4 goal is 10% of unduplicated patients and our DY5 goal is 20% unduplicated patients and 18,750 patient visits.
Category 3 outcomes:
IT-7.4: Our goal is to increase the percentage of children, age 6mos-20 years, who received a fluoride varnish application during the measurement period by 5% in DY4 and 10% in DY5.

Project Option 1.8.6- The expansion of existing dental clinics, the establishment of additional dental clinics, or the expansion of dental clinic hours: Expansion of Pediatric Dental Services

Unique ID #: 133355104.1.17/Pass 3

Performing Provider/TPI: Harris Health System/133355104

Project Description

Harris Health System plans to address the growing need for pediatric oral health services by implementing these services across three facilities within our system. Currently, Harris Health System only offers adult oral health care at some of our centers. Harris Health System is one of the few public health systems in the nation that offers oral health services to its patient population. The scope of this project is to increase access to pediatric oral health services in areas of high need in the community, specifically to serve zip codes 77504, 77099, 77093 and their surrounding areas.

Project Goals:

- Increase pediatric oral health workforce by expanding services to the pediatric and adolescent patient population. Harris Health System proposes to expand pediatric dental FTEs to 5.0.
- Establish pediatric and adolescent oral health services/clinics at three sites..
- Increase number of children and adolescents who will utilize the oral health care system.

Regional goals addressed with project:

- Increase access to primary and specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their condition, regardless of where they live or their ability to pay.
    - Oral health services are essential in preventing gum disease and cavities, which have been linked to other diseases such as diabetes and heart stroke. Access to oral health services is especially important for children and adolescents, since dental problems may affect quality of life and ability to succeed. Children from lower-income families often do not receive timely treatment for tooth decay, and they are more likely to suffer from chronic conditions (National Center for Chronic Disease Prevention and Health Promotion). Harris Health System will focus on underserved areas of Harris County.

- Develop a regional approach to health care delivery that leverages and improves on existing programs and infrastructure, is responsive to patient needs throughout the entire region, and improves health care outcomes and patient satisfaction.
    - Providing adequate access to preventive oral health services for children and adolescents at Harris Health System will improve health care outcomes and increase patient satisfaction.

The following challenges/issues are faced by Harris Health System as the performing provider for this project:

- Harris Health System currently does not offer pediatric and adolescent oral health services. The addition of these services will be a new challenge. Currently, there are no existing pediatric and adolescent oral health services offered at Harris Health System. This poses a challenge because we will be diving into a new pediatric service line. However, the system does have experience in operating a dental clinic with its current facility for adults.
- There are current space constraints to offer this service within our system. Our current sites are not built or equipped for pediatric oral health services; therefore, Harris Health will need to modify space available in order to satisfy the proposed service expansion.

5-year expected outcome for Performing Provider and patients:

Harris Health System's primary goal with this project is to increase access to appropriate levels of pediatric and adolescent oral health services in areas of high need. We plan to establish clinics that will increase the overall rate of annual dental visits for children and adolescents by increasing access to providers in these areas of high pediatric volumes. Upon implementation of these services, the proportion of children and adolescents who will utilize the oral health care system will increase, which increases preventive services and has the potential to decrease more costly chronic diseases in the future.

Starting Point/Baseline

Harris Health does not currently provide pediatric and adolescent oral health services at any of our sites; therefore, our baselines for patients and FTEs will be set at 0. In FY12, the system saw 53,359 unduplicated pediatric patients, which will guide us for expected volume. Of those 53,359 patients in FY12, 60% were funded.

Rationale

In fiscal year 2011, fewer than half of the 3.5 million Texas children eligible for dental services through Medicaid received preventive dental treatments. More than 1.38 million children did not receive any dental treatments at all. Such treatments include teeth cleanings, fluoride treatments, and sealants to prevent cavities. Compared to other States, Texas has lower proportions of children with teeth in excellent or very good condition.

Although oral health in Texas has improved over the past several decades, there are still significant disparities in some population groups, which include minorities and lower-income children. (NHANES, 1999-2004) Tooth decay is the most chronic childhood disease and is five times more common than asthma. Research shows that minority children living in poverty are most likely to experience these problems. (Oral Health in Texas, 2008) This same group tends to

have fewer sealants, more cavities, and the most advanced cases of oral disease. It has been demonstrated that adequate funding and targeting of school-based sealant programs can effectively eliminate such disparities as well. (Centers for Disease Control and Prevention, MMWR Morbid Mortal Wkly Rep. 2001) Harris Health System will address this significant disparity in oral health services for children and adolescents by adding oral health services at facilities in areas with high numbers of low-income minorities, including a school-based clinic.

Adequate oral health services are vital for the overall health of children and adolescents. Inadequate oral health can lead to more serious issues that include physical, mental, economic and social adverse effects. By providing oral health services to one of the most vulnerable populations at their early stages of life will improve the overall health of Harris County children and adolescents.

Project Components:

This project option does not include any required core components. However, Harris Health System will monitor quality through continuous improvement measurement. To improve efficiencies and reduce redundancies, we will monitor consistency of workflows between sites. Additionally, we plan to integrate pediatric dental health records into Harris Health's EMR to enhance efforts to improve quality of care and quality assurance in the delivery of dental care.

Milestones and metrics:

Harris Health System has chosen project option 1.8.6: The expansion of existing dental clinics, the establishment of additional dental clinics, or the expansion of dental clinic hours to best fit the scope and goal of this project.

Process Milestones and Metrics: P-4, P-4.1, P-4.2; P-7.1; P-X1, P-X1.1; P-X2 , P-X2.1; P-X3, P-X3.1;

P-X4,P-X4.1

Improvement Milestones and Metrics: I-14, I-14.1

Unique Community Need Identification Numbers:

- CN.1- Inadequate access to primary care
- CN.4- Inadequate access to dental care
- CN.6- Inadequate access to treatment and services designed for special needs populations, including disabled, homeless, children, elderly

The project focuses on CN.1, CN.4, and CN.6 by increasing access for pediatric and adolescent patients to oral health services. This aligns with CN.6 by addressing the importance of adequate access and dental treatments for children and potential long term benefits for overall health.

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

There is limited access for pediatric oral health, particularly for the low-income, uninsured, and Medicaid populations. Oral health is vital in disease prevention, and while preventive oral healthcare for children has grown within the past years, oral health problems continue to be an issue for children and adolescents, particularly minorities and low-income children. This project will allow Harris Health System to create a footprint by increasing the number of pediatric dentists in areas of high need. Treating cavities and other oral health problems at an early age has potential cost savings by preventing other chronic diseases that may come later in life.

Category 3

- **Outcome Domain(s):** OD-7 Oral Health

- **Improvement Target(s):**
  - **Stand-Alone Measures:**
    - IT-7.2 Topical Fluoride Application
      This measure focuses on measuring one of the goals for oral health improvement for our targeted population. This is an improvement measure that is important in preventive care and reducing the number of cavities in children. Harris Health System will begin to measure and report in DY4.
    - IT-7.4 Cavities: Percentage of children with untreated dental caries
      - Harris Health System hopes to increase use of preventive dental services and decrease disparities in oral health. We plan to measure and decrease the percent of children that go with untreated dental caries. We will begin to measure and report in DY4.

Relationship to other Projects and Other Performing Providers' Projects in the RHP:
Dental services for both adult and children is a service that is currently underfunded and incomplete in access for the targeted patient base. The dental initiatives represented in the RHP plan are specific to community need and location of the patient to ensure strong access to treatment. The outcome measures focus to the reduction of emergency room utilization, patient satisfaction, as well as increase access to the service line. The Region 3 initiative grid in the addendum directly reflects all relationships of dental initiatives.

Plan for Learning Collaborative:

As performing provider, Harris Health System plans to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system.

Project Valuation: The goal is to increase the number of children accessing dental services. Currently, Harris Health System only offers adult oral health care at some of our centers. Oral health services are essential in preventing gum disease and cavities, which have been linked to other diseases such as diabetes and heart stroke. Access to oral health services is especially important for children and adolescents, since dental problems may affect quality of life and ability to succeed. Children from lower-income families often do not receive timely treatment for tooth decay, and they are more likely to suffer from chronic conditions (National Center for Chronic Disease Prevention and Health Promotion). Treating cavities and other oral health problems at an early age has potential cost savings by preventing other chronic diseases that may come later in life.

<table>
<tr><td>133355104.1.17</td><td>1.8.6</td><td>N/A</td><td colspan="2">THE EXPANSION OF EXISTING DENTAL CLINICS, THE ESTABLISHMENT OF ADDITIONAL DENTAL CLINICS, OR THE EXPANSION OF DENTAL CLINIC HOURS: EXPANSION OF PEDIATRIC DENTAL SERVICES</td></tr>
<tr><td colspan="4">Harris Health System</td><td>133355104</td></tr>
<tr><td>Related Category 3 Outcome Measure(s):</td><td>133355104.3.22
133355104.3.23</td><td>IT-7.2
IT-7.4</td><td colspan="2">Cavities: Percentage of children with untreated dental caries
Topical Fluoride application</td></tr>
<tr><td>Year 2
(10/1/2012 – 9/30/2013)</td><td colspan="2">Year 3
(10/1/2013 – 9/30/2014)</td><td>Year 4
(10/1/2014 – 9/30/2015)</td><td>Year 5
(10/1/2015 – 9/30/2016)</td></tr>
<tr><td>Milestone 1 [P-X1]: Identify gaps in services and service needs

Metric 1 [P-X1.1]: Conduct gap assessment to identify community need for new site

Baseline: Comprehensive report that addresses needs for pediatric oral health in community
Goal: Identify location for new sites
Data Source: Needs assessment
Milestone 1 Estimated Incentive Payment (maximum amount): $4,089,774</td><td colspan="2">Milestone 2 [P-X2]: Staffing for pediatric dental services

Metric 1 [P-X2.1] Hire and train staff to operate and manage projects selected

Baseline: 0
Goal:
2 FTEs Dentist
2 FTEs Dental Assistant
1 FTE Dental Hygienist
2 FTEs Registration Staff
Data Source: Human Resources documentation

Milestone 2 Estimated Incentive Payment: $1,111,810

Milestone 3 [P-4]: Establish additional dental care clinics

Metric 1 [P-4.1]: Number of</td><td>Milestone 7 [I-14]: Increase number of special population members that access dental services

Metric 1 [I-14.1]: Increasing the number of children accessing dental services

Goal: 10% of unduplicated patients above baseline
Data Source: EMR
Milestone 7 Estimated Incentive Payment: $1,898,980

Milestone 8 [P-4]: Establish additional dental care clinics

Metric 1 [P-4.1]: Number of additional clinics and existing available space for pediatric dental clinic

Baseline: 2 sites
Goal: Add services at an</td><td>Milestone 10 [I-14]: Increase number of special population members that access dental services

Metric 1 [I-14.1]: Increasing the number of children accessing dental services

Goal: 20% of unduplicated patients above baseline
Data Source: EMR
Milestone 10 Estimated Incentive Payment: $4,696,712</td></tr>
</table>

133355104.1.17	1.8.6	N/A	THE EXPANSION OF EXISTING DENTAL CLINICS, THE ESTABLISHMENT OF ADDITIONAL DENTAL CLINICS, OR THE EXPANSION OF DENTAL CLINIC HOURS: EXPANSION OF PEDIATRIC DENTAL SERVICES
Harris Health System			133355104
Related Category 3 Outcome Measure(s):	133355104.3.22 133355104.3.23	IT-7.2 IT-7.4	Cavities: Percentage of children with untreated dental caries Topical Fluoride application

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
	additional clinics and existing available space for pediatric dental clinic Baseline: 0 Goal: Add services at 2 existing sites Data Source: Provider templates, EMR Milestone 3 Estimated Incentive Payment: $1,111,810 **Milestone 4** [P-X3]: Establish baseline data Metric 1 [P-X3.1]: Documentation of unduplicated patients served Goal: Establish baseline of pediatric dental visits Data Source: EMR	additional site for a total of 3 sites Data Source: Provider templates, EMR Data Source: New dental care schedule Milestone 8 Estimated Incentive Payment: $1,898,980 **Milestone 9**[P-X2]: Staffing for pediatric dental services Metric 1 [P-X2.1] Hire and train staff to operate and manage projects selected Baseline: 2 FTEs Dentist 2 FTEs Dental Assistant 1 FTE Dental Hygienist 2 FTEs Registration Staff Goal: Additional 3 FTEs Dentist for a	

133355104.1.17	*1.8.6*	*N/A*	***THE EXPANSION OF EXISTING DENTAL CLINICS, THE ESTABLISHMENT OF ADDITIONAL DENTAL CLINICS, OR THE EXPANSION OF DENTAL CLINIC HOURS: EXPANSION OF PEDIATRIC DENTAL SERVICES***
Harris Health System			*133355104*
Related Category 3 Outcome Measure(s):	*133355104.3.22* *133355104.3.23*	*IT-7.2* *IT-7.4*	*Cavities: Percentage of children with untreated dental caries* *Topical Fluoride application*

Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
	Milestone 4 Estimated Incentive Payment: $1,111,810 **Milestone 5** [P-X4]: Project planning for new pediatric and adolescent dental clinic in high medically underserved areas. Metric 1 [P-X4.1]: Planning documentation. Goal: Develop business plan to add new pediatric dental site. Data Source: Business Plan(s) Milestone 5 Estimated Incentive Payment*:* $1,111,810 **Milestone 6** [P-7]: Enhance efforts to improve quality of care and quality assurance in the delivery of dental	total of 5 FTEs Additional 3 FTEs Dental Assistants for a total of 5 FTEs Additional 3 FTEs Dental Hygienists for a total of 4 FTEs Additional 2 FTEs Registration Staff for a total of 4 FTEs Data Source: Human Resources documentation Milestone 9 Estimated Incentive Payment: $1,898,981	

133355104.1.17	*1.8.6*	*N/A*	***THE EXPANSION OF EXISTING DENTAL CLINICS, THE ESTABLISHMENT OF ADDITIONAL DENTAL CLINICS, OR THE EXPANSION OF DENTAL CLINIC HOURS: EXPANSION OF PEDIATRIC DENTAL SERVICES***
Harris Health System			*133355104*
Related Category 3 Outcome Measure(s):	*133355104.3.22* *133355104.3.23*	*IT-7.2* *IT-7.4*	*Cavities: Percentage of children with untreated dental caries* *Topical Fluoride application*

Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
	care Metric 1 [P-7.1]: Integrate oral health information into electronic health records. Baseline: Portion of adult dental sites on EMR Goal: Integrate pedi dental into EMR Data Source: patient electronic health records Milestone 6 Estimated Incentive Payment: $1,111,809		
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $4,089,774	Year 3 Estimated Milestone Bundle Amount: $5,559,049	Year 4 Estimated Milestone Bundle Amount: $5,696,941	Year 5 Estimated Milestone Bundle Amount: $4,696,712
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:** $20,042,476			

Matagorda Regional Medical Center

Pass 1

Project Option 1.9.2 - Improve access to specialty care: Establish a Chronic Disease Clinic to Expand Access to Specialty Care

Unique RHP Project Identification Number: 130959304.1.1
Performing Provider Name/TPI: Matagorda Regional Medical Center/ 130959304

Project Summary:
Provider:
Matagorda Regional Medical Center is a wholly owned part of Matagorda County Hospital District. The District also operates a primary care clinic for patients qualified for the District's Medical Assistance Program. The Hospital is a 58 bed acute care facility with a Level III trauma designation.

Volume Statistics - FY2012	Patient Payor Mix	Patient Demographics
Hospital admissions- 2594 Births - 381 Emergency visits- 18600 Surgeries – 1598 Outpatient visits -18260	Self-Pay- 11.5% Medicaid and CHIP- 12.8% Medicare- 50.1% Commercial Insurance- 22.5% Charity- 3.1%	Hispanic- 31.1% African American- 17.2% Caucasian- 50.1% Other- 1.6%

Intervention(s):
The CDSC will focus on providing access to specialty services and physicians that support care for a number of key chronic conditions identified by community need. Through the establishment of the CDSC, patient compliance with specialty referral visits will improve and the ability to manage chronic disease conditions on an ambulatory basis will improve. The CDSC will collaborate with the primary care community to share information, provide outreach to patients to improve compliance, collect and analyze data to improve systems, and ultimately improve the health of many.
Need for the project:
The chronic conditions as measured by the EHR of the local FQHC (MEHOP) indicates a rate of diabetes in the population of 26%, of hypertension of 46%, hyperlipidemia of 11% and COPD/Asthma at 3%. These rates are far above the rates for Texas and the nation. This clinic will bring resources to the community to improve treatment and compliance and ultimately reduce unnecessary hospital admissions.
Target Population:
All patients within the system with may benefit from this project (Medicaid and CHIP-23.4% / Self-Pay- 62.6%), specifically those with chronic diseases.
Category 1 or 2 expected patient benefits:
Our 5 year goal is an increase of 100 patients from the baseline in active patients in the CDSC system and a reduction in the admission rate for acute care hospitalizations for ambulatory care sensitive conditions for individuals under 75 years of age by 10% from 2013 baseline for those patients of the chronic clinic.
Category 3 outcomes:
IT-2.11: Our goal is to reduce the admission rate for acute care hospitalizations for ambulatory care sensitive conditions for individuals under 75 years of age by 10% from DY2 base for those patients of the chronic clinic.

Project Option 1.9.2 - Improve access to specialty care: Establish a Chronic Disease Clinic to Expand Access to Specialty Care

Unique RHP Project Identification Number: 130959304.1.1

Performing Provider Name/TPI: Matagorda Regional Medical Center/ 130959304

Project Description:
Matagorda Regional Medical Center proposed to expand specialty care for targeted populations with chronic diseases.

Collectively motivated by a Robert Wood Johnson Foundation Report ranking Matagorda County 185 out of 221 Texas counties in key health domains, representatives of the County, hospitals, school districts, physicians, the FQHC, churches, mental health system, social agencies and more – came together as a task force to begin the dialogue on improving the health profile of the community.

A joint planning team was formed with representatives of Matagorda County Hospital District/Matagorda Regional Medical Center, Matagorda Episcopal Health Outreach Program (MEHOP – FQHC), and Palacios Community Medical Center to explore potential models for collaboration. The transformation goals described in the Waiver helped the group crystallize their plans and a new partnership was formed to move the joint planning effort forward. This new organization, Coastal Health Connection, is being incorporated to further the concept of shared infrastructure and shared planning to improve the health of the community. The DSRIP project to establish a Chronic Disease Specialty Clinic (CDSC) is an outgrowth of this shared vision of a healthier community. The chronic conditions as measured by the EHR of the local FQHC (MEHOP) indicates a rate of diabetes in the population of 26%, of hypertension of 46%, hyperlipidemia of 11% and COPD/Asthma at 3%. These rates are far above the rates for Texas and the nation. For example, diabetes in Texas is reported to be 9.7% and 9.3% in the nation.[1] A review of hospital admission data from a 12 month period found a majority of patients had at least one of the targeted chronic disease conditions and that 10% of patients had a targeted chronic disease as a primary admitting diagnosis. Currently, primary care practitioners must often refer patients for specialty care to locations ranging from 45 - 90 minutes away. Most of the specific disease categories driving the poor overall health status of Matagorda County can be positively impacted by transforming care for the targeted population from one of fragmented resources to an organized system of care with the goal of reducing the rate of hospital admission.

The CDSC will focus on providing access to specialty services and physicians that support care for a number of key chronic conditions identified by community need. Through the establishment of the CDSC, patient compliance with specialty referral visits will improve and the ability to manage chronic disease conditions on an ambulatory basis will improve. The CDSC will collaborate with the primary care community to share information, provide outreach to patients to improve compliance, collect and analyze data to improve systems, and ultimately improve the health of many.

The CDSC will create and manage a data base of chronic disease patients to improve navigation through the system of care and to improve compliance and monitoring. This system will utilize the RHIE which is projected to be in place in Year 3 will connect primary care physicians to the chronic clinic. In addition to clinical staffing, care teams will be utilized to serve as a liaison

between referring physicians, specialty physicians, the patients, and other components of the care continuum. These teams will be led by a case manager and utilize community health workers (CHW). Once enrolled, patients will receive follow-up phone calls, appointment reminders, case management services and support from the care coordinator. The Clinic will be located on the Hospital Campus to further the convenience for access to supporting diagnostics and specialized services such as educational programs, wound care, outpatient procedures, etc. Transportation beyond the transportation already provided by local FQHC will be evaluated and added as needed.

The target zip codes include all of those in Matagorda County and it is expected this clinic will receive patients from surrounding counties since the patient panels at MEHOP include patients from Matagorda, Wharton, Jackson, and Brazoria counties.

Target Zip Codes:
77414,77404,77456,77465,77457,77419,77458,77415,77428,77440,77480,77483

Project Goals and Relationship to Regional Goals:
The objectives of this project are to (1) make access to specialty care more convenient and affordable by bringing services to the community and (2) provide care coordination to the chronic disease population in order to improve compliance and early disease intervention.

Project Goals:

- Increase the number of available specialty appointments for target chronic disease management
- Improve care coordination with primary care practitioners and other sectors of the care continuum.
- Decrease avoidable hospital admissions.
- Decrease number of disease related crisis visits to the emergency department.

This project meets the following Region 3 goals:

- Increase access to primary and specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their condition, regardless of where they live or their ability to pay.
- Transform health care delivery from a disease-focused model of episodic care to a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary or duplicative services, and builds on the accomplishments of our existing health care system.

Challenges:
The specialty physicians needed to collaborate with primary care practitioners in the care of patients with the target chronic diseases are generally not available in the region. Because several of the specialty physicians are not needed on a full-time basis, recruitment will be difficult and costly. Because of the socio-economic status of much of the patient population, physicians have been unable and/or unwilling to come to the area on a part-time basis or open their practice to the lower income population.

Due to the lack of resources available in the area, patients have been accustomed to being referred to a specialist located out of the area based on individual primary care preferences, self-referring, or choosing not to seek additional care. These patterns are long established and often multi-generational. Creating a new resource in the community will require changing the patterns of both the existing medical community and their patients.

Finally, although the Chronic Disease Specialty Clinic will be located in the County's population center, approximately 50% of the residents live in smaller outlying communities – some of which require as much as 30 minutes travel time. Transportation to the clinic will challenge some of the most vulnerable population to receive the specialty intervention.

Because the Chronic Disease Specialty Clinic will be fully staffed and supported on a local level with a clinic location conveniently located on the hospital campus, there is early positive indications of interest from large multi-specialty physician groups (Baylor, Texas Children's) to become a contracted provider of those needed physician services.
The infrastructure to be included in that clinic will provide the platform for the creation of care coordination teams and information systems to facilitate compliance and collaboration with the primary care physicians. The model will build on current successes with diabetes education in the community and include training for educators on other chronic disease categories.
Because this clinic will be a reflection of the mission of Matagorda Regional Medical Center and the partners of Coastal Health Connection, specialty services will be available to the entire community regardless of ability to pay. Coastal Health Connection will play a role in coordinating existing transportation services and develop plans for expansion.

5-Year Expected Outcome for Provider and Patients:
Matagorda Regional Medical Center expects to see a decrease in the admission rate for the specified chronic diseases. By creating a system of care focused on a coordinated, collaborative approach and early intervention, patients will not be as likely to get "lost" and end up in health crises. The expected outcome is to reduce the admission rate for the population of patients managed through the Chronic Disease Specialty Clinic and the care coordination resources associated with the Clinic. Our goal is an increase of 100 patients from the baseline in active patients in the CDSC system and a reduction in the admission rate for acute care hospitalizations for ambulatory care sensitive conditions for individuals under 75 years of age by 10% from 2013 baseline for those patients of the chronic clinic.

Starting Point/Baseline:
A chronic disease specialty clinic does not exist for the Matagorda County region and therefore we have no patients in a system of care for chronic diseases.

Rationale:

The target chronic conditions as measured by the EHR of the local FQHC (MEHOP) indicates a rate of diabetes in the population of 26%, hypertension of 46%, hyperlipidemia of 11% and COPD/Asthma at 3%. These rates are way above the rates for Texas and the nation. For example, Diabetes in Texas is reported to be 9.7% and 9.3% in the nation. Matagorda and Wharton counties are medically underserved, dental health and mental health shortage areas. Matagorda County lists 26% of citizens living in poverty. The percentage of children age 0 to 17 years living under the poverty level is higher at 29.0% for Matagorda County.[2] The largest school districts report nearly 75% of the children economically disadvantaged. In Bay City (county seat) alone this is a 25% increase in 10 years.[3] Matagorda County ranked 185 out of 221 (County Health Rankings, 2011) and 110 out of 221 for Wharton County for health factors. The shortage of health care professionals coupled with high poverty defines a population in dire need of health care. Many patients don't seek care until they can no longer work, or their illness keeps them virtually immobile. At this time they often seek care in the emergency room or at

MEHOP. For many, the emergency room is seen as free care. MRH has worked closely with MEHOP to establish a primary care home for these patients. Once the chronic condition is identified, the condition is critically out of control. There is only one cardiologist in the area and no other specialist for the targeted chronic conditions.

Due to the economic condition of the patients, referral to specialists outside the area is virtually impossible. Specialists won't accept the patient and/or the patient has no transportation. There is not currently a centralized location for determining best practice management of patients with the targeted disease categories. By creating a clinic with the respective specialists, data/information systems, and care coordination, patients and their primary care providers will have ready access to expertise that will reduce issues with non-compliance, reduce out of control health crises, and therefore reduce hospital admission rates and unnecessary visits to the emergency department.

Project Components:

The required core project components include the following:

a) Increase service availability with extended hours
b) Increase number of specialty clinic locations
c) Implement transparent, standardized referrals across the system
d) Conduct quality improvement for project using methods such as rapid cycle improvement

We will meet these project components with the establishment of the chronic disease specialty clinic as follows:

1. Identification of the type of specialists and the time commitment required to impact the chronic conditions/health disparities
   - Estimated cost for gap analysis: $50,000 - $75,000
2. Recruitment of the specialists, clinical support team and care team
   - Recruitment: $25,000/physician = $150,000
   - Staffing: $600,000/year (including physicians)
3. Equipping the facility to meet the needs of the specialists
   - New clinic: $290,000
4. Develop a collaborative model with the primary care community to utilize chronic clinic
   - Informational material, education, etc: $25,000/year
5. Establish of baseline metrics and then continual measurement for improvement while utilizing process techniques such as PDSA cycles for improvement
   - IT (patient tracking, scheduling, referral systems): $50,000 (one time) + $10,000/year
6. Technology – Utilizing RHIE, connect primary care physicians to the chronic clinic.
   - $2500/physician = $25,000/year
7. Communication of success in the county, area and region.
   - Educational material, etc.: $10,000

Milestones & Metrics:

The following milestones and metrics have been chosen for the Chronic Care Clinic project based on the core components and the needs of the target population:

- Process Milestones and Metrics: P-1 (P-1.1); P-3 (P-3.1); P-4 (P-4.1); P-8 (P-8.1); P-9;

P-11 (P-11.1)

- Improvement Milestones and Metrics: I-22 (I-22.1); I-23 (I-23.1); I-29 (I-29.1)

Unique community need identification number the project addresses:
The project addresses the following unique community needs as identified in the community needs assessment:

- CN.1 Access to Specialty Care for Chronic Conditions within Matagorda County
- CN.2 Population Diabetes rate of 26%; Hypertension rate of 45%; Hyperlipidemia of
  - 11%; as well as 3% COPD
- CN.3 Percent Uninsured (29.2%) and Percent Poverty (22%) in Matagorda County
- CN.4 HPSA score of 16

How the project represents a new initiative for the Performing Provider or significantly enhances an existing delivery system reform initiative:
For the key chronic conditions of hypertension, hyperlipidemia, diabetes, COPD and asthma there is one cardiologist and no other specialists in the county or nearby region. A clinic established to focus on the management of these critical chronic diseases in the greater Matagorda County region will reduce ambulatory care sensitive admissions and dramatically improve primary care physician's ability to control these long term diseases.

Related Category 3 Outcome Measure(s):
OD-2 Potentially Preventable Admissions:
IT-2.11 Ambulatory Care Sensitive Conditions Admissions Rate

- Rate of acute care hospitalizations for grand ma status and other epileptic convulsions, Chronic obstructive pulmonary diseases (COPD), asthma, heart failure, pulmonary edema, hypertension, angina, diabetes

Reasons/rationale for selecting the outcome measure(s):
The high percentage of the population as uninsured and high poverty creates a challenging approach for primary care physicians to control these chronic diseases. Frequently, a patient lives with a chronic disease for an extended period before seeking primary care. In many cases, specialty care is required to assist the primary physician in finding appropriate approaches to controlling the disease. With the exception of one cardiologist, there are no specialty care physicians within driving distance (30 miles) for the patient. Preventable hospitalizations for Matagorda County for Hypertension, COPD, Asthma, and short and long term Diabetes increased 44 % from 2008 to 2010.[4] This accounts for increased expenses over this period of over $1,000,000. With the rate of diabetes as measured by MEHOP at 3 times the national average, hospital discharges would be predicted to be at a higher than average rate as well. The establishment of a specialty chronic clinic will enable the primary care physicians to refer these patients for care and subsequently controlling these chronic diseases.

Relationship to Other Projects:
There are no other projects planned.

Relationship to Other Performing Providers' Projects in the RHP:
Healthcare costs are significantly increased within a patient base with such aggressive chronic conditions that have gone untreated. The initiatives focused to chronic disease

management focus to conditions such as asthma, hypertension, and diabetes and are similar in the approach of managing & proactively treating chronic conditions in order to reduce 30-day readmission rates, inappropriate emergency department utilization, and healthcare costs. The Region 3 Initiative grid allows a cross reference of initiatives associated with chronic disease management. (addendum)

The increased access to primary care visits will naturally generate additional need of specialty care visits based on the condition and acuity of the patients served. Understanding that the patient base targeted through this initiative will generate significant specialty care visits due to chronic conditions and lack of previous treatments, this initiative and similar initiatives will focus to 30-day readmission rate reductions, improvement for patient satisfaction scores, and admission rates specific to chronic conditions. Numerous initiatives have been included in the RHP plan and the addendum of the Initiative Grid can directly tie all specialty care projects together by category.

Plan for Learning Collaborative: We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system.

Project Valuation:
Matagorda County has an estimated population of 2850 people with diabetes; 4500 people with hypertension and 1050 with hyperlipidemia who are at poverty or below. Of the general population over 1000 have COPD or asthma. The value of the CDSC will be to control these chronic diseases and thereby improve the quality of life for these individuals. The impact of reduced preventable hospitalizations will be a savings compared to the base year of 2010 of $500,000 in year 4 and additional savings of $100,000 per year for the next 3 years. (This is a reduction of an additional 5 preventable hospitalizations per year. Year 5 savings of $600,000. Year 6 savings of $700,000, etc.)
Although only one project has been selected, the ability to create a comprehensive infrastructure for chronic disease management is critical to success in the desired outcomes. That infrastructure must include at least the following:

- ✓ Identification of the type of specialists and the time commitment required to impact the chronic conditions/health disparities
- ✓ Recruitment of the specialists, clinical support team and care team
- ✓ Equipping the facility to meet the needs of the specialist
- ✓ Develop a collaborative model with the primary care community to utilize chronic clinic
- ✓ Establish of baseline metrics and then continual measurement for improvement while utilizing process techniques such as PDSA cycles for improvement
- ✓ Technology – Utilizing RHIE, connect primary care physicians to the chronic clinic.
- ✓ Communication of success in the county, area and region.

[1&2] *DSHS, 2009 County Facts Profile, http://www.dshs.state.tx.us/chs*
[3] *Date reported to MEHOP by BCISD June/2012*
[4] *DSHS, 2009 County Facts Profile, http://www.dshs.state.tx.us/ph*

130959304.*1.1*	***1.9.2***	***1.9.2(A-D)***	***CHRONIC CARE CLINIC***
Matagorda Regional Medical Center			130959304
Related Category 3 Outcome Measure(s):	*OD-2*	*IT-2.11*	*Ambulatory Care Sensitive Conditions Admissions Rate*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-1]: Conduct specialty care gap assessment based on community need Metric 1 [P-1.1]:Document gap assessment of high demand specialty areas to build up supply of specialists to meet demand and improve specialty access Baseline: No gap assessment has been conducted Goal: Completion of gap assessment Data Source: Community Needs Assessment; Gap analysis; EHR Milestone 1 Estimated Incentive Payment *(maximum amount):* $523,067 **Milestone 2** [P-11]: Launch/expand a specialty care clinic. Metric 1 [P-11.1]: Establish chronic care clinic. Baseline: There is currently no specialty chronic care clinic Goal: Recruit specialty physicians (part and full time) as gap analysis indicates. Provide facilities for specialty physicians in Doman Freeman Phillips Medical Office	**Milestone 3** [I-22]: Increase the number of specialist providers, clinic hours and/or procedure hours available for the high impact/most impacted medical specialties. Metric 1 [I-22.1]: Specialists added to meet demand Baseline: One cardiologist practices in Matagorda County; no pulmonologist, oncologist, endocrinologist, gastroenter-oligist or rheumatologist practices in Matagorda County. Goal: Specialists are recruited as identified by gap analysis. Hire at least 3 specialists by the end of the project. Data Source: HR documents or other documentation demonstrating employed/contracted specialists Milestone 3 Estimated Incentive Payment: $570,637 **Milestone 4** [P-8]; Develop the technical capabilities to facilitate electronic referral Metric 1 [P-8.1.]: Utilizing HIET, provide technical capability to	**Milestone 5** [P-4]: Expand the ambulatory care medical specialties referral management department and related functions Metric 1 [P-4.1]: Referral Management System Utilization Baseline: Number of unique referrals place and tracked within the system during year 3 Goal: 250 unique referrals placed Data Source: EHR Milestone 5: Estimated Incentive Payment: $190,765 **Milestone 6** [I-22]: Increase the number of specialist providers, clinic hours and/or procedure hours available for the high impact/most impacted medical specialties. Metric 1 [I-22.1]: Specialists added to meet demand Baseline: Year 3 specialist added – 1 pulmonologist. Goal: Additional specialists added as identified in the gap analysis – projected to be an endocrinologist, and cardiologist. Data Source: HR documents or other documentation	**Milestone 11** [I-23]: Increase specialty care clinic volume of visits and evidence of improved access for patient's services. Metric 1 [I-23.1]: Documentation of increase number of visits. Demonstrate improvement over prior reporting period Baseline: Year 4 specialty patient encounters and visits Goal: Increase number of visits by 50% from DY4 Data Source: UDS Report – MEHOP; EHR, Milestone 11 Estimated Incentive Payment: $472,766 **Milestone 14** [P-4]: Expand the ambulatory care medical specialties referral management department and related functions Metric 1 [P-4.1]: Referral Management System Utilization Baseline: Number of unique referrals placed and tracked within the system during DY4 Goal: Increase number of unique referrals placed and tracked by 50%

130959304.*1.1*	***1.9.2***	***1.9.2**(A-D)*	***CHRONIC CARE CLINIC***	
Matagorda Regional Medical Center				130959304
Related Category 3 Outcome Measure(s):	*OD-2*	*IT-2.11*	*Ambulatory Care Sensitive Conditions Admissions Rate*	

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Building available spring 2013. Market availability of chronic specialty care to county/region. Data source: documentation of new chronic care clinic Milestone 2 Estimated Incentive Payment: $523,066	primary care providers who utilize the Chronic Clinic to directly refer patients into schedule. Baseline: No electronic referral system in place. Goal: Install capability at all primary care doctors by end of year 3. Data Source: HER Milestone 4 Estimated Incentive Payment: $570,638	demonstrating employed/contracted specialists Milestone 6 Estimated Incentive Payment: $190,766 **Milestone 7** [I-23]: Increase specialty care clinic volume of visits and evidence of improved access for patient's services. Metric 1 [I-23.1]: Documentation of increase number of visits. Demonstrate improvement over prior reporting period Baseline: Total number of Year 3 visits Goal: Number of visits increase from year 3 by 2000. Data Source: EHR Milestone 7 Estimated Incentive Payment: $190,765 **Milestone 8** [P-3]: Collect baseline data for wait times, backlog, and/or return appointments in specialties Metric 1 [P-3.1]: Establish baseline for performance indicators Baseline: Not yet developed Goal: Establish baseline Data Source: EHR	over DY4 Data Source: EHR Milestone 14 Estimated Incentive Payment: $472,766

130959304.***1.1***	***1.9.2***	***1.9.2***(*A-D*)	***CHRONIC CARE CLINIC***	
Matagorda Regional Medical Center				130959304
Related Category 3 Outcome Measure(s):	*OD-2*	*IT-2.11*	*Ambulatory Care Sensitive Conditions Admissions Rate*	

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
		Milestone 8 Estimated Incentive Payment: $190,766 **Milestone 9** [P-9]: Implement referral technology and processes that enable improved and more streamlined provider communications Metric 1 [P-9.1] Documentation of referrals technology Baseline: Providers using technology DY3 Goal: Increase number of providers using referral technology by 5 Data Source: EHR, Referral system Milestone9 Estimated Incentive Payment: $190,766 **Milestone 10** [I-29]: Increase the number of referrals of targeted patients to the specialty care clinic Metric 1 [I-29.1]: Targeted referral rate Baseline: number of referrals of targeted patients in Year 3 Goal: Increase number of patients referred by 50% from DY3. Data Source: EHR Milestone 10 Estimated Incentive	

130959304.***1.1***	***1.9.2***	***1.9.2(A-D)***	***CHRONIC CARE CLINIC***
Matagorda Regional Medical Center			130959304
Related Category 3 Outcome Measure(s):	*OD-2*	*IT-2.11*	*Ambulatory Care Sensitive Conditions Admissions Rate*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
		Payment: $190,765	
Year 2 Estimated Milestone Bundle Amount: $1,046,133	Year 3 Estimated Milestone Bundle Amount: $1,141,275	Year 4 Estimated Milestone Bundle Amount: $1,144,593	Year 5 Estimated Milestone Bundle Amount: $945,532
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:** $4,277,533			

Matagorda Regional Medical Center

Pass 3

Project Option 1.6.1 Expand Urgent Care Services
Unique RHP Project Identification Number: 130959304.3.1
Performing Provider Name/TPI: Matagorda Regional Medical Center/ 130959304

Project Summary:

Provider:
Matagorda Regional Medical Center is a wholly owned part of Matagorda County Hospital District. The District also operates a primary care clinic for patients qualified for the District's Medical Assistance Program. The Hospital is a 58 bed acute care facility with a Level III trauma designation.

Volume Statistics - FY2012	Patient Payor Mix	Patient Demographics
Hospital admissions- 2594 Births - 381 Emergency visits- 18600 Surgeries – 1598 Outpatient visits -18260	Self-Pay- 11.5% Medicaid and CHIP- 12.8% Medicare- 50.1% Commercial Insurance- 22.5% Charity- 3.1%	Hispanic- 31.1% African American- 17.2% Caucasian- 50.1% Other- 1.6%

Intervention(s):
To provide an alternative to care at the right time and right setting urgent care services will be expanded to evenings and weekends. An urgent care medical advice call center manned with RN professionals trained in pediatric as well as adult triage will promote the use of the expanded urgent care services.

Need for the project**:**
While there has been positive progress in expanding access to community based care, current data reflects that between 40 and 50% of Matagorda Regional Medical Center Emergency Department visits are for diagnosis that could safely be treated in a clinic setting. An urgent medical advice call center does not exist for the Matagorda County region nor does expanded night and weekend hours for urgent care in a primary care setting for the underserved and uninsured.

Target Population**:**
All patients within the system may benefit from this project (Medicaid and CHIP-23.4% / Self-Pay- 62.6%), specifically those with repetitive unnecessary ED visits.

Category 1 or 2 expected patient benefits**:**
Matagorda Regional Medical Center expects to see a decrease in the number of unnecessary visits to the Emergency Department by patients enrolled in the Navigation Program. Our goal is to have 3000 urgent care visits annually by the end of the project period.

Category 3 outcomes:
IT-9.2: Our goal is a 15% reduction in unnecessary Emergency Department visits.

Project Option 1.6.1- Expand Urgent Care Services: Expand Access to Urgent Care Services and Urgent Medical Advice

Unique RHP Project Identification Number: 130959304.1.2/Pass 3
Performing Provider Name/TPI: Matagorda Regional Medical Center/ 130959304

Project Description:
A joint planning team with representatives of Matagorda County Hospital District/Matagorda Regional Medical Center, Matagorda Episcopal Health Outreach Program (MEHOP – FQHC), and Palacios Community Medical Center has explored potential models to transform access, cost and delivery of health care. The transformation goals described in the Waiver helped the group crystallize their plans and a new partnership was formed to move the joint planning effort forward. This new organization, Coastal Health Connection, is currently being incorporated with these three organizations as the founders to further the concept of shared infrastructure and shared planning to improve the health of the community.

The DSRIP project to expand urgent care services including urgent medical advice is consistent with the goals of a shared vision of a healthier community. While there has been positive progress in expanding access to community based primary care, recent data reflects that between 40 and 50% of Matagorda Regional Medical Center Emergency Department visits are for diagnosis that could safely be treated in a clinic setting. The data further indicates low utilization of inpatient services by pediatric patients. It is proposed that urgent pediatric needs and/or inpatient services are unmet in the county. For underserved/underinsured patients access to care after normal hours is not available. There is no urgent medical advice call center to triage patients seeking primary care services. Expanding urgent care at the site of the FQHC will provide an introduction of patients to a primary care home setting and thereby engage these patients with a holistic approach to healthcare. The continued inappropriate use of the hospital emergency department as a source of non-emergent care underscores the need for a call center to timely triage patients and for a source for expanded hours urgent care.

Transportation beyond the transportation already provided by local FQHC will be evaluated and added as needed.

The target zip codes include all of those in Matagorda County and it is expected this clinic will receive patients from surrounding counties since the patient panels at MEHOP include patients from Matagorda, Wharton, Jackson, and Brazoria counties.

Target Zip Codes:
77414,77404,77456,77465,77457,77419,77458,77415,77428,77440,77480,77483

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

Project Goals:

- Establish urgent medical advice call center so that patients who need it can access it telephonically
- Provide extended hours of urgent care.
- Provide a point of entry for patients into a primary home setting.
- Decrease inappropriate visits to the hospital emergency department utilizing call center and expanded hours of primary urgent care.

This project meets the following Region 3 goals:

- Increase access to primary and specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their condition, regardless of where they live or their ability to pay.
- Transform health care delivery from a disease-focused model of episodic care to a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary or duplicative services, and builds on the accomplishments of our existing health care system.
- Develop a regional approach to health care delivery that leverages and improves on existing programs an infrastructure , is responsive to patient needs throughout the entire region and improves health care outcomes and patient satisfaction.

Challenges or Issues Faced:

Data collected by MCHD as well as MEHOP indicates a section of the population continually utilizes the emergency department (ED) as a source of primary care. This illustrates the need for transformation to the approach to healthcare by the community. The belief by individuals and families to care illustrates entrenched patterns that ED care is a minimal cost, primary care choice or urgent care is not available for all. Communication and demonstration of access to high quality care is paramount. Communication and demonstration of the availability of advice and care to a county where 50% of the residents live outside the county seat in remote low density areas will be critical to the success of the transformation. There currently is not any source of call advice for patients and parents to seek direction on appropriate venue for care. Finally, there are limited alternatives to the hospital emergency room for after hours and weekend care and no alternative for the uninsured and underinsured.

How the Project Addresses Challenges/Issues:

The availability of an urgent medical advice call center will enable health concerns to be heard and addressed in an optimum venue of care. Urgent care will be available in a non ED setting for expanded hours and weekends to reduce the number of unnecessary ED visits. Utilization of electronic health records and health information technology will facilitate continuity of care. Because this clinic will be a reflection of the mission of Matagorda Regional Medical Center and the partners of Coastal Health Connection services will be available to the entire community

regardless of ability to pay. Coastal Health Connection will play a role in coordinating existing transportation services and develop plans for expansion.

5-Year Expected Outcome for Provider and Patients:

Matagorda Regional Medical Center expects to see a decrease in the number of unnecessary visits to the ED by patients utilizing the call center and expanded urgent and walk-in care. Through continuity of approach to health care within Coastal Health Connection including formal communication networks between urgent call center and community based navigators it is anticipated that patients will receive the right care in the right setting. Consistent intervention with this collaborative approach will promote primary care in a patient centered home model where the patient receives care for both chronic and acute illnesses and health disparities are reduced. The expected outcome is to reduce the unnecessary ED visits creating a system of care focused on a coordinated, collaborative approach and early intervention, patients will be not be as likely to get "lost" and end up in a health crises. Our goal is to reduce unnecessary ED visits by 15%.

Starting Point/Baseline:

An urgent medical advice call center does not exist for the Matagorda County region nor does expanded night and weekend hours for urgent care in a primary care setting for the underserved and uninsured.

Rationale:
Reasons for selecting the project option:

The county is served by two acute care hospitals, Matagorda Regional Medical Center and Palacios Community Medical Center. In 2010, the facilities reported 19,368 emergency visits. The hospitals provided more than $16 million in uncompensated care, which accounted for 14.9% of total patient revenue, the second highest percentage in the region. Between 40 and 50% of the visits to the MRMC Emergency Department in 2012 could be considered non-emergent and potentially could be cared for in a less costly venue.

Matagorda County includes the towns of Bay City and Palacios, as well as 15 smaller communities spread throughout the county of more than 1,000 square miles. More than 36,000 people live within the county which has a median household income of $39,874. Nearly 20% of the population lives below the poverty level, and the county has the second highest rate of children living in poverty at 28.4%.

No urgent care medical advice is available by phone for the population. The population has demonstrated that care is often either not sought or the ED is used for primary care. A change is required to enable patients to receive advice 24/7 and to receive urgent care in a primary care setting.

Project Components:

The key project components for the enhancement of urgent medical advice and the expansion of urgent care services include:

8. Expand urgent care services at MEHOP from 6pm to 11pm Monday through Friday and Saturday and Sunday from 8am to 6pm
   - Recruitment of providers and support staff: $ 25,000
   - Staffing: $530,000-providers, nurse, insurance verification
   - Supplies: $ 25,000 on going
   - Security: $25,000
   - IT (Computers, licenses) - $50,000
   - Purchased Services - $200,000

9. Establish/expand access to medical advice and direction to the appropriate level of care to reduce Emergency Department use of non-emergent conditions and increase patient access to health care
   - Staffing: $ 200,000
   - Telephone System: $15,000
   - IT (scheduling, referral systems, patient tracking): $20,000 one time and $10,000 per year

10. Establish a process that in a timely manner triages patients seeking primary care services in an ED to an alternate primary care site.
    - Informational Material; $10,000
11. Survey patients who utilize call center and expanded urgent care to ensure patient satisfaction with services received
    - Survey: $10,000
12. Establish linkages between primary care, urgent care and ED in order to increase communication and improve care transitions
    - Staff: $30,000
13. Conduct quality improvement for project using methods such as rapid cycle improvement
    - Staff: $20,000
14. Communication of success in the county, area and region.
    - Educational material, etc.: $10,000

Milestones & Metrics:

The following milestones and metrics have been chosen for enhanced urgent medical advice and expanded urgent car services project based on the core components and the needs of the target population:

Process Milestones and Metrics: P-1 (P-1.1); P-2 (P-2.1);P-3 (P-3.1); P-4 (P-4.1); P-6 (P-6.1); P-8 (P-8.1) ; P-11 (P-11.1); I-14(I-14.1); I-16 (I-16.1); I-17 (I-17.1)

Unique community need identification number the project addresses:

The project addresses the following unique community needs as identified in the community needs assessment:

CN.1 Inadequate access to primary care

CN.8 High rates of inappropriate emergency department utilization
CN.23 Lack of patient navigation, patient and family education and information programs.

How the project represents a new initiative for the Performing Provider or significantly enhances an existing delivery system reform initiative:
The main focus of the hospital district has been acute focused with hospital and emergency department services. This initiative combined with patient navigator system will enable patients to receive the right care in the right setting and will promote the patient centered medical home initiative The project will also enhance another project of creating a system of care for chronic diseases by identifying undetected chronic disease and enabling patients to receive urgent care within the collaborative system.

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

- Reduce all ED visits (including ACSC)[71]
- Reduce pediatric Emergency Department visits (CHIPRA Core Measure)[72]
- Reduce Emergency Department visits for target conditions
    - Congestive Heart Failure
    - Diabetes
    - End Stage Renal Disease
    - Cardiovascular Disease /Hypertension
    - Behavioral Health/Substance Abuse
    - Chronic Obstructive Pulmonary Disease
    - Asthma

Reasons/rationale for selecting the outcome measure(s):

A high percentage of the population being uninsured, low income, and under-educated, causes connecting to the right setting for care can be challenging. The barriers created by these factors include economic and communication. Generations of families have come to rely on the emergency department of hospitals as their sole source of health care or avoided care until life was threatened.

While there are many factors involved in calculating actual cost savings available if a patient receives care in the most cost effective setting, the charge associated with the lowest acuity visit for a local hospital ED visit is over double that of the same coded visit in a local community clinic.[73] With over 9000 emergency department visits per year in Matagorda County potentially being eligible for care in a different venue, the impact could be significant.

[71] http://archive.ahrq.gov/data/safetynet/billappb.htm
[72] http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/CHIPRA-Initial-Core-Set-of-Childrens-Health-Care-Quality-Measures.html
[73] MCHD, MEHOP charge master

Relationship to Other Projects:
MCHD is also developing a Chronic Disease Specialty Clinic. Enhanced urgent care medical advice and expanded urgent care will partner with the Patient Care Navigation System that is being developed. All of these projects will overlap with an integrated referral system and have positive impact on appropriate use of the ED and reduce health disparities.

Relationship to Other Performing Providers' Projects in the RHP:
The triage and intake process of patient encounters is the front door to healthcare and an important factor of the success of healthcare transformation. The nurse triage/call center concept is unique in the regional sense of the RHP plan and focuses to outcome measures of ambulatory care sensitive condition readmission rates. The initiative grid attached in the addendum will show similarities with other projects suggested for this region.

Plan for Learning Collaborative: We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system.

Project Valuation:
Matagorda County Regional Medical Center has approximately 20,000 visits to the Emergency Department annually. Records reflect a potential of 40 – 50%[74] of the visits could have been treated in another venue. If the Enhanced and expanded urgent care is successful at reducing unnecessary ED visits by a conservative 15%, a savings of as much as $3,000,000[75] could be realized by the end of the project period (as compared to a standard physician office visit).

[1&2] *DSHS, 2009 County Facts Profile, http://www.dshs.state.tx.us/chs*
[3] *Date reported to MEHOP by BCISD June/2012*
[4] *DSHS, 2009 County Facts Profile, http://www.dshs.state.tx.us/ph*

[74] MCHD ED Records 2012
[75] Cost of an average ED visit compared to an office visit. *Consumer Health Ratings, 2011*

130959304.1.2	***1.6.1***	***N/A***	***Expand Urgent Care Services***	
Matagorda Regional Medical Center				130959304
Related Category 3 Outcome Measure(s):	*130959304.3.3*	*IT-9.2*	*ED appropriate utilization*	

Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Milestone 1 [P-1]: Collect baseline data from medical advice lines within RHP preferably from rural provider Metric 1 [P-1.1]:Document baseline data Baseline: None Goal: Completion of baseline Data Source: Prior documentation of baseline data Milestone 1 Estimated Incentive Payment *(maximum amount):* $129,448 **Milestone 2** [P-3]: Train nurse on clinical protocols Metric 1 ([P-11.1]: Train all nurses involved Baseline: None Goal: Train nurses prior to launching urgent medical advice call center.	**Milestone 5** : [P-3]: Train nurse on clinical protocols Metric 1 ([P-11.1]: Train all nurses involved Baseline: None Goal: Train nurses on routine basis Data source: HR records Milestone 5 Estimated Incentive Payment: $194,660 **Milestone 6** (P-6) Inform and educate patients on the nurse advice line Metric 1: Number or percent of targeted patient informed/educated Baseline: None Goal: Begin education of patients within 90 days of project start. Data Source: EHR, published flyers, news articles, Milestone 6 Estimated Incentive Payment: $194,659	**Milestone 8[I-11]:** Volume of ED visits for the target population who used the help line Metric 1 [I-11.1]: % of ED visits who used the help line compared to total of ED visits. Goal: 5% Data Source: EHR, Call center records, ED visits Milestone 8 Estimated Incentive Payment $99,712 **Milestone 9**[P-8] Participate in at least bi-weekly interactions with other providers and the RNP to promote collaborative learning Metric 1 [P-8.1]: Number of bi-weekly meetings, conference calls, webinars Baseline: None Goal: Begin after 1 year of data	**Milestone 14** [P-1]Establish clinical protocols for an urgent medical advice line with a vetting process. Metric 1 [P-1.1]: Submission of complete protocols Baseline: none Goal: Submission by Year 5 Data Source: Protocol Documents Milestone 14 Estimated Incentive Payment: $61,500 **Milestone 15** [P-4] Expand nurse advice line based on baseline data to increase access to patients based on need Metric 1 [P-4.1] Nurse advice line Baseline: Year 3 and 4 medical advice calls Goal: Add staffing to match need as identified Data Source: EHR, call records

130959304.1.2	***1.6.1***	***N/A***	***EXPAND URGENT CARE SERVICES***	
Matagorda Regional Medical Center				130959304
Related Category 3 Outcome Measure(s):	*130959304.3.3*	*IT-9.2*	*ED appropriate utilization*	

Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Data source: HR records Milestone 2 Estimated Incentive Payment: $129,448 **Milestone 3** [P-17] Establish expanded urgent care center at FQHC (MEHOP) <u>Metric 1</u> [P-1-17.1] Documentation of increased number of unique patients served by innovative program Baseline: None Goal: Initiate expanded service by 7/1/2013 Data Source; EHR, HIT, Milestone 3 Estimated Incentive Payment: $129,448 **Milestone 4** (P-6) Inform and educate patients on the nurse advice line <u>Metric 1</u> [P-6.1]: Number or percent of targeted patient informed/educated	**Milestone 7** [P-8] Participate in at least bi-weekly interactions with other providers and the RNP to promote collaborative learning <u>Metric 1</u> [P-8.1]: Number of bi-weekly meetings, conference calls, webinars Baseline: None Goal: Begin after 1 year of data collected Data Source: Documentation of meetings Milestone 7 estimated incentive Payment: $194,659	collected Data Source: Documentation of meetings Milestone 9 Estimated Incentive Payment $99,712 **Milestone 10** [I-12] Proportion of admission/readmissions of ED visits that used the help line vs those who did not sure the help line <u>Metric 1</u> [I-12.1]: Percent of ED visits that used the call center and got admitted/readmitted to hospital Goal: 1% Data Source: EHR, Claims Milestone 10 Estimated Incentive Payment $99,712 **Milestone 11** [I-14.1] Increase patients in defined population who utilized then nurse advice line and	Milestone 15 Estimated Incentive Payment $61,501 **Milestone 16[I-11]:** Volume of ED visits for the target population who used the help line <u>Metric 1</u> [I-11.1]: % of ED visits who used the help line compared to total of ED visits. Goal: 5% Data Source: EHR, Call center records, ED visits Milestone 16 Estimated Incentive Payment; $61,500 **Milestone 17** [P-8] Participate in at least bi-weekly interactions with other providers and the RNP to promote collaborative learning <u>Metric 1</u> [P-8.1]: Number of bi-weekly meetings, conference calls,

130959304.1.2	1.6.1	N/A	EXPAND URGENT CARE SERVICES
Matagorda Regional Medical Center			130959304
Related Category 3 Outcome Measure(s):	130959304.3.3	IT-9.2	ED appropriate utilization

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Baseline: None Goal: Begin education of patients within 90 days of project start. Data Source: EHR, published flyers, news articles, Milestone 4 Estimated Incentive Payment $129,448		were given an urgent medical appointment via the nurse advice and appointment line when needed Metric 1[I-14.1] : Number of urgent medical appointments scheduled via the nurse advice line Goal: Increase by 10% in Year 4 Data Source: EHR urgent care and call center phone records Milestone 11 Estimated Incentive Payment $99,712 **Milestone 12** [I-16]:Increase patients who utilized the nurse advice line and were given a medical home appointment via the nurse advice and appointment line when condition was not urgent Metric 1 [I-16.1]: Number of medical home appointments scheduled via the nurse advice and appointment line	webinars Goal: Begin after 1 year of data collected Data Source: Documentation of meetings Milestone17 Estimated Incentive Payment $61,501 **Milestone 18** [I-12] Proportion of admission/readmissions of ED visits that used the help line vs those who did not sure the help line Metric 1 [I-12.1]: Percent of ED visits that used the call center and got admitted/readmitted to hospital Goal: 1% Data Source: EHR, Claims Milestone 18 Estimated Incentive Payment $61,500 **Milestone 19** [I-14] Increase patients in defined population who utilized

130959304.1.2	1.6.1	N/A	EXPAND URGENT CARE SERVICES
Matagorda Regional Medical Center			130959304
Related Category 3 Outcome Measure(s):	*130959304.3.3*	*IT-9.2*	*ED appropriate utilization*
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
		when condition was not urgent Goal: 10% Increase in Year 4 Data Source: EHR Records and Call center records Milestone 12 Estimated Incentive Payment $99,712 **Milestone 13 (I-17)** Implement interventions to improve access to care of patients receiving urgent medical advice Metric 1 [I-17.1]: Documentation of increased number of unique patients served by the innovative program Goal: Increase number of intervention by 10% Data Source: EHR Milestone 13 Estimated Incentive Payment $99,713	then nurse advice line and were given an urgent medical appointment via the nurse advice and appointment line when needed Metric 1 [I-14.1] : Number of urgent medical appointments scheduled via the nurse advice line Goal: Increase by 10% in Year 5 Data Source: EHR urgent care and call center phone records Milestone 19 Estimated Incentive Payment $61,501 **Milestone 20** (I-16) Increase patients who utilized the nurse advice line and were given a medical home appointment via the nurse advice and appointment line when condition was not urgent Metric 1 [I-16.1]: Number of medical

130959304.1.2	*1.6.1*	*N/A*	*EXPAND URGENT CARE SERVICES*
Matagorda Regional Medical Center			130959304
Related Category 3 Outcome Measure(s):	*130959304.3.3*	*IT-9.2*	*ED appropriate utilization*

Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
			home appointments scheduled via the nurse advice and appointment line when condition was not urgent Goal: 10% Increase in Year 5 Data Source: EHR Records and Call center records Milestone 20 Estimated Incentive Payment $61,501 **Milestone 21 (I-17)** Implement interventions to improve access to care of patients receiving urgent medical advice Metric 1 [I-17.1]: Documentation of increased number of unique patients served by the innovative program Goal: Increase number of intervention by 10% Data Source: EHR Milestone 21 Estimated Incentive Payment $61,500

130959304.1.2	***1.6.1***	***N/A***	***EXPAND URGENT CARE SERVICES***
Matagorda Regional Medical Center			130959304
Related Category 3 Outcome Measure(s):	*130959304.3.3*	*IT-9.2*	*ED appropriate utilization*

Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $517,792	Year 3 Estimated Milestone Bundle Amount: $583,979	Year 4 Estimated Milestone Bundle Amount: $598,272	Year 5 Estimated Milestone Bundle Amount: $492,004
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)**:*** $2,192,046			

Memorial Hermann Hospital

Pass 1

Project Option: 1.1.1 Establish more primary care clinics: Physician Network Development

Performing Provider: Memorial Hermann Hospital/TPI 137805107
Unique Project ID: 137805107.1.1

- Provider: Memorial Hermann Hospital (Memorial) is an 860 bed hospital located in Houston, TX and is part of the Houston-Sugarland-Baytown MSA. The MSA population served by Memorial is approximately 6,000,000 people.

- Intervention(s): Memorial will expand the capacity of primary care through more clinics and available health care professionals to better accommodate the regional patient population and community so that patients have enhanced access to services. Memorial will aim to recruit 60+ new primary care providers and 18 new primary care locations are planned.

- Need for the project: The region has a growing shortage of primary care providers due to the aging population needing primary care services and the decline of new doctors interested in pursuing primary care. Expanding primary care clinics with extended hours will increase access and capacity and help create an organized structure of primary care providers, clinicians and staff.

- Target population: The target population is patients in the Houston Community including Downtown, Katy, the Inner Loop, Clear Lake, North and Northeast Houston. Memorial estimates the expanded primary care capacity will be able to serve an additional 100,000 to 150,000 people, 37.55% of which are anticipated to be Medicaid or uninsured.

- Category 1 or 2 expected patient benefits: Patients with limited primary care access often seek treatment for low acuity conditions at Emergency Departments which have a higher degree of unsatisfactory results and stress to the patient. The additional primary care capacity could decrease unnecessary ER visits by approximately 5% in DY2 and 15% over the DY2 baseline in DY5.

- Category 3 outcomes: IT 6.1 – Percent improvement over baseline of patient satisfaction scores - 10% improvement over baseline by DY5. Specifically, an improvement in patients' rating of whether patients are getting timely care appointments and information.

#96372

Project Option – 1.1.1 Establish more primary care clinics: Physician Network Development

Unique RHP Project Identification Number: 137805107.1.1
Performing Provider Name/TPI: Memorial Hermann Hospital (Memorial)/137805107

Project Description: In this project, Memorial will expand the network of primary care physicians in the community. Texas has a growing shortage of primary care doctors and nurses due to the needs of an aging population, a decline in the number of medical students choosing primary care, and thousands of aging baby boomers who are doctors and nurses looking towards retirement. The shortage of primary care workforce personnel in Texas is a critical problem that can be addressed under this Waiver. The shortage of primary care providers has contributed to increased wait times in hospitals, community clinics, and other care settings. Expanding primary care clinics will increase access and capacity and help create an organized structure of primary care providers, clinicians, and staff. Moreover, this expansion will strengthen an integrated health care system and play a key role in implementing disease management programs. A greater focus on primary care will be crucial to the success of an integrated health care system.

Goal(s) and relationship to Regional goal(s):

Project goals:

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

This project meets the following Region 3 goals:

This project addresses the RHP's goal to "[i]ncrease access to primary and specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their condition, regardless of where they live or their ability to pay."

Challenges and how addressed:

This project faces three key challenges. First, Memorial must raise awareness and change existing patterns for seeking health care services for some patients. A second challenge is to raise awareness for the service delivery model offered by these new sites so that patients who currently don't have access to after-hours care learn that this type of care is available through a physician's clinic rather than turning to emergent or urgent care clinics. And finally, recruiting 60 providers within four years in this competitive environment will be a challenge. Memorial will address these challenges by implementing other projects with reduce inappropriate ED use, educating patients on the benefits of primary care, and aggressively recruiting primary are providers.

5-year expected outcome for provider and patients:

Memorial will aim to recruit 60+ new primary care providers over the course of the Waiver. In addition, eighteen new primary care locations are planned to address patient access issues described above. These locations have been identified to reach people living across the Houston community including Downtown, Katy, the Inner Loop, and Clear Lake as examples. The clinics are scheduled to come on line during the course of the next four years providing easy access with early morning and after hours services along with weekend availability. These sites are estimated to provide new primary care capacity for 150,000 people.

Starting Point/Baseline: Memorial has identified the sites to expand primary care clinics.

Rationale:

Reasons for selecting the project option: In 2010, Texas had 176 patient care physicians per 100,000 population and 70 primary care physicians per 100,000 population with a state ranking of 46 and 47, respectively (comparable ratios for US total are 219.5 and 90.5, respectively). From 2001 to 2011, the Texas physician workforce grew 32.3%, exceeding the population growth of 25.1%. Therefore, there is a significant need to expand primary care in order to facilitate delivery system reform.

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

Unique community need identification number the project addresses:

CN1 – Primary Care

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

This project represents a significant improvement in Memorial's ability to deliver primary healthcare; which has a significant deficiency in Regions.

Related Category 3 Outcome Measure(s): OD-6 Patient Satisfaction. IT 6.1 Percent improvement over baseline of patient satisfaction scores.

Reasons/rationale for selecting the outcome measure(s):

If patients are getting timely patient care, appointments, and information then their satisfaction will increase. Therefore, patient satisfaction is an is a reasonable metric by which to judge the effectiveness of this project.

Relationship to Other Projects: This project is part of Memorial's larger plans to expand and develop primary care and specialty care services, while improving access to care. Expanding primary care supports/reinforces several of the Category 1 and 2 projects: Increasing the number of physicians rotating through the primary care residency program will have a direct impact on Expanding Primary Care Capacity (1.1); this project not only will increase the number of available physicians to participate in medical homes (2.1), it will also ensure that they are trained in the medical home concept; finally, the medical home concept of this training program also reinforces the Redesign of Primary Care (2.3), the Redesign to Improve the Patient Experience (2.4).

Relationship to Other Performing Providers' Projects in the RHP: Primary Care/Ambulatory Care clinics are a top priority to Region 3 due to the acuity of the regional patient mix, population concentration, and lack of primary care access points for our patient base. The regional approach of collaboration as well as existing patient referral pattern relationships allowed our team to properly identify the community needs based on the necessity of population, uninsured, and medically underserved patient bases. This program is consistent with our region and similar to numerous initiatives in our RHP plan sharing both concepts as well as outcome measures focused to percent improvement over baseline of patient satisfaction scores, reduction of inappropriate ED utilization, and third next available appointment status. The Region 3 Initiative Grid attached as a RHP Plan addendum reflects a grid of relationship for all initiatives.

Plan for Learning Collaborative: Transform health care delivery from a disease-focused model of episodic care to a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary or duplicative services, and builds on the accomplishments of our existing health care system

Project Valuation: The valuation of each Memorial Hermann project takes into account the transformational impact of the project, the population served by the project (both number of people and complexity of patient needs), the alignment of the project with community needs, the magnitude of costs avoided or reduced by the project, the degree of collaboration involved in the project, and the sustainability of the project.

The recruitment and expansion of primary care clinics and physicians will help address a substantial need in the community for increased access to primary care. It will also go a long way towards achieving the Waiver goal of improving outcomes while curbing the risk of healthcare costs, because primary care is one of the most cost effective methods to increase health outcomes.

137805107.1.1	***1.1.1***		***ESTABLISH MORE PRIMARY CARE CLINICS: PHYSICIAN NETWORK DEVELOPMENT***
Memorial Hermann Hospital			*137805107*
Related Category 3 Outcome Measure(s):	***020834001.3.1***	*IT-6.1*	***Percent Improvement Over Baseline of Patient Satisfaction Scores***
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1[P-X1]: Establish baseline for existing primary care clinic volume, number of primary healthcare workers and staff, and patient satisfaction in similar clinical settings in the community. Metric 1 [P-X1.1]: Establish baseline for future years. Goal: To determine baseline for measure of project improvement in future years. Data Source: Submission of documentation demonstrating study of baseline numbers. Milestone 1 Estimated Incentive Payment: $1,987,478 **Milestone 2** [P-8]: Participate in interactions with other providers and RHP to promote collaborative learning around shared or similar projects Metric 1[**P-8.1]:** Number meetings, conference calls or webinars organized by the RHP that the provider participated in. Goal: Participate in learning collaborative/meetings Data Source: Meeting Agendas, sign-n	**Milestone 3** [P-1]: Establish additional/expand existing/relocate primary care clinics. Metric 1 [P-1.1]: Number of additional clinics or expanded hours or space. Baseline/Goal: 5% increase over DY 2 baseline. Data Source: New primary care schedule or other Performing Provider document or other plans as designated by Performing Provider. Milestone 3 Estimated Incentive Payment: $2,168,231 **Milestone 4**[P-5]: Train/hire additional primary care providers and staff and/or increase the number of primary care clinics for existing providers. Metric 1 [P-5.1]: Documentation of increased number of providers and staff and/or clinic sites. Baseline/Goal: 5% increase over DY 2 baseline. Data Source: Documentation of	**Milestone 5** [I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 [I-12.1]: Documentation of increased number of visits. Demonstrate improvement over prior reporting period. Baseline/Goal: 5% increase over DY 2 baseline. Data Source: Registry, EHR, claims, or other Performing Provider source. Milestone 5 Estimated Incentive Payment: $1,449,689 **Milestone 6** [P-5]: Train/hire additional primary care providers and staff and/or increase the number of primary care clinics for existing providers. Metric 1 [P-5.1]: Documentation of increased number of providers and staff and/or clinic sites. Baseline/Goal: 10% increase over DY 2 baseline.	**Milestone 8** [I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 [I-12.1]: Documentation of increased number of visits. Demonstrate improvement over prior reporting period. Baseline/Goal: 10% increase over DY 2 baseline. Data Source: Registry, EHR, claims, or other Performing Provider source. Milestone 8 Estimated Incentive Payment: $1,197,569 **Milestone 9** [P-5]: Train/hire additional primary care providers and staff and/or increase the number of primary care clinics for existing providers. Metric 1 [P-5.1]: Documentation of increased number of providers and staff and/or clinic sites. Baseline/Goal: 15% increase over DY 2 baseline. 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

137805107.1.1	1.1.1		ESTABLISH MORE PRIMARY CARE CLINICS: PHYSICIAN NETWORK DEVELOPMENT
Memorial Hermann Hospital			137805107
Related Category 3 Outcome Measure(s):	020834001.3.1	IT-6.1	Percent Improvement Over Baseline of Patient Satisfaction Scores

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
sheets, conference calls, presentations, email Milestone 2 Estimated Incentive Payment: $1,987,478	completion of all items described by the RHP plan for this measure; hospital or other Performing Provider report, policy, contract, or other documentation. Milestone 4 Estimated Incentive Payment: $2,168,230	Data Source: Documentation of completion of all items described by the RHP plan for this measure; hospital or other Performing Provider report, policy, contract, or other documentation. Milestone 6 Estimated Incentive Payment: $1,449,689 **Milestone 7** [I-11]: Patient satisfaction with primary care services. Metric 1 [I-11.2]: Percentage of patients receiving survey. Specifically, the percentage of patients that are provided the opportunity to respond to the survey. Demonstrate improvement over prior reporting period. Baseline/Goal: 5% improvement. Data Source: Performing provider documentation of survey distribution; EHR. Milestone 7 Estimated Incentive Payment: $1,449,689	documentation. Milestone 9 Estimated Incentive Payment: $1,197,569 **Milestone 10** [I-11]: Patient satisfaction with primary care services. Metric [I-11.2]: Percentage of patients receiving survey. Specifically, the percentage of patients that are provided the opportunity to respond to the survey. Demonstrate improvement over prior reporting period. Baseline/Goal: 10 % improvement. Data Source: Performing provider documentation of survey distribution; EHR. Milestone 10 Estimated Incentive Payment: $1,197,569
Year 2 Estimated Milestone Bundle Amount: $3,974,954	Year 3 Estimated Milestone Bundle Amount: $4,336,461	Year 4 Estimated Milestone Bundle Amount: $4,349,067	Year 5 Estimated Milestone Bundle Amount: $3,592,708
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $16,253,190			

Project Option: 1.13.1 Develop and Implement Crisis Stabilization Services
Performing Provider: Memorial Hermann Hospital/TPI 137805107
Unique Project ID: 137805107.1.2

- Provider: Memorial Hermann Hospital (Memorial) is an 860 bed hospital located in Houston, TX and is part of the Houston-Sugarland-Baytown MSA. The MSA population served by Memorial is approximately 6,000,000 people.

- Intervention(s): Memorial will develop a crisis stabilization clinic that would provide rapid access to initial psychiatric treatment and outpatient services. The goal is to identify consumers with behavioral health needs that can be addressed and avoid unnecessary use of emergency departments, hospitalization or incarceration.

- Need for the project: From 20072012, Emergency Psych volumes coming into Memorial's acute care hospitals that could have been treated at a lower level of care was approximately 22,000 patients. Of that number, 11% (7,400) of those patients could have been discharged immediately if an emergency appointment with a psychiatrist or mental health nurse practitioner were rapidly available (within 24 hours).

- Target population: The target population is emergent psychiatric patients coming into Memorial's acute care facility. A crisis clinic would provide rapid access to initial psychiatric treatment and outpatient services to a large volume community jointly in need of investment in mental health services. It is estimated that 20% of people in Harris County suffer from behavioral health issues of which 25% are uninsured and another 18% or 701,559 are covered by Medicaid. Of the 701,559 residents covered by Medicaid, approximately 8% have received some type behavioral health treatment.

- Category 1 or 2 expected patient benefits: The establishment of these behavioral health services will decrease emergency department visits by behavioral health patients through increasing bed availability for acute patients, decrease emergency department wait times which cause emergency department bottleneck; decrease unnecessary admissions to inpatient behavioral programs and/or county juvenile and judicial systems.

- Category 3 outcomes: IT 3.8 – By DY5, Memorial expects to demonstrate an improvement on its Behavioral Health/Substance Abuse 30day readmission rate by at least 10% over baseline measurement.

Project Option-1.13.1 Develop and Implement Crisis Stabilization Services

Unique RHP Project Identification Number: 137805107.1.2

Performing Provider Name/TPI: Memorial Hermann Hospital (Memorial)/TPI 137805107

Project Description:

Memorial's proposal is to develop a crisis stabilization clinic better identifies people with behavioral health needs, responds to those needs and links persons with the most appropriate level of care. Our goal is to keep individuals healthy and safe, develop processes and intervention to manage challenging behaviors, and avoid unnecessary use of emergency departments, hospitalization or incarceration. The clinic will be staffed with a nurse practitioner, social worker and other patient care staff to provide an outpatient emergency appointment for patients with no immediate access for mental health care.

The clinic will use a short-term treatment model to reduce acute symptoms of mental illness provided in a secure and protected clinically staffed, psychiatrically supervised, treatment environment.

The target population will be emergent psychiatric patients coming into Memorial's acute care facility. From 2007-2012, Emergent Psych volumes coming into Memorial Hermann's acute care hospitals that could have been treated at an lower level of care was approximately 22,000 patients. Of that number, 11% (2400) of these patients could have been discharged from the hospitals immediately if an emergency appointment with a psychiatrist or mental health nurse practitioner were rapidly available (within 24 hours). A Crisis Clinic would provide rapid access to initial psychiatric treatment and outpatient services to a large urban community greatly in need of investment in mental health services.

Further analysis will be completed to assess the behavioral health needs of patient currently receiving crisis services in the jails, other area emergency departments or psychiatric hospitals. A gap analysis will be used to develop a data-driven plan for specific community-based crisis stabilization alternatives that will meet the behavioral health needs of the patients. A complete review of potential crisis alternative service models will be explored to determine acceptable and feasible models for implementation of this program. The clinic will develop a setting where access to behavioral healthcare is available to the community beyond the traditional hours of private providers. This setting would most appropriately assess and treat mental health consumers at the moment of crisis. This would remove a layer of emergency services which, in its current state, only provides a referral to appropriate care once the imminent crisis has passed. Providing an appropriate setting and access to care for behavioral health consumers in crisis, staffed with appropriately licensed professionals, provides a community resource that efficiently responds to these crises and reduces the number of visits to emergency departments for behavioral health conditions.

Goal(s) and relationship to Regional goal(s):

Project goals:

Promote better health outcomes for behavioral health patients. Decrease unnecessary ED visits. Decrease unnecessary admissions and readmissions. The goal of this project is to establish a crisis clinic to broaden access to behavioral healthcare that may include the building of a new facility or expansion of operating hours in a select number of clinics capable of treating this particular patient population.

This project meets the following Region 3 goals:

This project addresses the RHP's goal to "[i]ncrease access to primary and specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their condition, regardless of where they live or their ability to pay."

Challenges:

Individuals with chronic mental health conditions struggle with non-compliance in prescribed health maintenance activities, including medicine management, follow-up, and Medicaid enrollment active. Memorial also anticipates the challenge of recruiting competent behavioral healthcare staff to work non-traditional hours. Memorial will address these challenges by focusing on patient education and making the patient the center of care decisions to the fullest extent possible. Additionally, Memorial will engage in aggressive recruitment to locate and hire professional staff.

5-year expected outcome for provider and patients:

With the addition of behavioral health crisis services to the current programs offered at Memorial, we expect to decrease emergency department visits by behavioral health patients thus increasing bed availability for acute patients; decrease emergency department wait times which cause emergency department bottlenecks; decrease unnecessary admissions to inpatient behavioral health programs and or county jails/judicial systems. All of these situations will result in a significant cost savings for area hospitals, local mental health authorities and county justice organizations. Most importantly, behavioral health patients will receive necessary treatment in a more efficient and timely manner.

Starting Point/Baseline: Currently, Memorial does not have a crisis clinic available to patients with mental healthcare needs.

Rationale:

A Behavioral Health Crisis Clinic would provide an efficient portal for outpatient stabilization and comprehensive Behavioral Health Social Work services. This would ensure patients with chronic or emergent needs are connected to comprehensive Behavioral Health Services and are provided with an outpatient crisis follow-up resource for future events in place for system acute care hospitals. Patients will meet with a licensed Clinical Social Worker in the Behavioral Health

Crisis Clinic to develop a comprehensive Behavioral Health treatment plan, be educated about navigating the fragmented Behavioral Health/Mental Health care delivery system, and if appropriate set up a case management relationship to address compliance issues with health maintenance activities for a 90 period. After 90 days, patient will be reevaluated for compliance with community providers and/or on-going case management services.

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

Project components:

a) Convene community stakeholders who can support the development of crisis stabilization services to conduct a gap analysis of the current community crisis system and develop a specific action plan that identifies specific crisis stabilization services to address identified gaps

- Memorial will conduct baseline focus groups with local Behavioral Health Providers, local planning/advisory councils and county mental health authority.

b) Analyze the current system of crisis stabilization services available in the community including capacity of each service, current utilization patterns, eligibility criteria and discharge criteria for each service.

- Memorial will examine the current service delivery system, determining the availability of persons in need and also determining adequacy or limitations of services for persons in need.

- Memorial will review the current state of the available mental health workforce, including community based and hospital inpatient services.

c) Assess the behavioral health needs of patients currently receiving crisis services in the jails, EDs, or psychiatric hospitals. Determine the types and volume of services needed to resolve crises in community-based settings. Then conduct a gap analysis that will result in a data-driven plan to develop specific community-based crisis stabilization alternatives that will meet the behavioral health needs of the patients.

- Memorial will utilize social indicators and prevalence data on the general population related to mental health risk factors, estimate the need for services.

- Memorial will develop an on-going data collection system/process that Leadership will utilize to update the services currently available and compare with services needed (Gap Analysis.)

d) Explore potential crisis alternative service models and determine acceptable and feasible models for implementation.

- Memorial will analyze the differences in profiles between those receiving services and those not receiving services.

e) Review the intervention(s) impact on access to and quality of behavioral health crisis stabilization services and identify "lessons learned," opportunities to scale all or part of the intervention(s) to a broader patient population, and identify key challenges associated with expansion of the intervention(s), including special considerations for safety-net populations.

- Memorial will develop an on-going data collection system/process that Leadership will utilize to update the services currently available and compare with services needed (Gap Analysis.)

- Memorial will recommend and prioritize steps to strategically enhance services to achieve the greatest impact on mental health service needs and system development on an ongoing basis.

Unique community need identification number the project addresses:

- CN.1 - Primary Care
- CN.8 - High rates of inappropriate emergency department utilization
- CN.9 - High rates of preventable hospital readmissions
- CN.6-Inadequate access to treatment and services designed for special needs populations, including disabled, homeless, children, and elderly

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

This project would significantly enhance Memorial's ability to deliver vital healthcare services. Our community does not currently have sufficient resources to deal with the needs of the behavioral healthcare population and this project would directly address that deficiency. The patients at our facilities would demonstrably benefit from such a project. Emergent Psychiatric volumes which entered our acute care facilities from 2007-2012 that potentially could have been managed outpatient from 2007- 2012 was approximately 61%, or over 22,000 patient encounters. Close to 2,500, or 11% of these patient encounters could have been discharged immediately from the system if an emergency appointment with a psychiatrist or nurse practitioner within 24 hours was rapidly available.

Related Category 3 Outcome Measure(s): OD-3 Potentially Preventable Readmissions; IT-3.8 Behavioral Health /Substance Abuse 30 day readmission rate

Reasons/rationale for selecting the outcome measure(s):

When patients with behavioral healthcare needs are receiving the correct treatment in the correct setting this will improve their health outcomes and significantly reduce the amount of potentially preventable readmissions for these patients.

Relationship to other Projects: This project is part of Memorial Hermann's larger vision to expand and develop primary and specialty care services, while improving access to care and implementing delivery improvements targeted to specific populations (in this case, behavioral health patients). In the current state of fragmented healthcare delivery, Behavioral Health consumers are left to navigate primary care systems that do not provide behavioral health treatment and are not staffed with behavioral health professionals trained to meet the needs of this targeted population.

Relationship to Other Performing Providers' Projects in the RHP: Numerous community needs assessments reflect an extreme need for behavioral health services to include outpatient treatment centers, crisis stabilization units, inpatient beds, and much more. The lack of funding as well as complexity of the regions patient base has limited the amount of behavioral health treatments available to our region and continues to drive cost in emergent and inpatient situations. The Crisis Stabilization Unit has a direct correlation to all behavioral health programs recommended in the RHP plan and will be a focus of two of the largest Local Mental Health Authorities of our region. Both CSU's share the outcome measures of mental health admissions & readmissions, and improvement of patient satisfaction scores. The Region 3 Initiative Grid attached in the addendum reflects the direct relationships of this initiative.

Plan for Learning Collaborative: We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system.

Project Valuation:

Approach for valuing project: The valuation of each Memorial Hermann project takes into account the transformational impact of the project, the population served by the project (both number of people and complexity of patient needs), the alignment of the project with community needs, the magnitude of costs avoided or reduced by the project, the degree of collaboration involved in the project, and the sustainability of the project.

Rationale/justification for valuation: A crisis clinic will significantly reduce unnecessary hospital readmissions and thereby increase the efficient allocation of resources in Region 3. Furthermore, the crisis stabilization center will add a much needed component to the healthcare infrastructure in the community, thus meeting one of the three main goals of the waiver.

137805107.1.2	***1.13.1***	A-E	***DEVELOP AND IMPLEMENT CRISIS STABILIZATION SERVICES TO ADDRESS THE IDENTIFIED GAPS IN THE CURRENT COMMUNITY CRISIS SYSTEM: HEALTH CRISIS CLINIC***
Memorial Hermann Hospital			137805107
Related Category 3 Outcome Measure(s):	***137805107.3.2***	IT-3.8	***Behavioral Health /Substance Abuse 30 day readmission rate***

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-1]: Conduct stakeholder meetings among consumers, family members, law enforcement, medical staff and social workers from EDs and psychiatric hospitals, EMS, and relevant community behavioral health services providers. Metric 1[P-1.1] Number of meetings and participants. Goal: Convene stakeholders Data Source: Attendance lists Milestone 1 Estimated Incentive Payment: $1,349,984 **Milestone 2 [P-X1]:** Establish baseline for inappropriate ED utilization, and measure of appropriate crisis alternatives. Metric 1 [P-X1.1]: Establish baseline for future years. Goal: To determine baseline for measure of project improvement in future years. Data Source: Submission of documentation demonstrating study of baseline numbers.	**Milestone 4** [P-5]: Develop administration of operational protocols and clinical guidelines for crisis services. Metric 1 [P-5.1]: Completion of policies and procedures. Goal: Better operations of project Data Source: Internal policy and procedures documents and operations manual. Milestone 4 Estimated Incentive Payment: $1,472,760 **Milestone 5** [P-2]: Identify licenses, equipment requirements and other components needed to implement and operate options selected. Metric 1[P-2.1]: Develop a project plan and timeline detailing the operational needs, training materials, equipment and components. Goal: Develop a project plan to improve project operations Data Source: Project plan. Milestone 5 Estimated Incentive	**Milestone 8** [P-7]: Participate in at least quarterly interactions (meetings, conference call or webinars) with other providers and the RHP to promote collaborative learning around shared or similar projects Metric 1 [P-7-1]: Number of quarterly meetings, conference calls or webinars organized by the RHP that the provider participated in. Data source: Documentation of quarterly meetings, conference calls, or webinars including agendas for phone calls, slides from webinars and/or meeting notes. Goal: Investment in learning and sharing of ideas is central to improvement. Milestone 8 Estimated Incentive Payment: $2,215,563 **Milestone 9** [I-12]: Utilization of appropriate crisis alternatives. Metric 1 [I-12.1]: Goal: 5% increase in utilization of appropriate crisis alternatives.	**Milestone 10** [I-12]: Utilization of appropriate crisis alternatives. Metric 1 [I-12.1]: Goal: 5% increase in utilization of appropriate crisis alternatives. Data source: Claims, encounter and clinical record data. Milestone 10 Estimated Incentive Payment: **$***$1,830,248* **Milestone 11** [P-7]: Participate in at least quarterly interactions (meetings, conference call or webinars) with other providers and the RHP to promote collaborative learning around shared or similar projects Metric 1 [P-7-1]: Number of quarterly meetings, conference calls or webinars organized by the RHP that the provider participated in. Goal: Investment in learning and sharing of ideas is central to improvement. Data source: Documentation of quarterly meetings, conference calls, or webinars including agendas for phone calls, slides from webinars and/or meeting notes.

137805107.1.2	***1.13.1***	A-E	***DEVELOP AND IMPLEMENT CRISIS STABILIZATION SERVICES TO ADDRESS THE IDENTIFIED GAPS IN THE CURRENT COMMUNITY CRISIS SYSTEM: HEALTH CRISIS CLINIC***
Memorial Hermann Hospital			137805107
Related Category 3 Outcome Measure(s):	***137805107.3.2***	IT-3.8	***Behavioral Health /Substance Abuse 30 day readmission rate***

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 2 Estimated Incentive Payment: $1,349,984 **Milestone 3** [P-2]: Conduct mapping and gap analysis of current crisis system. Metric 1 [P-2.1]: Produce a written analysis of community needs for crisis services. Goal: Better information to reach targeted patients Data Source: Written plan Milestone 3 Estimated Incentive Payment: $1,349,985	Payment: **Milestone 6** [P-4]: Hire and train staff to operate and manage projects selected Metric 1[P-4.1]: Number of staff secured and trained. Goal: Better project operations Data Source: Project records; Training curricula as developed in P-2. Milestone 6 Estimated Incentive Payment: $1,472,760 **Milestone 7** [P-7]: Participate in at least quarterly interactions (meetings, conference call or webinars) with other providers and the RHP to promote collaborative learning around shared or similar projects Metric 1 [P-7-1]: Number of quarterly meetings, conference calls or webinars organized by the RHP that the provider participated in. Goal: Investment in learning and sharing of ideas is central to improvement.	Data source: Claims, encounter and clinical record data. Milestone 9 Estimated Incentive Payment: $2,215,562	Milestone 11 Estimated Incentive Payment: *$1,830,247*

137805107.1.2	***1.13.1***	A-E	***DEVELOP AND IMPLEMENT CRISIS STABILIZATION SERVICES TO ADDRESS THE IDENTIFIED GAPS IN THE CURRENT COMMUNITY CRISIS SYSTEM: HEALTH CRISIS CLINIC***
Memorial Hermann Hospital			137805107
Related Category 3 Outcome Measure(s):	***137805107.3.2***	IT-3.8	***Behavioral Health /Substance Abuse 30 day readmission rate***

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	Data source: Documentation of quarterly meetings, conference calls, or webinars including agendas for phone calls, slides from webinars and/or meeting notes. Milestone 7 Estimated Incentive Payment: $1,472,760		
Year 2 Estimated Milestone Bundle Amount: $4,049,953	Year 3 Estimated Milestone Bundle Amount: $4,418,281	Year 4 Estimated Milestone Bundle Amount: $4,431,125	Year 5 Estimated Milestone Bundle Amount: $3,660,495
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $16,559,854			

Project Option: 1.1.1 - 1.1 Expand Primary Care Capacity: Pediatric Clinic Expansion – North Harris County Pediatric Clinic

Unique Project ID: 137805107.1.3
Performing Provider Name/TPI: Memorial Hermann Hospital/ 137805107

Project Summary:

Provider: Memorial Hermann Hospital (Memorial) is an 860 bed hospital located in Houston, TX and is part of the Houston-Sugarland-Baytown MSA. The MSA population served by Memorial is approximately 6,000,000 people.

Intervention(s): Memorial will establish the North Harris County Pediatric Clinic which will provide primary care for pediatric patients in that area of Harris County. Memorial will contract UTHSC-H to provide physician services to complement Memorial's investment in new technology, equipment and space to better provide pediatric services.

Need for the project: Prospective pediatric patients in the targeted service area described below currently face many roadblocks to adequate primary care including economic burdens, language barriers and lack of knowledge for seeking pediatric care. Due to the shortage of primary care providers in the community, the average wait period for a primary care appointment is 17 days, which results in increased reliance on hospital EDs for primary care and non-emergent care. The project will increase the percentage of patients who receive appropriate primary care including preventative services and regular monitoring for patients with chronic illnesses.

Target population: The target population is uninsured and underinsured children in the area of Harris County that is between Cypress Parkway and FM 1960 to the North, Tomball Parkway to the West, West Road to the South and Hwy. 59N to the East. It is estimated that 38.4% of the patients in the service area for this clinic are either uninsured or underinsured children and rely on Memorial Hermann's and other hospitals' emergency departments for primary care services.

Category 1 or 2 expected patient benefits: The clinic will provide a more appropriate setting for pediatric primary care for the target population. They will benefit primarily from better access to primary care and better management of illness and chronic conditions.

Category 3 outcomes: IT 1.1 – Reduce the average length of time in days between the day a patient requests an appointment and the third available appointment. The goal will be to decrease number of days to third next available appointment to zero days (same day) for primary care by DY5.

Project Option 1.1.1- Establish More Primary Care Clinics: Pediatric Clinic Expansion - North Harris County Pediatric Clinic

Unique RHP Project Identification Number: 137805107.1.3

Performing Provider Name/TPI: Memorial Hermann Hospital (Memorial)/137805107

Project Description: Using the strengths developed during their longstanding partnership, Memorial and The University of Texas Health Science Center at Houston (UTHSC-H) intend to work together to address the shortage of pediatric primary and specialty care in Region 3. In this project, Memorial will establish the North Harris County Pediatric Clinic, which will provide primary care for pediatric patients in an area of Harris County that is between Cypress Pkwy and FM 1960 to the north, Tomball Parkway to the west, West Road to the south, and Highway 59N to the east. Memorial has defined the service area for this clinic as a priority area for pediatric services, because it contains 15 of the 81 census tracts that make up the top 10% of all census tracts in Harris County with the greatest number of people below the age of 18 that are living below the federal poverty level (FPL). (The census tracts are 5511, 5506.03, 5503.02, 5503.01, 5502, 5501, 5338.02, 2415, 2408.01, 2407.01, 2405.02, 2227, 2226, 2225.03, and 2225.01.) The number of children living below the FPL in these 15 census tract areas is estimated to be approximately 15,465. Furthermore, these areas have particularly high numbers of Hispanics (49.9%), for whom language, as well as poverty, may pose a barrier to obtaining primary care for their children. Black/African Americans, another segment of the population that tend to be medically underserved, also make up a significant proportion of the population in these census tracts (35.1%). The service area for this clinic includes large populations with economic, cultural, language, and transportation barriers to receiving primary care. (All population statistics are from the U.S. Census Bureau, 2010 Census. Poverty statistics are from the U.S. Census Bureau, Small Area Estimates Branch. Release date: 11.2011. Table 1: 2010 Poverty and Median Income Estimates - Counties.) In order to address the unique needs of different communities in the greater Houston area, Memorial has chosen to establish a pediatric clinic in this area as an independent DSRIP project.

Using their longstanding partnership to provide quality healthcare as a base, Memorial will contract UTHSC-H to provide physician services to complement Memorial's investment in new technology, equipment and space to better provide pediatric services. Specifically, UTHSC-H will redirect pediatricians already on its staff who have the capacity to care for additional patients, recruit additional pediatricians, or increase residency programs to fill the need for additional pediatric specialists. UTHSC-H is uniquely positioned to attract and retain new physicians due to its accomplishments as a world-class academic and research institution. This additional service line will avoid duplication and draw on the strength of UTHSC-H's academic presence in the field of pediatric medicine, and will also benefit Memorial by increasing the quantity, quality, and scope of services provided at its facilities.

Practically, Memorial will subcontract with UTHSC-H to provide physician and other services needed to implement this project. For example, Memorial will lease additional space to open the North Harris County clinic**.** This space will include additional consulting, exam and procedure rooms. Memorial will also subcontract with UTHSC-H to provide primary care providers and support staff to operationalize the project. For all services in which UTHSC-H is a subcontractor, Memorial will pay an agreed rate that is set in advance and represents fair market value for services negotiated in the ordinary course of business through an arms-length transaction.

Goal(s) and relationship to Regional goal(s):

Project goals:

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

This project meets the following Region 3 goals:

One of the goals of the region is to "Increase access to primary and specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their condition, regardless of where they live or their ability to pay". Expansion of primary care capacity certainly relates to this goal as it will make it easier for Memorial to provide care to underserved populations.

Challenges and how addressed:

This project faces three key challenges. First, Memorial must raise awareness and change existing patterns for seeking health care services for some patients. A second challenge is to raise awareness for the service delivery model offered by these new sites so that patients who currently don't have access to after-hours care learn that this type of care is available through a physician's clinic rather than turning to emergent or urgent care clinics. And finally, recruiting additional primary care providers and pediatric specialists in this competitive environment will be a challenge. Memorial will address these challenges by implementing other projects to reduce inappropriate ED use, educating patients on the benefits of primary care, and aggressively recruiting primary care providers by offering competitive salaries and other incentives to practice in the outlying clinics.

5-year expected outcome for provider and patients:

There will be shortening of waiting times for primary pediatric care appointments and increased uptake of primary pediatric care services in this specific service area, which will increase the percentage of patients who receive appropriate primary health care, including preventative services and regular monitoring for those patients with chronic illnesses.

Starting Point/Baseline: Memorial has identified the targeted service area needing increased access to pediatric primary care. Since this will be a new clinic, the baseline will have to be established during DY3.

Rationale:

In 2010, Texas had 176 patient care physicians per 100,000 population and 70 primary care physicians per 100,000 population with a state ranking of 46 and 47, respectively (comparable ratios for US total are 219.5 and 90.5, respectively). From 2001 to 2011, the Texas physician workforce grew 32.3%, exceeding the population growth of 25.1%. Therefore, there is a significant need to expand primary care in order to facilitate delivery system reform.

Research has shown that access to primary care is associated with better health outcomes at less cost. Access to primary care ensures better preventive care and better management of chronic disease, with lack of access often resulting in more expensive care, received in hospitals and emergency departments (ED). For the fiscal year 2010, 10% of all potentially preventable hospitalizations (PPR) were ambulatory care sensitive. In 2009, 41% (390,945) of ED visits in Houston were primary care related (PCR), including non-urgent, primary care treatable, and primary care preventable, and for 26.8% (104,762) of these PCR visits, Medicaid was the payor. Getting more patients into primary care will help to reduce the use of this more costly care. Placing more primary care providers out in the communities will help to address transportation access barriers and the expansion of clinic service hours will provide a greater selection of available appointment times. By increasing primary care capacity, engaging more people in the primary care system, and avoiding inappropriate utilization of costly services, the community will experience better health outcomes and greater patient satisfaction.[76]

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

[76] PPR rate was from the Texas Health and Human Services Commission report on Potentially Preventable Readmissions in the Texas Medicaid Population, Fiscal year 2010, published January, 2012. The statistics for ED use were from the Houston Hospitals Emergency Department Use Study (January 1, 2009 through December 31, 2009), Final Report included in the 2010 Harris County Community Needs Assessment for Memorial Hermann.

Because UTHSC-H will IGT on behalf of Memorial for its successful implementation of delivery system improvements under the Waiver, this structure results in a payment from a private hospital to an entity that provides its IGT, which arguably raises questions regarding provider donations. Nonetheless, this collaboration is the most effective and efficient structure to expand access to pediatric services to the community, and ensure overall improvement to the Region 3 delivery system. This collaboration is a natural progression of the existing relationship and the clinical strengths of Memorial and UTHSC-H. Memorial is the largest not-for-profit healthcare system in Texas and serves the greater Houston community through 12 hospitals, a vast network of affiliated physicians and numerous specialty programs and services. With over 4,000 medical staff members, 26 residency programs, 48 fellowship programs, and over 1,300 physicians in training, Memorial is dedicated to providing high quality health services in order to improve the health of the people in Southeast Texas. The mission of UTHSC-H is to educate health science professionals, discover and translate advances in the biomedical and social sciences, and model the best practices in clinical care and public health. UTHSC-H strives to improve the health of the public in the State of Texas through educating future public health practitioners and bringing evidence based public health practices to Texas. UTHSC-H's faculty of over 900 physicians in 80 specialties provide comprehensive care for patients while teaching 800 medical students and over 900 residents in over 60 accredited residency/fellowship programs.

Core Components:

Through the new North Harris County Pediatric Clinic, we propose to:

a) Expand primary care clinic space

-Memorial will identify and lease appropriate space within the defined service area to establish the new clinic that includes reception, consulting, exam and procedure rooms, and will provide the necessary equipment and furnishings.

b) Expand primary care clinic hours

- UT Physicians will be contracted at fair market value to provide primary care physicians, advanced practice providers, and support staff to operate the clinic.

c) Expand primary care clinic staffing

-In addition to regular business hours, the clinic will operate with expanded evening and Saturday hours to increase access for individuals that are not able to leave their jobs for healthcare appointments, and to provide care for those needing urgent care services that can be accommodated in a primary care clinic.

Unique community need identification number the project addresses:

CN1 – Primary Care

CN8 – High rates of inappropriate emergency department utilization

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

This project represents a significant improvement in Memorial's ability to deliver primary healthcare to babies, children, and adolescents. This new initiative proposes to add space, providers, support staff, and extended service hours in a location where economic and cultural barriers to receiving appropriate healthcare are indicative of a need for services that are conveniently located and available when needed. This project is an expansion of services in order to improve access to care.

Related Category 3 Outcome Measure(s):

OD-1 Primary Care and Chronic Disease Management IT-1.19 Antidepressant Medication Management - NQF 0105 (Standalone measure)

The management of antidepressant medication in children ages 6 and over who were discharged alive) from an acute inpatient setting (including acute care psychiatric facilities) with a principal mental health diagnosis: A) the acute phase treatment period consisting at least 84 days (12 weeks) of continuous treatment with antidepressant medication during the 114-day period following the IPSD (inclusive), and B) the continuation phase treatment period consisting of at least 180 days (6 months) of continuous treatment with antidepressant medication (Table AMM-D) during the 231-day period following the IPSD (inclusive).

OD-1 Primary Care and Chronic Disease Management IT-1.1 Third next available appointment (Non- standalone measure)

Reduce the average length of time in days between the day a patient makes a request for an appointment with a physician and the third available appointment for a new patient physical, routine exam, or return visit exam.

Reasons/rationale for selecting the outcome measure(s):

This project is specifically geared towards increasing primary care services for pediatric patients. If this population is receiving adequate levels of primary behavioral healthcare then the management of anti-depressant medication is expected to improve. Additionally, the immediate goal of the project is to allow greater access to primary care for pediatric patients—this should directly correlate to reduced wait times for available appointments. Therefore, this outcome measure is a reasonable gauge of the effectiveness of this project.

Relationship to Other Projects: This project is part of Memorial's larger plans to expand and develop primary care and specialty care services, while improving access to care. Expanding primary care supports/reinforces several of the Category 1 and 2 projects: increasing the number of physicians rotating through the primary care residency program will have a direct impact on Expanding Primary Care Capacity (1.2); this project not only will increase the number of available physicians to participate in medical homes (2.1), it will also ensure that they are trained in the medical home concept; this project reinforces the Redesign of Primary Care (2.3), the Redesign to Improve the Patient Experience (2.4).

Relationship to Other Performing Providers' Projects in the RHP: Children are the future of healthcare and will dictate the treatments needed as well as the cost of healthcare in future years so it is critical that they receive the access needed throughout their pediatric lives. The focus of pediatric specialty care is similar throughout the region with a concentrated focus in the Harris county proper geographic region and allows for the expansion of access to numerous specialties such as cardiology, neurology, ENT, and many more. The outcome measures focus to appropriate length of stay, per episode cost of care, and improved cost savings. The Region 3 Initiative grid allows for a cross reference of similar initiatives in our region. (addendum)

Plan for Learning Collaborative: Memorial will participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system.

Project Valuation: The valuation of each Memorial project takes into account the transformational impact of the project, the population served by the project (both number of people and complexity of patient needs), the alignment of the project with community needs, the magnitude of costs avoided or reduced by the project, the degree of collaboration involved in the project, and the sustainability of the project.

The expansion of primary care clinics will help address a substantial need in the community for increased access to primary care. It will also go a long way towards achieving the Waiver goal of improving outcomes while curbing the risk of healthcare costs, because primary care is one of the most cost effective methods to increase health outcomes.

137805107.1.3	*OPTION 1.1.1*		*PEDIATRIC CLINIC EXPANSION*
Memorial Hermann Hospital			*137805107*
Related Category 3 Outcome Measure(s):	*137805107.3.4* *137805107.3.3*	**IT-1.19** **IT-1.1**	**Antidepressant Medication Management - NQF 0105 (Standalone measure)** **Third next available appointment (Non-standalone measure)**

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-1]: Expand existing primary care clinics Metric 1 [P-1.1]: Amount of additional space aquired to expand clinic services. Baseline/Goal: TBD Data Source: New primary care schedule and other UT Physicians' documents. Milestone 1 Estimated incentive payment: $2,200,710 **Milestone 2** [P-5]: Hire additional primary care providers and staff Metric 1 [P-5.1]: Documentation of increased number of providers and staff. Baseline/Goal: TBD Data Source: UT Physicians' report, policy, contract or other documentation Milestone 2 Estimated incentive payment: $2,200,710	**Milestone 3 [P-4]:** Expand the hours of a primary care clinic, including evening and/or weekend hours Metric 1 [P-4.1]: Increased number of hours at primary care clinic over baseline Baseline/Goal: TBD Data Source: Clinic documentation Milestone 3 Estimated incentive payment: $4,800,245	**Milestone 4 [I-12]:** Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 [I-12.1]: Documentation of increased number of visits. Demonstrate improvement over prior reporting period. Goal: TBD Data Source: Registry, EHR, claims or other UT Physicians' source Milestone 4 Estimated incentive payment: $4,800,221	**Milestone 5 [I-11]:** Patient satisfaction with primary care services. Metric 1 [I-11.1]: Improved Patient satisfaction scores Goal: TBD Data Source: CG-CAHPS3 or other developed evidence based satisfaction assessment tool, available in formats and language to meet patient population. Milestone 5 Estimated incentive payment: $3,923,828
Year 2 Estimated Milestone Bundle Amount: $4,401,420	Year 3 Estimated Milestone Bundle Amount: $4,800,245	Year 4 Estimated Milestone Bundle Amount: $4,800,221	Year 5 Estimated Milestone Bundle Amount: $3,923,828
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $17,925,714			

Project Option: 1.1.1 - 1.1 Expand Primary Care Capacity: Pediatric Clinic Expansion – Houston Ship Channel South Pediatric Clinic

Unique Project ID: 137805107.1.4
Performing Provider Name/TPI: Memorial Hermann Hospital/ 137805107

Project Summary:

Provider: Memorial Hermann Hospital (Memorial) is an 860 bed hospital located in Houston, TX and is part of the Houston-Sugarland-Baytown MSA. The MSA population served by Memorial is approximately 6,000,000 people.

Intervention(s): Memorial will establish the Houston Ship Channel South Pediatric Clinic which will provide primary care for pediatric patients in that area of Harris County. Memorial will contract UTHSC-H to provide physician services to complement Memorial's investment in new technology, equipment and space to better provide pediatric services.

Need for the project: Prospective pediatric patients in the targeted service area described below currently face many roadblocks to adequate primary care including economic burdens, language barriers and lack of knowledge for seeking pediatric care. Due to the shortage of primary care providers in the community, the average wait period for a primary care appointment is 17 days, which results in increased reliance on hospital EDs for primary care and non-emergent care. The project will increase the percentage of patients who receive appropriate primary care including preventative services and regular monitoring for patients with chronic illnesses.

Target population: The target population is uninsured and underinsured children in the South area of the Houston Ship Channel that is between the Houston Ship Channel to the North, 610S to the West, Beltway 8S to the South and Beltway 8E to the East. It is estimated that 46.6% of the patients in the service area for this clinic are either uninsured or underinsured children and rely on Memorial Hermann's and other hospitals' emergency departments for primary care services.

Category 1 or 2 expected patient benefits: The clinic will provide a more appropriate setting for pediatric primary care for the target population. They will benefit primarily from better access to primary care and better management of illness and chronic conditions.

Category 3 outcomes: IT 1.1 – Reduce the average length of time in days between the day a patient requests an appointment and the third available appointment. The goal will be to decrease number of days to third next available appointment to zero days (same day) for primary care by DY5.

Project Option 1.1.1- Establish More Primary Care Clinics: Pediatric Clinic Expansion – Houston Ship Channel South Pediatric Clinic

Unique RHP Project Identification Number: 137805107.1.4

Performing Provider Name/TPI: Memorial Hermann Hospital (Memorial)/137805107

Project Description: 1.1/1.1.1: Using the strengths developed during their longstanding partnership, Memorial and The University of Texas Health Science Center at Houston (UTHSC-H) intend to work together to address the shortage of pediatric primary and specialty care in Region 3. In this project, Memorial will establish the Houston Ship Channel South Pediatric Clinic, which will provide primary care for pediatric patients in an area of Harris County that is between the Houston Ship Channel to the north, 610S to the west, Beltway 8S to the south, and Beltway 8E to the east. Memorial has defined the service area for this clinic as a priority area for pediatric services, because it contains 10 of the 81 census tracts that make up the top 10% of all census tracts in Harris County with the greatest number of people below the age of 18 living below the federal poverty level (FPL). (The census tracts included are 3333, 3328, 3235, 3234, 3230, 3220, 3213, 3209, 3208, and 3202.) The number of children living below the FPL in these 10 census tract areas is estimated to be approximately 10,113. Furthermore, these areas have particularly high numbers of Hispanics (69%), for whom language, as well as poverty, may pose a barrier to obtaining primary care for their children. The service area for this clinic includes a large population, for whom there exists economic, cultural, language, and transportation barriers to receiving primary care. (All population statistics are from the U.S. Census Bureau, 2010 Census. Poverty statistics are from the U.S. Census Bureau, Small Area Estimates Branch. Release date: 11.2011. Table 1: 2010 Poverty and Median Income Estimates - Counties.) In order to address the unique needs of different communities in the greater Houston area, Memorial has chosen to establish a pediatric clinic in this area as an independent DSRIP project.

Using their longstanding partnership to provide quality healthcare as a base, Memorial will contract UTHSC-H to provide physician services to complement Memorial's investment in new technology, equipment and space to better provide pediatric services. Specifically, UTHSC-H will redirect pediatricians already on its staff who have the capacity to care for additional patients, recruit additional pediatricians, or increase residency programs to fill the need for additional pediatric specialists. UTHSC-H is uniquely positioned to attract and retain new physicians due to its accomplishments as a world-class academic and research institution. This additional service line will avoid duplication and draw on the strength of UTHSC-H's academic presence in the field of pediatric medicine, and will also benefit Memorial by increasing the quantity, quality, and scope of services provided at its facilities.

Practically, Memorial will subcontract with UTHSC-H to provide physician and other services needed to implement this project. For example, Memorial will lease additional space to open the

North Harris County clinic**.** This space will include additional consulting, exam and procedure rooms. Memorial will also subcontract with UTHSC-H to provide primary care providers and support staff to operationalize the project. For all services in which UTHSC-H is a subcontractor, Memorial will pay an agreed rate that is set in advance and represents fair market value for services negotiated in the ordinary course of business through an arms-length transaction.

Goal(s) and relationship to Regional goal(s):

Project goals:

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

This project meets the following Region 3 goals:

One of the goals of the region is to "Increase access to primary and specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their condition, regardless of where they live or their ability to pay". Expansion of primary care capacity certainly relates to this goal as it will make it easier for Memorial to provide care to underserved populations.

Challenges and how addressed:

This project faces three key challenges. First, Memorial must raise awareness and change existing patterns for seeking health care services for some patients. A second challenge is to raise awareness for the service delivery model offered by these new sites so that patients who currently don't have access to after-hours care learn that this type of care is available through a physician's clinic rather than turning to emergent or urgent care clinics. And finally, recruiting additional primary care providers and pediatric specialists in this competitive environment will be a challenge. Memorial will address these challenges by implementing other projects to reduce inappropriate ED use, educating patients on the benefits of primary care, and aggressively recruiting primary care providers by offering competitive salaries and other incentives to practice in the outlying clinics.

5-year expected outcome for provider and patients:

There will be shortening of waiting times for primary pediatric care appointments and increased uptake of primary pediatric care services in this specific service area, which will increase the percentage of patients who receive appropriate primary health care, including preventative services and regular monitoring for those patients with chronic illnesses.

Starting Point/Baseline: Memorial has identified the targeted service area needing increased access to pediatric primary care. Since this will be a new clinic, the baseline will have to be established during DY3.

Rationale:

Reasons for selecting the project option: In 2010, Texas had 176 patient care physicians per 100,000 population and 70 primary care physicians per 100,000 population with a state ranking of 46 and 47, respectively (comparable ratios for US total are 219.5 and 90.5, respectively). From 2001 to 2011, the Texas physician workforce grew 32.3%, exceeding the population growth of 25.1%. Therefore, there is a significant need to expand primary care in order to facilitate delivery system reform.

Research has shown that access to primary care is associated with better health outcomes at less cost. Access to primary care ensures better preventive care and better management of chronic disease, with lack of access often resulting in more expensive care, received in hospitals and emergency departments (ED). For the fiscal year 2010, 10% of all potentially preventable hospitalizations (PPR) were ambulatory care sensitive. In 2009, 41% (390,945) of ED visits in Houston were primary care related (PCR), including non-urgent, primary care treatable, and primary care preventable, and for 26.8% (104,762) of these PCR visits, Medicaid was the payor. Getting more patients into primary care will help to reduce the use of this more costly care. Placing more primary care providers out in the communities will help to address transportation access barriers and the expansion of clinic service hours will provide a greater selection of available appointment times. By increasing primary care capacity, engaging more people in the primary care system, and avoiding inappropriate utilization of costly services, the community will experience better health outcomes and greater patient satisfaction.[77]

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

[77] PPR rate was from the Texas Health and Human Services Commission report on Potentially Preventable Readmissions in the Texas Medicaid Population, Fiscal year 2010, published January, 2012. The statistics for ED use were from the Houston Hospitals Emergency Department Use Study (January 1, 2009 through December 31, 2009), Final Report included in the 2010 Harris County Community Needs Assessment for Memorial Hermann.

Because UTHSC-H will IGT on behalf of Memorial for its successful implementation of delivery system improvements under the Waiver, this structure results in a payment from a private hospital to an entity that provides its IGT, which arguably raises questions regarding provider donations. Nonetheless, this collaboration is the most to effective and efficient structure to expand access to pediatric services to the community, and ensure overall improvement to the Region 3 delivery system. This collaboration is a natural progression of the existing relationship and the clinical strengths of Memorial and UTHSC-H. Memorial is the largest not-for-profit healthcare system in Texas and serves the greater Houston community through 12 hospitals, a vast network of affiliated physicians and numerous specialty programs and services. With over 4,000 medical staff members, 26 residency programs, 48 fellowship programs, and over 1,300 physicians in training, Memorial is dedicated to providing high quality health services in order to improve the health of the people in Southeast Texas. The mission of UTHSC-H is to educate health science professionals, discover and translate advances in the biomedical and social sciences, and model the best practices in clinical care and public health. UTHSC-H strives to improve the health of the public in the State of Texas through educating future public health practitioners and bringing evidence based public health practices to Texas. UTHSC-H's faculty of over 900 physicians in 80 specialties provide comprehensive care for patients while teaching 800 medical students and over 900 residents in over 60 accredited residency/fellowship programs.

Core Components:

Through the new Houston Ship Channel South Pediatric Clinic, we propose to:

a) Expand primary care clinics

-Memorial will identify and lease appropriate space within the defined service area to establish the new clinic that includes reception, consulting, exam and procedure rooms, and will provide the necessary equipment and furnishings.

b) Expand primary care clinic hours

- In addition to regular business hours, the clinic will operate with expanded evening and Saturday hours to increase access for individuals that are not able to leave their jobs for healthcare appointments, and to provide care for those needing urgent care services that can be accommodated in a primary care clinic.

c) Expand primary care clinic staffing

- UT Physicians will be contracted at fair market value to provide primary care physicians, advanced practice providers, and support staff to operate the clinic.

Unique community need identification number the project addresses:

CN1 – Primary Care

CN8 – High rates of inappropriate emergency department utilization

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

This project represents a significant improvement in Memorial's ability to deliver primary healthcare to babies, children, and adolescents. This new initiative proposes to add space, providers, support staff, and extended service hours in a location where economic and cultural barriers to receiving appropriate healthcare are indicative of a need for services that are conveniently located and available when needed. This project is an expansion of services in order to improve access to care.

Related Category 3 Outcome Measure(s):

OD-1 Primary Care and Chronic Disease Management IT-1.19 Antidepressant Medication Management - NQF 0105 (Standalone measure)

The management of antidepressant medication in children ages 6 and over who were discharged alive) from an acute inpatient setting (including acute care psychiatric facilities) with a principal mental health diagnosis: A) the acute phase treatment period consisting at least 84 days (12 weeks) of continuous treatment with antidepressant medication during the 114-day period following the IPSD (inclusive), and B) the continuation phase treatment period consisting of at least 180 days (6 months) of continuous treatment with antidepressant medication (Table AMM-D) during the 231-day period following the IPSD (inclusive).

OD-1 Primary Care and Chronic Disease Management IT-1.1 Third next available appointment (Non- standalone measure)

Reduce the average length of time in days between the day a patient makes a request for an appointment with a physician and the third available appointment for a new patient physical, routine exam, or return visit exam.

Reasons/rationale for selecting the outcome measure(s):

This project is specifically geared towards increasing primary care services for pediatric patients. If this population is receiving adequate levels of primary behavioral healthcare then the management of anti-depressant medication is expected to improve. Additionally, the immediate goal of the project is to allow greater access to primary care for pediatric patients—this should directly correlate to reduced wait times for available appointments. Therefore, this outcome measure is a reasonable gauge of the effectiveness of this project.

Relationship to Other Projects: This project is part of Memorial's larger plans to expand and develop primary care and specialty care services, while improving access to care. Expanding primary care supports/reinforces several of the Category 1 and 2 projects: increasing the number of physicians rotating through the primary care residency program will have a direct impact on Expanding Primary Care Capacity (1.2); this project not only will increase the number of available physicians to participate in medical homes (2.1), it will also ensure that they are trained in the medical home concept; this project reinforces the Redesign of Primary Care (2.3), the Redesign to Improve the Patient Experience (2.4).

Relationship to Other Performing Providers' Projects in the RHP: Children are the future of healthcare and will dictate the treatments needed as well as the cost of healthcare in future years so it is critical that they receive the access needed throughout their pediatric lives. The focus of pediatric specialty care is similar throughout the region with a concentrated focus in the Harris county proper geographic region and allows for the expansion of access to numerous specialties such as cardiology, neurology, ENT, and many more. The outcome measures focus to appropriate length of stay, per episode cost of care, and improved cost savings. The Region 3 Initiative grid allows for a cross reference of similar initiatives in our region. (addendum)

Plan for Learning Collaborative: Memorial will participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system.

Project Valuation: The valuation of each Memorial project takes into account the transformational impact of the project, the population served by the project (both number of people and complexity of patient needs), the alignment of the project with community needs, the magnitude of costs avoided or reduced by the project, the degree of collaboration involved in the project, and the sustainability of the project.

The expansion of primary care clinics will help address a substantial need in the community for increased access to primary care. It will also go a long way towards achieving the Waiver goal of improving outcomes while curbing the risk of healthcare costs, because primary care is one of the most cost effective methods to increase health outcomes.

<table>
<tr><td>137805107.1.4</td><td>OPTION 1.1.1</td><td></td><td colspan="2">PEDIATRIC CLINIC EXPANSION</td></tr>
<tr><td colspan="4">Memorial Hermann Hospital</td><td>137805107</td></tr>
<tr><td>Related Category 3 Outcome Measure(s):</td><td>137805107.3.6
137805107.3.5</td><td>IT-1.19, IT-1.1</td><td colspan="2">Antidepressant Medication Management - NQF 0105 (Standalone measure)
Third next available appointment (Non-standalone measure)</td></tr>
<tr><th>Year 2
(10/1/2012 – 9/30/2013)</th><th colspan="2">Year 3
(10/1/2013 – 9/30/2014)</th><th>Year 4
(10/1/2014 – 9/30/2015)</th><th>Year 5
(10/1/2015 – 9/30/2016)</th></tr>
<tr><td>Milestone 1 [P-1]: Expand existing primary care clinics

Metric 1 [P-1.1]: Amount of additional space aquired to expand clinic services.
Baseline/Goal: TBD
Data Source: New primary care schedule and other UT Physicians' documents.

Milestone 1 Estimated incentive payment: $ 2,114,778

Milestone 2 [P-5]: Hire additional primary care providers and staff

Metric 1 [P-5.1]: Documentation of increased number of providers and staff.
Baseline/Goal: TBD
Data Source: UT Physicians' report, policy, contract or other documentation

Milestone 2 Estimated incentive payment: $ 2,114,778</td><td colspan="2">Milestone 3 [P-4]: Expand the hours of a primary care clinic, including evening and/or weekend hours

Metric 1 [P-4.1]: Increased number of hours at primary care clinic over baseline
Baseline/Goal: TBD
Data Source: Clinic documentation

Milestone 3 Estimated incentive payment: $ 4,614,218</td><td>Milestone 4 [I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services.

Metric 1 [I-12.1]: Documentation of increased number of visits. Demonstrate improvement over prior reporting period.
Goal: TBD
Data Source: Registry, EHR, claims or other UT Physicians' source

Milestone 4 Estimated incentive payment: $ 4,627,632</td><td>Milestone 5 [I-11]: Patient satisfaction with primary care services.

Metric 1 [I-11.1]: Improved Patient satisfaction scores
Goal: TBD
Data Source: CG-CAHPS3 or other developed evidence based satisfaction assessment tool, available in formats and language to meet patient population.

Milestone 5 Estimated incentive payment: $ 3,822,826</td></tr>
</table>

137805107.1.4	*OPTION 1.1.1*		*PEDIATRIC CLINIC EXPANSION*
Memorial Hermann Hospital			*137805107*
Related Category 3 Outcome Measure(s):	*137805107.3.6* *137805107.3.5*	**IT-1.19, IT-1.1**	**Antidepressant Medication Management - NQF 0105 (Standalone measure)** **Third next available appointment (Non-standalone measure)**
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Year 2 Estimated Milestone Bundle Amount: $4,229,556	Year 3 Estimated Milestone Bundle Amount: $4,614,218	Year 4 Estimated Milestone Bundle Amount: $4,627,632	Year 5 Estimated Milestone Bundle Amount: $3,822,826
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $17,294,232			

Project Option: 1.1.1 - 1.1 Expand Primary Care Capacity: Pediatric Clinic Expansion – Houston Ship Channel North Pediatric Clinic

Unique Project ID: 137805107.1.5
Performing Provider Name/TPI: Memorial Hermann Hospital System/ 020834001

Project Summary:

Provider: Memorial Hermann Hospital System (Memorial Hermann) is a 1,164 bed hospital system consisting of 4 campuses in the Houston-Sugarland-Baytown MSA. The system serves a population of approximately 6,000,000 people.

Intervention(s): Memorial will establish the Houston Ship Channel North Pediatric Clinic which will provide primary care for pediatric patients in that area of Harris County. Memorial will contract UTHSC-H to provide physician services to complement Memorial's investment in new technology, equipment and space to better provide pediatric services.

Need for the project: Prospective pediatric patients in the targeted service area currently face many roadblocks to adequate primary care including economic burdens, language barriers and lack of knowledge for seeking pediatric care. Due to the shortage of primary care providers in the community, the average wait period for a primary care appointment is 17 days, which results in increased reliance on hospital EDs for primary care and non-emergent care. The project will increase the percentage of patients who receive appropriate primary care including preventative services and regular monitoring for patients with chronic illnesses.

Target population: The target population is uninsured and underinsured children in North the area of the Houston Ship Channel that is between Beltway 8 to the North, 610E to the West, the Houston Ship Channel to the South, and Baytown to the East. It is estimated that 41.4% of the patients in the service area for this clinic are either uninsured or underinsured children and rely on Memorial Hermann's and other hospitals' emergency departments for primary care services.

Category 1 or 2 expected patient benefits: The clinic will provide a more appropriate setting for pediatric primary care for the target population. They will benefit primarily from better access to primary care and better management of illness and chronic conditions.

Category 3 outcomes: IT 1.1 – Reduce the average length of time in days between the day a patient requests an appointment and the third available appointment. The goal will be to decrease number of days to third next available appointment to zero days (same day) for primary care by DY5.

Project Option 1.1.1 Establish More Primary Care Clinics: Pediatric Clinic Expansion – Houston Ship Channel North Pediatric Clinic

Unique RHP Project Identification Number: 137805107.1.5

Performing Provider Name/TPI: Memorial Hermann Hospital (Memorial)/137805107

Project Description: 1.1/1.1.1: Using the strengths developed during their longstanding partnership, Memorial and The University of Texas Health Science Center at Houston (UTHSC-H) intend to work together to address the shortage of pediatric primary and specialty care in Region 3. In this project, Memorial will establish the Houston Ship Channel North Pediatric Clinic, which will provide primary care for pediatric patients in an area of Harris County that is between Beltway 8 to the north, 610E to the west, the Houston Ship Channel to the south, and Baytown to the east. Memorial has defined the service area for this clinic as a priority area for pediatric services, because it contains 8 of the 81 census tracts that make up the top 10% of all census tracts in Harris County with the greatest number of people below the age of 18 that are living below the federal poverty level (FPL). (The census tracts included are 2535, 2526, 2523.01, 2335, 2331.02, 2327.01, 2324.03, and 2323.01.) The number of children living below the FPL in these 8 census tract areas is estimated to be approximately 8,054. Furthermore, these areas have particularly high numbers of Hispanics (64%), for whom language, as well as poverty, may pose a barrier to obtaining primary care for their children. Black/African Americans, another segment of the population that tend to be medically underserved, also make up a significant proportion of the population in these census tracts (18.5%). The service area for this clinic includes large populations with economic, cultural, language, and transportation barriers to receiving primary care. (All population statistics are from the U.S. Census Bureau, 2010 Census. Poverty statistics are from the U.S. Census Bureau, Small Area Estimates Branch. Release date: 11.2011. Table 1: 2010 Poverty and Median Income Estimates - Counties.) In order to address the unique needs of different communities in the greater Houston area, Memorial has chosen to establish a pediatric clinic in this area as an independent DSRIP project.

Using their longstanding partnership to provide quality healthcare as a base, Memorial will contract UTHSC-H to provide physician services to complement Memorial's investment in new technology, equipment and space to better provide pediatric services. Specifically, UTHSC-H will redirect pediatricians already on its staff who have the capacity to care for additional patients, recruit additional pediatricians, or increase residency programs to fill the need for additional pediatric specialists. UTHSC-H is uniquely positioned to attract and retain new physicians due to its accomplishments as a world-class academic and research institution. This additional service line will avoid duplication and draw on the strength of UTHSC-H's academic presence in the field of pediatric medicine, and will also benefit Memorial by increasing the quantity, quality, and scope of services provided at its facilities.

Practically, Memorial will subcontract with UTHSC-H to provide physician and other services needed to implement this project. For example, Memorial will lease additional space to open the North Harris County clinic**.** This space will include additional consulting, exam and procedure rooms. Memorial will also subcontract with UTHSC-H to provide primary care providers and support staff to operationalize the project. For all services in which UTHSC-H is a subcontractor, Memorial will pay an agreed rate that is set in advance and represents fair market value for services negotiated in the ordinary course of business through an arms-length transaction.

Goal(s) and relationship to Regional goal(s):

Project goals:

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

This project meets the following Region 3 goals:

One of the goals of the region is to "Increase access to primary and specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their condition, regardless of where they live or their ability to pay". Expansion of primary care capacity certainly relates to this goal as it will make it easier for Memorial to provide care to underserved populations.

Challenges and how addressed:

This project faces three key challenges. First, Memorial must raise awareness and change existing patterns for seeking health care services for some patients. A second challenge is to raise awareness for the service delivery model offered by these new sites so that patients who currently don't have access to after-hours care learn that this type of care is available through a physician's clinic rather than turning to emergent or urgent care clinics. And finally, recruiting additional primary care providers and pediatric specialists in this competitive environment will be a challenge. Memorial will address these challenges by implementing other projects to reduce inappropriate ED use, educating patients on the benefits of primary care, and aggressively recruiting primary care providers by offering competitive salaries and other incentives to practice in the outlying clinics.

5-year expected outcome for provider and patients:

There will be shortening of waiting times for primary pediatric care appointments and increased uptake of primary pediatric care services in this specific service area, which will increase the percentage of patients who receive appropriate primary health care, including preventative services and regular monitoring for those patients with chronic illnesses.

Starting Point/Baseline: Memorial has identified the targeted service area needing increased access to pediatric primary care. Since this will be a new clinic, the baseline will have to be established during DY3.

Rationale:

In 2010, Texas had 176 patient care physicians per 100,000 population and 70 primary care physicians per 100,000 population with a state ranking of 46 and 47, respectively (comparable ratios for US total are 219.5 and 90.5, respectively). From 2001 to 2011, the Texas physician workforce grew 32.3%, exceeding the population growth of 25.1%. Therefore, there is a significant need to expand primary care in order to facilitate delivery system reform.

Research has shown that access to primary care is associated with better health outcomes at less cost. Access to primary care ensures better preventive care and better management of chronic disease, with lack of access often resulting in more expensive care, received in hospitals and emergency departments (ED). For the fiscal year 2010, 10% of all potentially preventable hospitalizations (PPR) were ambulatory care sensitive. In 2009, 41% (390,945) of ED visits in Houston were primary care related (PCR), including non-urgent, primary care treatable, and primary care preventable, and for 26.8% (104,762) of these PCR visits, Medicaid was the payor. Getting more patients into primary care will help to reduce the use of this more costly care. Placing more primary care providers out in the communities will help to address transportation access barriers and the expansion of clinic service hours will provide a greater selection of available appointment times. By increasing primary care capacity, engaging more people in the primary care system, and avoiding inappropriate utilization of costly services, the community will experience better health outcomes and greater patient satisfaction.[78]

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

[78] PPR rate was from the Texas Health and Human Services Commission report on Potentially Preventable Readmissions in the Texas Medicaid Population, Fiscal year 2010, published January, 2012. The statistics for ED use were from the Houston Hospitals Emergency Department Use Study (January 1, 2009 through December 31, 2009), Final Report included in the 2010 Harris County Community Needs Assessment for Memorial Hermann.

Because UTHSC-H will IGT on behalf of Memorial for its successful implementation of delivery system improvements under the Waiver, this structure results in a payment from a private hospital to an entity that provides its IGT, which arguably raises questions regarding provider donations. Nonetheless, this collaboration is the most to effective and efficient structure to expand access to pediatric services to the community, and ensure overall improvement to the Region 3 delivery system. This collaboration is a natural progression of the existing relationship and the clinical strengths of Memorial and UTHSC-H. Memorial is the largest not-for-profit healthcare system in Texas and serves the greater Houston community through 12 hospitals, a vast network of affiliated physicians and numerous specialty programs and services. With over 4,000 medical staff members, 26 residency programs, 48 fellowship programs, and over 1,300 physicians in training, Memorial is dedicated to providing high quality health services in order to improve the health of the people in Southeast Texas. The mission of UTHSC-H is to educate health science professionals, discover and translate advances in the biomedical and social sciences, and model the best practices in clinical care and public health. UTHSC-H strives to improve the health of the public in the State of Texas through educating future public health practitioners and bringing evidence based public health practices to Texas. UTHSC-H's faculty of over 900 physicians in 80 specialties provide comprehensive care for patients while teaching 800 medical students and over 900 residents in over 60 accredited residency/fellowship programs.

Core Components:

We propose to meet all required project components listed below:

a) Expand primary care clinic space

- Memorial will identify and lease appropriate space within the defined service area to establish the new clinic that includes reception, consulting, exam and procedure rooms, and will provide the necessary equipment and furnishings.

b) Expand primary care clinic hours

- In addition to regular business hours, the clinic will operate with expanded evening and Saturday hours to increase access for individuals that are not able to leave their jobs for healthcare appointments, and to provide care for those needing urgent care services that can be accommodated in a primary care clinic.

c) Expand primary care clinic staffing

- UT Physicians will be contracted at fair market value to provide primary care physicians, advanced practice providers, and support staff to operate the clinic.

Unique community need identification number the project addresses:

CN1 – Primary Care

CN8 – High rates of inappropriate emergency department utilization

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

This project represents a significant improvement in Memorial's ability to deliver primary healthcare to babies, children, and adolescents. This new initiative proposes to add space, providers, support staff, and extended service hours in a location where economic and cultural barriers to receiving appropriate healthcare are indicative of a need for services that are conveniently located and available when needed. This project is an expansion of services in order to improve access to care.

Related Category 3 Outcome Measure(s):

OD-1 Primary Care and Chronic Disease Management IT-1.19 Antidepressant Medication Management - NQF 0105 (Standalone measure)

The management of antidepressant medication in children ages 6 and over who were discharged alive) from an acute inpatient setting (including acute care psychiatric facilities) with a principal mental health diagnosis: A) the acute phase treatment period consisting at least 84 days (12 weeks) of continuous treatment with antidepressant medication during the 114-day period following the IPSD (inclusive), and B) the continuation phase treatment period consisting of at least 180 days (6 months) of continuous treatment with antidepressant medication (Table AMM-D) during the 231-day period following the IPSD (inclusive).

OD-1 Primary Care and Chronic Disease Management IT-1.1 Third next available appointment (Non- standalone measure)

Reduce the average length of time in days between the day a patient makes a request for an appointment with a physician and the third available appointment for a new patient physical, routine exam, or return visit exam.

Reasons/rationale for selecting the outcome measure(s):

This project is specifically geared towards increasing primary care services for pediatric patients. If this population is receiving adequate levels of primary behavioral healthcare then the management of anti-depressant medication is expected to improve. Additionally, the immediate goal of the project is to allow greater access to primary care for pediatric patients—this should directly correlate to reduced wait times for available appointments. Therefore, this outcome measure is a reasonable gauge of the effectiveness of this project.

Relationship to Other Projects: This project is part of Memorial's larger plans to expand and develop primary care and specialty care services, while improving access to care. Expanding primary care supports/reinforces several of the Category 1 and 2 projects: increasing the number of physicians rotating through the primary care residency program will have a direct impact on Expanding Primary Care Capacity (1.2); this project not only will increase the number of available physicians to participate in medical homes (2.1), it will also ensure that they are trained in the medical home concept; this project reinforces the Redesign of Primary Care (2.3), the Redesign to Improve the Patient Experience (2.4).

Relationship to Other Performing Providers' Projects in the RHP: Children are the future of healthcare and will dictate the treatments needed as well as the cost of healthcare in future years so it is critical that they receive the access needed throughout their pediatric lives. The focus of pediatric specialty care is similar throughout the region with a concentrated focus in the Harris county proper geographic region and allows for the expansion of access to numerous specialties such as cardiology, neurology, ENT, and many more. The outcome measures focus to appropriate length of stay, per episode cost of care, and improved cost savings. The Region 3 Initiative grid allows for a cross reference of similar initiatives in our region. (addendum)

Plan for Learning Collaborative: Memorial will participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system.

Project Valuation: The valuation of each Memorial project takes into account the transformational impact of the project, the population served by the project (both number of people and complexity of patient needs), the alignment of the project with community needs, the magnitude of costs avoided or reduced by the project, the degree of collaboration involved in the project, and the sustainability of the project.

The expansion of primary care clinics will help address a substantial need in the community for increased access to primary care. It will also go a long way towards achieving the Waiver goal of improving outcomes while curbing the risk of healthcare costs, because primary care is one of the most cost effective methods to increase health outcomes.

137805107.1.5	*OPTION 1.1.1*		*PEDIATRIC CLINIC EXPANSION*
Memorial Hermann Hospital			*137805107*
Related Category 3 Outcome Measure(s):	*137805107.3.8* *137805107.3.7*	**IT-1.19, IT-1.1**	**Antidepressant Medication Management - NQF 0105 (Standalone measure)** **Third next available appointment (Non-standalone measure)**

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-1]: Expand existing primary care clinics Metric 1 [P-1.1]: Amount of additional space aquired to expand clinic services. Baseline/Goal: TBD Data Source: New primary care schedule and other UT Physicians' documents. Milestone 1 Estimated incentive payment: $ 2,114,778 **Milestone 2 [P-5]**: Hire additional primary care providers and staff Metric 1 [P-5.1]: Documentation of increased number of providers and staff. Baseline/Goal: TBD Data Source: UT Physicians' report, policy, contract or other documentation Milestone 2 Estimated incentive payment: $ 2,114,778	**Milestone 3 [P-4]:** Expand the hours of a primary care clinic, including evening and/or weekend hours Metric 1 [P-4.1]: Increased number of hours at primary care clinic over baseline Baseline/Goal: TBD Data Source: Clinic documentation Milestone 3 Estimated incentive payment: $ 4,614,218	**Milestone 4 [I-12]:** Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 [I-12.1]: Documentation of increased number of visits. Demonstrate improvement over prior reporting period. Goal: TBD Data Source: Registry, EHR, claims or other UT Physicians' source Milestone 4 Estimated incentive payment: $ 4,627,632	**Milestone 5 [I-11]:** Patient satisfaction with primary care services. Metric 1 [I-11.1]: Improved Patient satisfaction scores Goal: TBD Data Source: CG-CAHPS3 or other developed evidence based satisfaction assessment tool, available in formats and language to meet patient population. Milestone 5 Estimated incentive payment: $ 3,822,826

137805107.1.5	*OPTION 1.1.1*		*PEDIATRIC CLINIC EXPANSION*
Memorial Hermann Hospital			*137805107*
Related Category 3 Outcome Measure(s):	*137805107.3.8* *137805107.3.7*	**IT-1.19, IT-1.1**	**Antidepressant Medication Management - NQF 0105 (Standalone measure)** **Third next available appointment (Non-standalone measure)**

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Year 2 Estimated Milestone Bundle Amount: $ 4,229,556	Year 3 Estimated Milestone Bundle Amount: $ 4,614,218	Year 4 Estimated Milestone Bundle Amount: $ 4,627,632	Year 5 Estimated Milestone Bundle Amount: $ 3,822,826
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $ 17,294,232			

Memorial Hermann Northwest Hospital

Pass 1

Project Option: 1.1.1 Establish more primary care clinics: Primary Care Expansion School Based Health

Performing Provider: Memorial Hermann Hospital System/TPI 020834001
Unique Project ID: 020834001.1.1

- Provider: Memorial Hermann Hospital System (Memorial Hermann) is a 1,164 bed hospital system consisting of 4 campuses in the Houston-Sugarland-Baytown MSA. The system serves a population of approximately 6,000,000 people.

- Intervention(s): Memorial Hermann intends to increase the number of school-based primary care sites in low income communities for people with limited access in the community. The project will expand the Memorial Hermann Health Centers for Schools program by 3 health centers and 1 mobile dental van.

- Need for the project: Many low-income children and teens receive services in urgent and emergent care settings for conditions that could be managed in a more coordinated manner if provided in the primary care setting. By enhancing access points by providing care where children and teens are located – at school – students and their families will align themselves with the primary care system resulting in better health outcomes, patient satisfaction, appropriate utilization and reduced cost of services.

- Target population: The target population is children and teens who are uninsured or underinsured and attend school in the following zip codes and school districts: 77506 (Pasadena ISD), 77099 (Alief ISD) and 77032 (Aldine ISD). It is estimated that 35% of the patients in the service area for this clinic are either uninsured or underinsured teens or children and attend schools in the zip codes mentioned above.

- Category 1 or 2 expected patient benefits: The 3 new health centers and 1 mobile dental van will result in serving approximately 18 additional schools, opening access to approximately 15,000 additional students and providing approximately 12,000 visits.

- Category 3 outcomes: IT 7.2 – A baseline will be established in DY3 of children with untreated dental issues. By DY4 a 25% improvement in DY3 repeat patients will be expected and by DY5 an additional 15% improvement will be expected over the baseline.

Project Option - 1.1.1 Establish more primary care clinics: Primary Care Expansion School Based Health

Unique RHP Project Identification Number: 020834001.1.1

Performing Provider Name/TPI: Memorial Hermann Hospital System/TPI 020834001

Project Description: Increase the number of school based primary care sites in low income communities for people with limited access in the community. Memorial initially proposes to offer this service to patients in the following zip codes: 77506, 77099, and 77032.

Memorial Hermann wishes to expand the Memorial Hermann Health Centers for Schools Program, which is designed as a medical home for uninsured children and a secondary access point for insured children. Memorial Hermann Health Centers for Schools exists for many reasons, but its primary purpose is to combat barriers to primary care for school aged children. Schools to be served by this award-winning program have always been selected by identifying students with the highest prevalence of unmet medical and psychosocial needs. Primary medical, dental and mental health care is provided.

The Memorial Hermann Health Centers for Schools are located in schools and school districts that have students with documented barriers to healthcare. Feeder patterns are served, providing students with a medical and dental home from kindergarten through high school. Through transportation from feeder schools provided by the collaborating school districts, the Health Centers offer access to primary medical, mental health, nutritional and dental care services to underserved children. Medicaid is billed for enrolled students for eligible services; however, services are free for the uninsured and under-insured.

The scope of services offered at the six centers includes sick and injury care, general and sports physicals, immunizations, chronic care (asthma, obesity, cholesterol), mental health therapy and social service referrals, nutritional guidance, as well as other specific care to meet students' needs. The Dental Clinics provide services that include periodic oral examinations, diagnostic x-rays, prophylaxis, fluoride treatments, oral hygiene instructions, sealants, amalgam and composite fillings, extractions, stainless steel crowns, pulpotomies, and root canals.

The Health Centers for Schools program provides readily accessible, primary healthcare, mental health, nutritional and dental care services to uninsured and underinsured children. The program does not collect cash, but bills for eligible services for Medicaid enrolled patients. (Mobile Dental Program does not presently bill). Students have a safe place to talk about sensitive issues; practitioners take their time addressing health problems that impede learning; the full spectrum of primary medical/ mental health/ and dental care is provided on site; and students and their families are continually educated on the importance of regular healthcare. The clinic's social worker and navigator also assist students' families in obtaining health, mental health and dental care not offered at the clinic and link families in need of basic services to community agencies.

This request proposes to expand the Memorial Hermann Health Centers for Schools program by health centers and 1 mobile dental van. Memorial initially proposes to offer this service to patients in the following zip codes: 77506 (Pasadena Independent School District), 77099

(Alief Independent School District), and 77032 (Aldine Independent School District). This expansion will result in serving approximately 18 additional schools, opening up access to approximately 15,000 additional students and providing approximately 12,000 visits.

Goal(s) and relationship to Regional goal(s):

Project goals:

The primary goal of this project is to bring increased primary care to school aged children, who will otherwise not obtain it. Furthermore, this care will be provided in school, so as not to disrupt their learning and development. This particular project will increase the number of school-based clinics providing primary medical, mental health, and dental care sites in low-income communities for children.

This project meets the following Region 3 goals:

This project addresses the RHP's goal to "[i]ncrease access to primary and specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their condition, regardless of where they live or their ability to pay."

Challenges and how addressed:

This project has two primary challenges: (1) finding qualified professionals to staff the additional clinic; (2) reaching out to children and their parents to educate them about the benefits of the program. In order address these challenges, Memorial will engage in an aggressive strategy to recruit staff for the new clinics at the inception of the project and will prepare simple and effective educational materials to reach children and their parents.

5-year expected outcome for provider and patients:

This request proposes to expand the Memorial Hermann Health Centers for Schools program by 3 health centers and 1 mobile dental van. This expansion will result in serving approximately 18 additional schools, opening up access to approximately 15,000 additional students and providing approximately 12,000 visits. The clinics will operate Monday through Friday, 40 hours a week, twelve months a year. Memorial also expects to see improvement in certain clinical measures for the students engaged in the program such as: asthma exacerbations, emergency room visits, and hospitalizations.

- Asthma exacerbations, emergency room visits, and hospitalizations were reduced by 83% for the asthma population whose care is managed by the clinics. For students in the Healthy Eating and Lifestyle Program (HELP), 77% reduced their BMI. For students in the cholesterol program, 67% reduced their cholesterol. For students in the mobile dental program, 25% of children had caries at recall as compared to Healthy People 2020 Objectives which call for the proportion of children with one or more caries to be no more than 52% among children aged 4-11 and no more than 51% for adolescents aged 12+. Furthermore, .8% of established SBHC patients used an ER for primary care purposes versus the community experience for uninsured patients of 10.5%. This reduction in ER usage equates to $199,005 in ER costs.

Starting Point/Baseline: Presently, Memorial Hermann Health Centers for Schools reside in the Lamar Consolidated School District (2 centers), the Houston Independent School District (3 centers), and the Pasadena Independent School District (1 center). A fully established center will incur 4,000 medical, dental, and mental health therapy visits a year.

Rationale:

In our current system, more often than not, children and teens receive services in urgent and emergent care settings for conditions that could be managed in a more coordinated and comprehensive manner if provided in the primary care setting. This often results in more costly, less coordinated care and a lack of appropriate follow-up care. Families may experience barriers in accessing primary care services secondary to transportation, cost, lack of assigned provider, physical disability, inability to receive appointments in a timely manner and a lack of knowledge about what types of services can be provided in the primary care setting. Care may be foregone and or addressed only after medical and dental conditions have escalated. By enhancing access points by providing care where children and teens are located—at school--students and their families will align themselves with the primary care system resulting in better health outcomes, patient satisfaction, appropriate utilization and reduced cost of services.

Students perform better when they show up for class healthy and ready to learn. School-based health centers (SBHCs) ensure that kindergarteners through high schoolers can get a flu shot, have an annual physical, have their teeth examined and their eyes checked, or speak to a mental health counselor in a safe, nurturing place – without the barriers that families too often face. Memorial already has proven positive results with its existing program, which it wishes to expand upon. For example, in 2011:

- 9,125 children were served in 21,000 visits—84% were able to return to their classroom on the same day. (Schools receive $30 in federal support per child in attendance.)
- Asthma exacerbations, emergency room visits, and hospitalizations were reduced by 83%.
- 0.8% of SBHC patients used an ER for primary care purposes versus 10.5% of the general uninsured population under age 18 (source: Community Tracking Study, Medicaid/SCHIP Cuts and Hospital Emergency Department Use, Peter J. Cunningham).
- 67% of students with high cholesterol reduced their cholesterol; 50% achieved acceptable cholesterol levels.
- Students who received therapy from licensed clinical social workers: improved grade point averages: 2.7 to 3.2; reduced days absent: 1.5 to 1.0 days; and reduced detention/suspension incidents: 1.3 to 0.4 days.
- 25% of students seen in the mobile dental clinic had caries at recall as compared to Healthy People 2020 Objectives which call for the proportion of children with one or more caries to be no more than 52% among children aged 4-11 and no more than 51% for adolescents aged 12+.
- 93.1% of students with 3+ clinic visits for acute or chronic reasons receive a bi-annual physical.

- 93.4% of sexually active youth decreased their high-risk behaviors by abstaining or consistent use of birth control.

The program monitors measurable objectives in eight (8) categories: healthcare access (reduced ER usage, increased time in the classroom); school performance (improved grades, reduced absenteeism, reduced suspensions/detentions); asthma management (exacerbations/ER visits/hospitalizations); cholesterol management (lipid levels); BMI (Body Mass Index); mental health therapy (increased functional status); dental care (reduction of caries at recall); and reproductive health behavior (decrease in at-risk behaviors). As each center beocmes fully operational, each of these outcome measures will be implemented and monitored.

Benchmarks are derived from the National Association of School Based Health Centers, The Academy of Pediatrics, and Healthy People 2020. (Pre-post outcome data is also applied.) Healthy People 2020 provides a framework for prevention for the Nation. It is a statement of national health objectives designed to identify the most significant preventable threats to health and to establish national goals to reduce these threats.

Project components:

The core project components include:
a) Expand primary care clinic space
b) Expand primary care clinic hours
c) Expand primary care clinic staffing

Unique community need identification number the project addresses:

- CN1 – Inadequate access to primary care
- CN.4 - Inadequate access to dental care
- CN.6 - Inadequate access to treatment and services designed for special needs populations, including disabled, homeless, children, elderly. **Note: This statement is true only as it applies to children.**

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

Through this project Memorial will significantly enhance its ability to improve the health outcomes of children in the community.

Related Category 3 Outcome Measure(s): OD-7: Oral Health;

IT 7.2 Cavities: Percentage of children with untreated dental caries (Healthy People 2020)

Reasons/rationale for selecting the outcome measure(s):

Rationale/Evidence: Children who have regular access to a dental provider are less likely to suffer from untreated dental caries

Relationship to Other Projects: This project is part of Memorial Hermann's larger plans to expand and develop primary care and specialty care services, while improving access to care. Expanding primary care supports/reinforces several of the Category 1 and 2 projects: Increasing the number of nurse practitioners, licensed clinical social workers, and general dentists will have a direct impact on Expanding Primary Care Capacity (1.1); this project not only will increase the number of available nurse practitioners, licensed clinical social workers, and general dentists to participate in medical homes (2.1), it will also ensure that they are trained in the medical home concept; finally, the medical home concept of this program also reinforces the Redesign of Primary Care (2.3), the Redesign to Improve the Patient Experience (2.4).

Relationship to Other Performing Providers' Projects in the RHP: Memorial Hermann Healthcare System reflects the vision of other Performing Providers' in the RHP by increasing individual and families' access to health, mental health and dental care, improving the quality of healthcare, reducing costly ED usage for primary care treatable issues, educating the community on alternative healthcare resources available to them and the importance of a medical and dental home, and reducing overall healthcare costs.

Primary Care/Ambulatory Care clinics are a top priority to Region 3 due to the acuity of the regional patient mix, population concentration, and lack of primary care access points for our patient base. The regional approach of collaboration as well as existing patient referral pattern relationships allowed our team to properly identify the community needs based on the necessity of population, uninsured, and medically underserved patient bases. This program is consistent with our region and similar to numerous initiatives in our RHP plan sharing both concepts as well as outcome measures focused to percent improvement over baseline of patient satisfaction scores, reduction of inappropriate ED utilization, and third next available appointment status. The Region 3 Initiative Grid attached as a RHP Plan addendum reflects a grid of relationship for all initiatives.

Plan for Learning Collaborative: We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system.

Project Valuation:

Approach for valuing project: The valuation of each Memorial Hermann project takes into account the transformational impact of the project, the population served by the project (both number of people and complexity of patient needs), the alignment of the project with community needs, the magnitude of costs avoided or reduced by the project, the degree of collaboration involved in the project, and the sustainability of the project.

Rationale/justification for valuation: The expansion of primary care clinics for school aged children help address a substantial need in the community for increased access to primary care for one of the most vulnerable populations. It will also go a long way towards achieving the Waiver goal of improving outcomes while curbing the risk of healthcare costs, because primary care is one of the most cost effective methods to increase health outcomes.

020834001.1.1	*1.1.1*	*A-C*	***Establish more primary care clinics: Primary Care Expansion School Based Health***
Memorial Hermann Hospital System			020834001
Related Category 3 Outcome Measure(s):	***020834001.3.1***	*IT-7.2*	***Cavities: Percentage of children with untreated dental cavities (Healthy People 2012)***

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1 [P-X1]: Determine which schools and school districts in need of additional school health centers. Metric 1 [P-X1]:Conduct needs assessment to determine areas most in need of school based health clinics. Baseline/Goal: To establish process to target most underserved schools. Data Source: Project plan that describes target population at particular schools for additional school clinics. Milestone 1 Estimated Incentive Payment: $ 1,801,730 **Milestone 2** [P-X2]: Establish baseline for existing primary care clinic volume, number of primary healthcare workers and staff, and patient satisfaction in similar clinical settings in the community. Metric 1 [P-X2]: Establish baseline for future years. Goal: To determine baseline for measure of project improvement in	**Milestone 3**[P-8]: Participate in interactions with other providers and RHP to promote collaborative learning around shared or similar projects Metric 1 [P-8.1]: Number meetings, conference calls or webinars organized by the RHP that the provider participated in. Baseline/Goal: Participate in learning collaborative Data Source: Meeting Agendas, sign-n sheets, conference calls, presentations, email Milestone 3 Estimated Incentive Payment: $1,965,591 **Milestone 4** [P-5]: Train/hire additional primary care providers and staff and/or increase the number of primary care clinics for existing providers. Metric 1 [P-5.1]: Documentation of increased number of providers and staff and/or clinic sites. Baseline/Goal: 5% increase over	**Milestone 5** [P-8]: Participate in interactions with other providers and RHP to promote collaborative learning around shared or similar projects Metric 1[P-8.1]: Number meetings, conference calls or webinars organized by the RHP that the provider participated in. Baseline/Goal: Participate in learning collaborative Data Source: Meeting Agendas, sign-n sheets, conference calls, presentations, email Milestone 5 Estimated Incentive Payment: $1,314,204 **Milestone 6**[P-5]: Train/hire additional primary care providers and staff and/or increase the number of primary care clinics for existing providers. Metric 1 [P-5.1]: Documentation of increased number of providers and staff and/or clinic sites.	**Milestone 8**[I-15]: Increase access to primary care capacity. Metric 1[I-15.1]: Increase percentage of target population reached. Goal: To reach at least 15% more of targeted population as identified by analysis in DY2 Data Source: Documentation of target population reached, as designated in the project plan. Milestone 8 Estimated Incentive Payment: $1,628,469 **Milestone 9** [I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 [I-12.1]: Documentation of increased number of visits. Demonstrate improvement over prior reporting period. Goal: 5% increase over DY 2 baseline. Data Source: Registry, EHR, claims, or other Performing Provider source. Milestone 9 Estimated Incentive Payment: $1,628,470

020834001.1.1	*1.1.1*	*A-C*	***ESTABLISH MORE PRIMARY CARE CLINICS: PRIMARY CARE EXPANSION SCHOOL BASED HEALTH***
Memorial Hermann Hospital System			020834001
Related Category 3 Outcome Measure(s):	***020834001.3.1***	*IT-7.2*	***Cavities: Percentage of children with untreated dental cavities (Healthy People 2012)***

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
future years. Data Source: Submission of documentation demonstrating study of baseline numbers Milestone 2 Estimated Incentive Payment: $ 1,801,731	DY 2 baseline. Data Source: Documentation of completion of all items described by the RHP plan for this measure; hospital or other Performing Provider report, policy, contract, or other documentation. Milestone 4 Estimated Incentive Payment: $ 1,965,592	Baseline/Goal: 10% increase over DY 2 baseline. Data Source: Documentation of completion of all items described by the RHP plan for this measure; hospital or other Performing Provider report, policy, contract, or other documentation. Milestone 6 Estimated Incentive Payment: $ 1,314,204 **Milestone 7 [**I-15]: Increase access to primary care capacity. Metric 1[I-15.1]: Increase percentage of target population reached. Goal: To reach at least 10% more of targeted population as identified by analysis in DY2 Data Source: Documentation of target population reached, as designated in the project plan. Milestone 7 Estimated Incentive Payment: $1,314,203	

020834001.1.1	*1.1.1*	*A-C*	***ESTABLISH MORE PRIMARY CARE CLINICS: PRIMARY CARE EXPANSION SCHOOL BASED HEALTH***
Memorial Hermann Hospital System			020834001
Related Category 3 Outcome Measure(s):	***020834001.3.1***	*IT-7.2*	***Cavities: Percentage of children with untreated dental cavities (Healthy People 2012)***

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Year 2 Estimated Milestone Bundle Amount: : $3,603,461	Year 3 Estimated Milestone Bundle Amount: $3,931,183	Year 4 Estimated Milestone Bundle Amount: $3,942,611	Year 5 Estimated Milestone Bundle Amount: $3,256,939
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $14,734,194			

Project Option: 1.6.2 24-Hour Nurse Triage Line
Performing Provider: Memorial Hermann Hospital System/TPI 020834001
Unique Project ID: 020834001.1.2

- Provider: Memorial Hermann Hospital System (Memorial Hermann) is a 1,164 bed hospital system consisting of 4 campuses in the Houston-Sugarland-Baytown MSA. The system serves a population of approximately 6,000,000 people.

- Intervention(s): Memorial Hermann will implement a region-wide 24-hour nurse triage line that will assist patients considering an ER visit in determining what level of care they need to access and connect them to an appropriate resource. The goal is to ensure efficient use of the system's ER department and reduce unnecessary visits.

- Need for the project: Over 35% of all emergency room visits in Harris County are primary care treatable. These visits result because patients do not have the clinical knowledge to assess their condition and unnecessarily visit the ER. Once the 24-hour Nurse Triage Line is in place, it is anticipated that the demand for the ER will decline and more significantly, there will be a reduction in inappropriate demand.

- Target population: The target population is any patient in the region that is considering an ER visit. Incoming calls are anticipated to be from uninsured and insured individuals and represent both urgent and non-urgent health care situations. The 24-hour Nurse Triage Line will reduce costs and improve access to care for uninsured and Medicaid populations by recommending to patients the most suitable intensity of care and connecting them to that care through CHWs. This will result in more appropriate utilization of facilities reducing expenditures for uncompensated care and better serving managed care patients within financial limitations.

- Category 1 or 2 expected patient benefits: Memorial Hermann will aim to reach between 50,000 and 100,000 patients in a 12-month period. By DY5, Memorial Hermann expects to increase utilization by 10% over the baseline in DY2.

- Category 3 outcomes: IT 9.4 - In DY5, Memorial Hermann intends to improve the same measurement by at least 15% over baseline.

Project Option- 1.6.2 Establish/expand access to medical advice and direction to the appropriate level of care to reduce Emergency Department use for non-emergent conditions and increase patient access to health care: 24 HOUR NURSE TRIAGE LINE

Unique RHP Project Identification Number: 020834001.1.2
Performing Provider Name/TPI: Memorial Hermann Hospital System/TPI 020834001

Project Description:

Implement a region-wide 24 Hour Nurse Triage Line, seven days a week that will assist patients residing in the region, who are considering an ER visit, in determining what level of care they need to access and connect them to an appropriate resource. Twelve FTE dedicated triage nurses will manage the hotline at all times. Six triage clerks and 5 Community Health Workers ("CHWs") will provide support to the program. Nurses will be added as call volume dictates and adjusted during peak intervals. After listening to a caller's concerns, the nurse will provide guidance on whether or not an ED visit is warranted. If an ED visit is not necessary, the nurse will refer the caller to a CHW who will arrange an appointment at a nearby urgent care center, federally qualified health center (FQHC), or physician's office. CHWs will follow up with all patients within 24 hours to ensure they have attended or plan to attend their scheduled appointments. Bilingual services will be provided as needed.

Memorial Hermann's Nurse Triage Line project is designed to serve the entire region, regardless of callers' current healthcare affiliations, significantly expanding the services offered by the previous Ask Your Nurse line to meet the growing healthcare needs of the region. Incoming calls are anticipated to be from uninsured and insured individuals and represent both urgent and non-urgent healthcare situations. The CHW's will navigate all primary care treatable calls to appropriate private and safety-net providers in the region taking into account a caller's health care needs, insurance status, income level, location and language. Memorial Hermann has a highly, successful ER Navigator program and anticipates applying those best practices to the CHW's processes for this project.

Goal(s) and relationship to Regional goal(s):

Project Goal:

> Provide medical advice to callers and help them determine the appropriate place for them to receive that care. If it is determined that they do not need emergency care, they will be connected to the appropriate resource. Data will be captured on the number of calls redirected from the emergency room, and the number of callers who sought care in the suggested alternative.

This project meets the following Region 3 goals:

This project addresses the RHP's goal to "[i]ncrease access to primary and specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their condition, regardless of where they live or their ability to pay."

Challenges and how addressed:

The key challenge in implementing this project will be the hiring and training of staff. To address this challenge, Memorial Hermann will establish training programs in the initial stages of implementing this project.

5-year expected outcome for provider and patients:

Memorial Hermann will aim to significantly expand the use of the nurse call line in order to reach as many as 100,000 patients in a 12 month period.

Starting Point/Baseline:

Memorial Hermann intends to benchmark on the outcomes of the previous community-wide Ask Your Nurse triage line. This service operated from 2003 to 2011 in Harris County.

Rationale:

Over 35% of all emergency room visits in Harris County are primary care treatable. These visits result because people do not have the clinical knowledge to assess the nature of their illness or are unaware that other resources are available in the community. When Harris County had a community nurse triage line, data showed that 1 out of every 4 callers was redirected from an emergency center. This nurse triage line will also be staffed with navigators who can connect the patient to an alternative source for care, thus breaking the ER cycle and the significant costs associated with that care. The line will be a 1-800 number so that it can serve the whole region and be staffed to handle the call volume. Since the service did exist in Harris County, many of the avenues for distribution of the number (such as insert with water bills, posters and cards in ERs and clinics, and many other avenues) can be used again.

Once the 24-hour Nurse Triage Line is in place, it is anticipated that demand for the ED will decline and more significantly, there will be a reduction in inappropriate demand. Based on historical experience, projections indicate that approximately half of the calls will be triaged to lower-level care settings. Routing patients to a lower level of care reduces patient costs. Indirect impact includes reducing bad debt from non-emergent ED patients. This free telephone service will help patients avoid long waits and unnecessary expense at area EDs. Over time, by associating a care coordination and navigation component through the CHWs, it is reasonable to project that the health status of individuals connecting through the system will also result in additional documentable savings related to hospital admissions and readmissions when compared to a stratified sample of patients that match the demographics of those using the service.

Project components:

Required core project components:

a) Develop a process (including a call center) that in a timely manner triages patients seeking primary care services in an ED to an alternate primary care site. Survey patients who use the nurse advice line to ensure patient satisfaction with the services received.

- Memorial Hermann will develop processes and procedures in this call center to triage patients and ensure they are cared for in the most appropriate setting. Memorial Hermann will also encourage patients to participate in surveys to monitor their satisfaction.

b) Enhance linkages between primary care, urgent care, and Emergency Departments in order to increase communication and improve care transitions for patients.

- The staff at the patient call center will be able to directly facilitate transfer and communication between EDs, urgent cares, and primary care sites of service.

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.

- Memorial Hermann will conduct ongoing quality improvement processes in order to continually and effective manage the program.

Unique community need identification number the project addresses:

- CN1 – Inadequate access to primary care
- CN.7 – Insufficient access to care coordination practice management and integrated care treatment programs

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

By introducing a region-wide, 24 Hour Nurse Triage Line, Memorial Hermann is implementing a new initiative designed to assist all callers regardless of their current insurance status and/or current healthcare affiliations, thus reaching many more patients in need. The project represents a significant benefit to the community both in educating consumers about accessing appropriate healthcare facilities for primary care treatable conditions and reducing healthcare costs across the region. The Memorial Hermann 24 Hour Nurse Triage Line will increase the capacity of the region to provide appropriate, less costly, alternative healthcare solutions that will enhance our current service offerings and impact systemic change across the region as consumers become more informed about their healthcare options.

Related Category 3 Outcome Measure(s):

OD-9: Right Care, Right Setting; IT-9.4: Other Outcome Improvement Project

Reasons/rationale for selecting the outcome measure(s):

The 24 Hour Nurse Triage Line will allow patients to speak with a healthcare professional who can advise them and direct them to seek appropriate care. This will directly reduce the number of patients seeking that advice from the ED or other inappropriate sites of care.

Relationship to other Projects: This project is part of Memorial Hermann's larger plans to expand and develop primary care and specialty care services, while improving access to care and containing the costs of care.

Relationship to Other Performing Providers' Projects in the RHP: Memorial Hermann Healthcare System reflects the vision of other Performing Providers' in the RHP by increasing individual and families' access to healthcare, improving the quality of healthcare, reducing costly ED usage for primary care treatable issues, educating the community on alternative healthcare resources available to them and the importance of a medical home, and reducing overall healthcare costs.

The triage and intake process of patient encounters is the front door to healthcare and an important factor of the success of healthcare transformation. The nurse triage/call center concept is unique in the regional sense of the RHP plan and focuses to outcome measures of ambulatory care sensitive condition readmission rates. The initiative grid attached in the addendum will show similarities with other projects suggested for this region.

Plan for Learning Collaborative: We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system.

Project Valuation:

Approach for valuing project: The valuation of each Memorial Hermann project takes into account the transformational impact of the project, the population served (both number of people and complexity of patient needs), the alignment with community needs, the magnitude of costs avoided or reduced, the degree collaboration involved, and the sustainability of the project.

Rationale/justification for valuation: The Nurse advice line has already proven its ability to lower healthcare costs. In addition, the expansion of the line will increase patient satisfaction and health outcomes as they receive the right care in the right setting. The reduction of costs and the increase in health outcomes are cornerstone issues under the Waiver.

<table>
<tr><td>020834001.1.2</td><td>1.6.2</td><td>A-C</td><td colspan="2">ESTABLISH/EXPAND ACCESS TO MEDICAL ADVICE AND DIRECTION TO THE APPROPRIATE LEVEL OF CARE TO REDUCE EMERGENCY DEPARTMENT USE FOR NON-EMERGENT CONDITIONS AND INCREASE PATIENT ACCESS TO HEALTH CARE: 24 HOUR NURSE TRIAGE LINE</td></tr>
<tr><td colspan="4">Memorial Hermann Hospital System</td><td>020834001</td></tr>
<tr><td>Related Category 3 Outcome Measure(s):</td><td>020834001.3.2</td><td>IT-9.4</td><td colspan="2">Other Outcome Improvement Target</td></tr>
</table>

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1 [P-2]: Collect baseline data to track access for specified patient population. Metric1[P-2.1]: Documentation of baseline assessment Baseline/Goal: To analyze current demographics of patients utilizing Houston ERs for PCR purposes. Data Source: UTSPH ER Algorithm Study. Milestone 1 Estimated Incentive Payment: $1,703,006 **Milestone 2** [P-8]: Participate in interactions with other providers and RHP to promote collaborative learning around shared or similar projects Metric 1[P-8.1]: Number meetings, conference calls or webinars organized by the RHP that the provider participated in. Baseline/Goal: Participate in learning collaborative Data Source: Meeting Agendas, sign-	**Milestone 3**[P-4]: Expand nurse advice line by 10% to increase access to patients based on need within the RHP. Metric 1[P-4.1]: Number of nurses staffing nurse advice line per shift Baseline/Goal:_ To increase the number of nurses available per shift by 10% Data Source: Documentation of nurse advice line staffing levels. Milestone 3 Estimated Incentive Payment: $1,857,888 **Milestone 4** [P-8]: Participate in interactions with other providers and RHP to promote collaborative learning around shared or similar projects Metric 1[P-8.1]: Number meetings, conference calls or webinars organized by the RHP that the provider participated in. Baseline/Goal: Participate in learning collaborative Data Source;_Meeting Agendas,	**Milestone 5** [I-13]: Increase in the number of patients that access the call center. Metric 1 [I-13.1]: Utilization of call center. Goal: Increase utilization by 5% over baseline in DY2. Data Source: Call logs. The triage line software will record the # of calls received, the # of calls abandoned, track nurse recommendations and referrals and CHW follow-up activities. Milestone 5 Estimated Incentive Payment: $1,242,192 **Milestone 6** [P-8]: Participate in interactions with other providers and RHP to promote collaborative learning around shared or similar projects Metric 1[P-8.1]: Number meetings, conference calls or webinars organized by the RHP that the provider participated in. Baseline/Goal: Participate in learning	**Milestone 8** [I-13]: Increase in the number of patients that access the call center. Metric 1 [I-13.1]: Utilization of call center. Goal: Increase utilization by 10% over baseline in DY2. Data Source: Call logs. The triage line software will record the # of calls received, the # of calls abandoned, track nurse recommendations and referrals and CHW follow-up activities. Milestone 8 Estimated Incentive Payment: $1,539,238 **Milestone 9**[P-4]: Expand nurse advice line by 20% based on baseline data to increase access to patients based on need within the RHP. Metric 1[P-4.1]: Number of nurses staffing nurse advice line per shift Baseline/Goal:_ To increase the number of nurses available per shift by 20% Data Source: Documentation of nurse advice line staffing levels Milestone 9 Estimated Incentive

020834001.1.2	1.6.2	A-C	ESTABLISH/EXPAND ACCESS TO MEDICAL ADVICE AND DIRECTION TO THE APPROPRIATE LEVEL OF CARE TO REDUCE EMERGENCY DEPARTMENT USE FOR NON-EMERGENT CONDITIONS AND INCREASE PATIENT ACCESS TO HEALTH CARE: 24 HOUR NURSE TRIAGE LINE
Memorial Hermann Hospital System			020834001
Related Category 3 Outcome Measure(s):	020834001.3.2	IT-9.4	Other Outcome Improvement Target

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
n sheets, conference calls, presentations, email Milestone 2 Estimated Incentive Payment: $1,703,005	sign-n sheets, conference calls, presentations, email Milestone 4 Estimated Incentive Payment: $1,857,888	collaborative Data Source: Meeting Agendas, sign-n sheets, conference calls, presentations, email Milestone 6 Estimated Incentive Payment: $1,242,192 **Milestone 7**[P-4]: Expand nurse advice line by 15% based on baseline data to increase access to patients based on need within the RHP. Metric 1[P-4.1]: Number of nurses staffing nurse advice line per shift Baseline/Goal:_ To increase the number of nurses available per shift by 15% Data Source: Documentation of nurse advice line staffing levels Milestone 7 Estimated Incentive Payment: $1,242,193	Payment: $1,539,239
Year 2 Estimated Milestone Bundle Amount: $3,406,011	Year 3 Estimated Milestone Bundle Amount: $3,715,776	Year 4 Estimated Milestone Bundle Amount: $3,726,577	Year 5 Estimated Milestone Bundle Amount: $3,078,477
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $13,926,841			

Project Option: 1.12.2 Home Health Psych Services
Performing Provider: Memorial Hermann Hospital System/TPI 020834001
Unique Project ID: 020834001.1.3

- Provider: Memorial Hermann Hospital System (Memorial Hermann) is a 1,164 bed hospital system consisting of 4 campuses in the Houston-Sugarland-Baytown MSA. The system serves a population of approximately 6,000,000 people.

- Intervention(s): Memorial Hermann proposes to expand home health service to include psychiatric services. The program would include specialized training and certifications for nurses and the addition of social work services to link clients to additional community care programs. The goal of the project would be to provide support of those patients with mental health issues, to better manage their care in the home and community, and reduce the number of visits to emergency departments for psychiatric care that could be managed in the home/community environment.

- Need for the project: Texas ranks 49th in state per capita for mental health funding, and Harris County (greater Houston) ranks among the lowest in Texas counties. One of every five Houstonians (665,000) has a mental illness. Of these, 181,690 have a serious mental illness. About 20 percent, or 435,352, of adults aged 18 to 54 will have a mental disorder during a given year. A smaller subgroup of nine percent, or 195,908, of Houstonians will have a mental disorder and will experience at least transitory impairment.

- Target population: The target population is patients who 1) use hospital ERs for non-emergent treatment for psychiatric diagnosis, 2) admit to hospitals for medical and/or psychiatric diagnosis and do not have safe/effective discharge plans so an unnecessary readmission occurs, 3) admit to hospitals are treated and stabilized and stay in a hospital longer than required because a lack of community resources to address psychiatric diagnoses exists.

- Category 1 or 2 expected patient benefits: The psychiatric home health program in year one of operation would be able to admit up to 800 patients on to service. By DY5 patients utilizing the psychiatric home health program will increase by 15% over baseline.

- Category 3 outcomes: IT 3.8 Behavioral Health/Substance Abuse (BH/SA) 30-day readmission rate will experience a 10% reduction in DY5 over the baseline in DY5.

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

Unique RHP Identification Number: 020834001.1.3

Performing Provider Name/TPI: Memorial Hermann Hospital System/TPI 020834001

Project Description: Memorial Hermann proposes to expand home health service to include psychiatric services. The program would include specialized training and certifications for nurses and the addition of social work services to link clients to additional community care programs. Both program additions help to better manage psychiatric patients in the home setting. Memorial has identified a significant need for additional resources in the discharge planning process for individuals with behavior health needs. Currently, these individuals are discharged without appropriate home care services or are linked with home care agencies that do not have expertise and training to care for this specific population.

We are aiming to serve the population of patients who 1) use hospital ER's for non-emergent treatment for psychiatric diagnosis, 2) admit to hospitals for medical and/or psychiatric diagnosis and do not have safe/effective discharge plans so an unnecessary readmissions occurs, 3) admit to hospitals are treated and stabilized, but stay in a hospital setting longer than required because a lack of community resources to address psychiatric diagnosis exists.

Goal(s) and relationship to Regional goal(s):

Project Goals:

Texas proposes to take specific steps to broaden access to care that will include an expansion of community-based service options. The goal of psychiatric home services would be to provide support to those patients with a mental health issue, to better manage their care in the home and community, and reduce the number of visits to emergency departments for psychiatric care that could be managed in the home/community environment.

This project meets the following Region 3 goals:

This project addresses the RHP's goal to "[d]evelop a culture of ongoing transformation and innovation that maximizes the use of technology and best-practices, facilitates regional collaboration and sharing, and engages patients, providers, and other stakeholders in the planning, implementation, and evaluation processes."

Challenges and how addressed:

The challenges in implementing a psychiatric home health program are: 1) the organization's ability to recruit and retain qualified staff to operate the program and provide clinical care to the psychiatric population, 2) the population's payor mix and high volume of uninsured, 3) the organization's ability to develop standard metrics and comparison data specific to the psychiatric population, 4) the organization's ability to educate and gain program support from physicians, 5)

the organization's ability to efficiently obtain industry required documentation and signatures from physicians.

5-year expected outcome for provider and patients:

Memorial Hermann has calculated an assumption that a psychiatric home health program in year one of operation would be able to admit up to 800 patients on to service. Memorial expects that once the project is fully operational, it will be able to admit up to 800 patients to this service every year.

Starting Point/Baseline: Memorial does not currently have a comprehensive service to psychiatric services delivered at home.

Rationale:

Positive healthcare outcomes are contingent on the ability of the patient to obtain both routine examinations and healthcare services as soon as possible after a specific need for care has been identified. However, many Texans are unable to access either routine services or needed care in a timely manner either because they lack transportation or because they are unable to schedule an appointment due to work scheduling conflicts (or school scheduling conflicts in the case of children) or because they have obligations to provide care for children or elderly relatives during normal work hours. While such barriers to access can compromise anyone's ability to make or keep scheduled appointments, individuals with behavioral health needs may be especially negatively affected. Many individuals with behavioral health needs are reticent to seek treatment in the first place and such barriers may be sufficient to prevent access entirely. Others may be easily discouraged by such barriers and may drop out of treatment. Any such delay in accessing services or any break or disruption in services may result in functional loss and the worsening of symptoms. These negative health outcomes come at great personal cost to the individual and also result in increased costs to payers when care is finally obtained.

Project components:
There are no required components for this project option.

Unique community need identification number the project addresses:

- CN.3 -- Inadequate access to behavioral health care

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

This project represents a fundamental change in the manner by which Memorial will delivery behavioral health services. By delivering care in the home Memorial will be increasing efficient in caring for our patients and will increase overall patient satisfaction.

Related Category 3 Outcome Measure(s): OD-3: Potentially Preventable Re-Admissions – 30 day Readmission Rates; Establish Baseline Rates; IT 3.8 Behavioral Health/Substance Abuse 30 day readmission rate.

Reasons/rationale for selecting the outcome measure(s):

The increase in health outcomes, which is a proven result of delivering services in the home, will decrease potentially preventable re-admissions.

Relationship to other Projects: This project is part of Memorial Hermann's larger plans to expand and develop primary care and specialty care services, while improving access to care and implementing delivery improvements targeted to specific populations (in this case, behavioral health patients).

Relationship to Other Performing Providers' Projects in the RHP: The cohabitation of primary care and behavioral health is an important focus of our region in order to treat the patient base with comprehensive physical and behavioral healthcare issues. There are multiple initiatives in our RHP plan that address this need and all can be found on the Region 3 Initiative Grid in the addendums. The outcome measures focused to screening measures and access of the patient base.

Plan for Learning Collaborative: We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system.

Project Valuation:

Approach for valuing project: The valuation of each Memorial Hermann project takes into account the transformational impact, the population served (both number of people and complexity of patient needs), the alignment with community needs, the magnitude of costs avoided or reduced, the degree of collaboration involved, and the sustainability of the project.

Rationale/justification for valuation: This project's value is justified by the fact that it directly addresses on of the most fundamental and unmet healthcare needs in Harris County and in Region 3 generally, behavioral health. It also empowers patients by delivering services to them at home.

020834001.1.3	1.12.2	N/A	***EXPAND THE NUMBER OF COMMUNITY BASED SETTINGS WHERE BEHAVIORAL HEALTH SERVICES MAY BE DELIVERED IN UNDERSERVED AREAS: HOME HEALTH PSYCH SERVICES***
Memorial Hermann Hospital System			020834001
Related Category 3 Outcome Measure(s):	***020834001.3.3***	IT-3.8	***Behavioral Health/Substance Abuse (BH/SA) 30-Day Readmission Rate***

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-X1]: Establish baseline for number of staff for community based behavioral health services, number of patients reached by community based behavioral health services, and number of sites for community based behavioral healthcare delivery. Metric 1 [P-X1.1]:Establish baseline for future years. Data Source: Submission of documentation demonstrating study of baseline numbers. Goal: To determine baseline for measure of project improvement in future years. Milestone 1 Estimated Incentive Payment: **Milestone 2 [**P-8]: Participate in interactions with other providers and RHP to promote collaborative learning around shared or similar projects Metric 1[P-8.1]: Number meetings, conference calls or webinars organized by the RHP that the	**Milestone 3** [P-3]: Develop administrative protocols and clinical guidelines for project Metric 1 [P-3.1]: Manual of operations for the project detailing administrative protocols and clinical guidelines Baseline/Goal: Completion of protocol manual Data Source: Manual **Milestone 4 [**P-4]: Hire and train staff to operate the project Metric 1[P-4.1]: Number of staff secured and trained Baseline/Goal: Increase staffing 5% over baseline Data Source: Project records and training guides. Milestone 4 Estimated Incentive Payment: **Milestone 5 [**P-8]: Participate in interactions with other providers and RHP to promote collaborative learning around shared or similar projects	**Milestone 7** **CQI**: P-8 Participate in interactions with other providers and RHP to promote collaborative learning around shared or similar projects Metric **CQI: P-8.1** Number meetings, conference calls or webinars organized by the RHP that the provider participated in. Data Source Meeting Agendas, sign-n sheets, conference calls, presentations, email **Milestone 8** [I-11]: Increased utilization of community behavioral healthcare. Metric 1[I-11.1]: Percent utilization of community behavioral healthcare services. Goal: Increase community utilization of community based healthcare	**Milestone 10** **CQI**: P-8 Participate in interactions with other providers and RHP to promote collaborative learning around shared or similar projects Metric **CQI: P-8.1** Number meetings, conference calls or webinars organized by the RHP that the provider participated in. Data Source Meeting Agendas, sign-n sheets, conference calls, presentations, email **Milestone 11** [I-11]: Increased utilization of community behavioral healthcare. Metric 1[I-11.1]: Percent utilization of community behavioral healthcare services. Goal: Increase community utilization of community based healthcare services by 15% over baseline

020834001.1.3	1.12.2	N/A	***EXPAND THE NUMBER OF COMMUNITY BASED SETTINGS WHERE BEHAVIORAL HEALTH SERVICES MAY BE DELIVERED IN UNDERSERVED AREAS: HOME HEALTH PSYCH SERVICES***
Memorial Hermann Hospital System			020834001
Related Category 3 Outcome Measure(s):	***020834001.3.3***	IT-3.8	***Behavioral Health/Substance Abuse (BH/SA) 30-Day Readmission Rate***

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
provider participated in. Data Source: Meeting Agendas, sign-n sheets, conference calls, presentations, email Milestone 2 Estimated Incentive Payment:	Metric 1[**P-8.1]** Number meetings, conference calls or webinars organized by the RHP that the provider participated in. Data Source: Meeting Agendas, sign-n sheets, conference calls, presentations, email **Milestone 6**: P-6 Establish behavioral health services in new community-based settings in underserved areas Metric [P-6.1]: Number of new community-based settings where behavioral health services are delivered Baseline/Goal: %5 increase in community based sites over DY2 baseline. Data Source: Patient and project records.	services by 10% over baseline Data Source: Claims data and encounter data from community behavioral health sites and expanded transportation programs. **Milestone 9**: P-6 Establish behavioral health services in new community-based settings in underserved areas Metric [P-6.1]: Number of new community-based settings where behavioral health services are delivered Baseline/Goal: %10 increase in community based sites over DY2 baseline. Data Source: Patient and project records.	Data Source: Claims data and encounter data from community behavioral health sites and expanded transportation programs.
Year 2 Estimated Milestone Bundle Amount: $4,097,086	Year 3 Estimated Milestone Bundle Amount: $4,469,701	Year 4 Estimated Milestone Bundle Amount: $4,482,694	Year 5 Estimated Milestone Bundle Amount: $3,703,095

020834001.1.3	1.12.2	N/A	***EXPAND THE NUMBER OF COMMUNITY BASED SETTINGS WHERE BEHAVIORAL HEALTH SERVICES MAY BE DELIVERED IN UNDERSERVED AREAS: HOME HEALTH PSYCH SERVICES***
Memorial Hermann Hospital System			020834001
Related Category 3 Outcome Measure(s):	***020834001.3.3***	IT-3.8	***Behavioral Health/Substance Abuse (BH/SA) 30-Day Readmission Rate***
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $16,752,576			

Project Option: 1.1.2 Expand Existing Primary Care Capacity: Convenient Care Centers
Performing Provider: Memorial Hermann Hospital System/TPI 020834001
Unique Project ID: 020834001.1.4

- Provider: Memorial Hermann Hospital System (Memorial Hermann) is a 1,164 bed hospital system consisting of 4 campuses in the Houston-Sugarland-Baytown MSA. The system serves a population of approximately 6,000,000 people.

- Intervention(s): Memorial Hermann will create neighborhood centers that integrate all ambulatory services in a highly coordinated, efficient and accessible manner for the greater Houston MSA. The goal of the project is to expand the capacity of primary care to better accommodate the needs of the regional patient population and community.

- Need for the project: In the greater Houston MSA, patients often receive services in urgent and emergent care settings for conditions that could be managed in a more coordinated manner if provided in the primary care setting. This often results in more costly, less coordinated care and a lack of appropriate follow-up care.

- Target population: The target population is patients in the greater Houston MSA that would benefit from seeking primary care at an ambulatory facility as opposed to an acute care facility. It is estimated that 37.55% of the patients in Memorial Hermann's service area are either Medicaid eligible or uninsured and rely on Memorial Hermann's and other hospitals emergency department for primary care services.

- Category 1 or 2 expected patient benefits: Memorial Hermann will seek a 5% over baseline improvement in satisfaction scores of patients who take surveys to assess the quality of their care in the primary care centers.

- Category 3 outcomes: IT 6.1 - By DY5, Memorial Hermann intends to improve its patient satisfaction scores by at least 10% over the DY4 measurement in the same area and a 15% improvement over the baseline.

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Project Option- 1.1.2 Expand existing primary care capacity: Convenient Care Centers

Unique RHP Project Identification Number: 020834001.1.4

Performing Provider Name/TPI: Memorial Hermann Hospital System Memorial/020834001

Project Description: Create neighborhood centers that integrate all ambulatory services in a highly coordinated, efficient and accessible manner (imaging, emergency care, Primary Care, Specialty Care, Lab, Therapy, and Pharmacy for the Greater Houston Metropolitan Statistical area targeting pediatric and adult primary care patients.

Goal(s) and relationship to Regional goal(s):

Project goals:

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

This project meets the following Region 3 goals:

This project addresses the RHP's goal to "[i]ncrease access to primary and specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their condition, regardless of where they live or their ability to pay."

Challenges and how addressed:

The key challenges facing the implementation of this project are the recruitment and locating appropriate space. Memorial will address these challenges by putting in place an aggressive recruitment effort and identifying possible locations in the early stages of the project.

5-year expected outcome for provider and patients:

Memorial expects that his project will significantly increase access to primary care for pediatric and adult primary care patients in the Greater Houston Metropolitan Statistical Area.

Starting Point/Baseline: The creation of a convenient care center network is a new initiative and as such will require the creation of a baseline as an early milestone for the project.

Rationale:

Reasons for selecting the project option: In our current system, more often than not, patients receive services in urgent and emergent care settings for conditions that could be managed in a more coordinated manner if provided in the primary care setting. This often results in more costly, less coordinated care and a lack of appropriate follow-up care. Patients may experience barriers in accessing primary care services secondary to transportation, cost, lack of assigned provider, physical disability, inability to receive appointments in a timely manner and a lack of

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

Project components:

Required core project components:

a) Expand primary care clinic

   -Memorial will increase sites of the primary care network in the Greater Houston Metropolitan Statistical Area.

b) Expand availability of primary care clinic hours

   - Memorial will expand clinic hours in the Greater Houston Metropolitan Statistical Area, eventually moving to 24 hour, 7 day per week primary care availability.

c) Expand primary care provider availability

   – Memorial will recruit additional primary care physicians and clinical extenders (nurse practitioners and physician assistants) to staff the primary care network.

Unique community need identification number the project addresses:

- CN.1 - Inadequate access to primary care
- CN.8 - High rates of inappropriate emergency department utilization
- CN.9 - High rates of preventable hospital readmissions
- CN.6 - Inadequate access to treatment and services designed for special needs populations, including disabled, homeless, children, and elderly

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

This project would significantly enhance Memorial's ability to deliver vital healthcare services. Moreover, this is a new initiative for Memorial and, to our knowledge, Harris County. Therefore, this project will be highly contributive to the reform of the delivery system in Region 3.

Related Category 3 Outcome Measure(s): OD-6 Patient Satisfaction; Establish Baseline Rates; IT 6.1 Percent improvement over baseline of patient satisfaction scores. As a new initiative, the creation of a baseline for patient satisfaction related to appointment availability and patient satisfaction will be created as an early milestone for the project to ensure patients are getting timely care, appointments, and information.

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Reasons/rationale for selecting the outcome measure(s):

When patients with primary care needs are receiving the correct treatment in the correct setting this will improve their satisfaction with the services being provided.

Relationship to other Projects: This project is part of Memorial Hermann's larger plans to expand and develop primary care and specialty care services, while improving access to care.

Relationship to Other Performing Providers' Projects in the RHP: Primary Care/Ambulatory Care clinics are a top priority to Region 3 due to the acuity of the regional patient mix, population concentration, and lack of primary care access points for our patient base. The regional approach of collaboration as well as existing patient referral pattern relationships allowed our team to properly identify the community needs based on the necessity of population, uninsured, and medically underserved patient bases. This program is consistent with our region and similar to numerous initiatives in our RHP plan sharing both concepts as well as outcome measures focused to percent improvement over baseline of patient satisfaction scores, reduction of inappropriate ED utilization, and third next available appointment status. The Region 3 Initiative Grid attached as a RHP Plan addendum reflects a grid of relationship for all initiatives.

Plan for Learning Collaborative: We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system.

Project Valuation: The valuation of each Memorial Hermann project takes into account the transformational impact of the project, the population served by the project (both number of people and complexity of patient needs), the alignment of the project with community needs, the magnitude of costs avoided or reduced by the project, the degree of collaboration involved in the project, and the sustainability of the project.

Rationale/justification for valuation: A convenient care center will promote better access to services for many patients who cannot reliably travel between many disparate healthcare providers to receive services. This increased efficiency should lead to better health outcomes in the community which justifies the valuation of this project.

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020834001.1.4	*1.1.2*	*A-C*	***EXPAND EXISTING PRIMARY CARE CAPACITY: CONVENIENT CARE CENTERS***
Memorial Hermann Hospital System			*020834001*
Related Category 3 Outcome Measure(s):	*020834001.3.4*	*IT-6.1*	***Percent Improvement over Baseline of Patient Satisfaction Scores***
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1[P-X1]: Establish baseline for measures P-1, P-4, P-5, I-11, and I-12. This milestone will be a comprehensive assessment of all the baseline data that will be necessary to measure the future success of the project/ Metric 1 [P-X1.1]: Submission of baseline assessment documentation Baseline/Goal: To establish baseline for future years. Data Source: Provider documentation of baseline study Milestone 1 Estimated Incentive Payment :$ 2,023,862 **Milestone 2** [P-8]: Participate in interactions with other providers and RHP to promote collaborative learning around shared or similar projects Metric 1[**P-8.1]** Number meetings, conference calls or webinars organized by the RHP that the provider participated in. Goal: Participate in learning collaborative Data Source: Meeting Agendas, sign-n sheets, conference calls, presentations,	**Milestone 3 [**P-8]: Participate in interactions with other providers and RHP to promote collaborative learning around shared or similar projects Metric 1 [P-8.1]: Number meetings, conference calls or webinars organized by the RHP that the provider participated in. Goal: Participate in learning collaborative Data Source: Meeting Agendas, sign-n sheets, conference calls, presentations, email Milestone 3 Estimated Incentive Payment :$ 1,471,950 **Milestone 4** [P-4]:Expand the hours of a primary care clinic, including evening and/or weekend hours. Metric 1 [P-4.1]: Increased number of hours at primary care clinic over baseline. Baseline/Goal: Increase hour to include after hours or weekend hours. Data Source: Clinic documentation.	**Milestone 6** [P-8]: Participate in interactions with other providers and RHP to promote collaborative learning around shared or similar projects Metric 1 [P-8.1]: Number meetings, conference calls or webinars organized by the RHP that the provider participated in. Goal: Participate in learning collaborative Data Source: Meeting Agendas, sign-n sheets, conference calls, presentations, email Milestone 6 Estimated Incentive Payment :$ 1,107,171 **Milestone 7** [P-4]: Expand the hours of a primary care clinic, including evening and/or weekend hours. Metric 1 [P-4.1]: Increased number of hours at primary care clinic over baseline. Baseline/Goal: Increase hour to include after hours or weekend hours. Data Source: Clinic documentation.	**Milestone 10** [I-11]:Patient satisfaction with primary care services. Metric 1 [I-11.1]: Patient satisfaction scores: Average reported patient satisfaction scores, specific rangers and items to be determined by assessment tool scores. Demonstrate improvement over prior reporting period. Baseline/Goal: 4% improvement. Data Source: CG-CAHPS or other developed evidence-based satisfaction assessment tool, available in formats and language to meet patient population. Metric 2 [I-11.2]: Percentage of patients receiving survey. Specifically, the percentage of patients that are provided the opportunity to respond to the survey. Demonstrate improvement over prior reporting period. Baseline/Goal: 5% improvement. Data Source: Performing provider documentation of survey distribution; EHR. Milestone 10 Estimated Incentive Payment :$ 1,829,240 **Milestone 11** [P-8]: Participate in interactions with other providers and RHP to promote collaborative learning around shared or

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020834001.1.4	1.1.2	A-C	EXPAND EXISTING PRIMARY CARE CAPACITY: CONVENIENT CARE CENTERS
Memorial Hermann Hospital System			020834001
Related Category 3 Outcome Measure(s):	020834001.3.4	IT-6.1	Percent Improvement over Baseline of Patient Satisfaction Scores

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
email Milestone 2 Estimated Incentive Payment :$ 2,023,862	Milestone 4 Estimated Incentive Payment :$ 1,471,950 **Milestone 5** [P-1]: Establish additional/expand existing/relocate primary care clinics. Metric 1 [P-1.1]: Number of additional clinics or expanded hours or space. Baseline/Goal: 1 primary care clinic. Data Source: New primary care schedule or other Performing Provider document or other plans as designated by Performing Provider. Milestone 5 Estimated Incentive Payment: $ 1,471,949	Milestone 7 Estimated Incentive Payment :$ 1,107,171 **Milestone 8** [P-5]:Train/hire additional primary care providers and staff and/or increase the number of primary care clinics for existing providers. Metric 1 [P-5.1]: Documentation of increased number of providers and staff and/or clinic sites. Baseline/Goal: Addition of 1 primary care clinic/provider. Data Source: Documentation of completion of all items described by the RHP plan for this measure; hospital or other Performing Provider report, policy, contract, or other documentation. Milestone 8 Estimated Incentive Payment :$ 1,107,172 **Milestone 9** [I-11]: Patient satisfaction with primary care services. Metric 1 [I-11.1]: Patient satisfaction scores: Average reported patient	similar projects Metric 1[**P-8.1]:** Number meetings, conference calls or webinars organized by the RHP that the provider participated in. Data Source: Meeting Agendas, sign-n sheets, conference calls, presentations, email Milestone 11 Estimated Incentive Payment :$ 1,829,240

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020834001.1.4	*1.1.2*	*A-C*	***EXPAND EXISTING PRIMARY CARE CAPACITY: CONVENIENT CARE CENTERS***
Memorial Hermann Hospital System			*020834001*
Related Category 3 Outcome Measure(s):	*020834001.3.4*	*IT-6.1*	***Percent Improvement over Baseline of Patient Satisfaction Scores***

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
		satisfaction scores, specific rangers and items to be determined by assessment tool scores. Demonstrate improvement over prior reporting period. Baseline/Goal: 2% improvement. Data Source: CG-CAHPS or other developed evidence-based satisfaction assessment tool, available in formats and language to meet patient population. Metric 2 [I-11.2]: Percentage of patients receiving survey. Specifically, the percentage of patients that are provided the opportunity to respond to the survey. Demonstrate improvement over prior reporting period. Baseline/Goal: 5% improvement. Data Source: Performing provider documentation of survey distribution; HER Milestone 9 Estimated Incentive Payment :$ 1,107,172	
Year 2 Estimated Milestone Bundle Amount: $4,047,724	Year 3 Estimated Milestone Bundle Amount: $4,415,849	Year 4 Estimated Milestone Bundle Amount: $4,428,686	Year 5 Estimated Milestone Bundle Amount: $3,658,480
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $16,550,739			

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Project Option 1.1.1 - 1.1 Expand Primary Care Capacity: Pediatric Clinic Expansion – Houston Northwest Pediatric Clinic

Unique Project ID: 020834001.1.5
Performing Provider Name/TPI: Memorial Hermann Hospital/ 137805107

Project Summary:

Provider: Memorial Hermann Hospital (Memorial) is an 860 bed hospital located in Houston, TX and is part of the Houston-Sugarland-Baytown MSA. The MSA population served by Memorial is approximately 6,000,000 people.

Intervention(s): Memorial will establish the Houston Northwest Pediatric Clinic which will provide primary care for pediatric patients in that area of Harris County. Memorial will contract UTHSC-H to provide physician services to complement Memorial's investment in new technology, equipment and space to better provide pediatric services.

Need for the project: Prospective pediatric patients in the targeted service area described below currently face many roadblocks to adequate primary care including economic burdens, language barriers and lack of knowledge for seeking pediatric care. Due to the shortage of primary care providers in the community, the average wait period for a primary care appointment is 17 days, which results in increased reliance on hospital EDs for primary care and non-emergent care. The project will increase the percentage of patients who receive appropriate primary care including preventative services and regular monitoring for patients with chronic illnesses.

Target population: The target population is uninsured and underinsured children in the area of Harris County that is between Halls Bayou to the North, Beltway 8 to the West, I-10W and I-610NW to the South, and the Hardy Toll Road to the East. It is estimated that 39.8% of the patients in the service area for this clinic are either uninsured or underinsured children and rely on Memorial Hermann's and other hospitals' emergency departments for primary care services.

Category 1 or 2 expected patient benefits: The clinic will provide a more appropriate setting for pediatric primary care for the target population. They will benefit primarily from better access to primary care and better management of illness and chronic conditions.

Category 3 outcomes: IT 1.1 – Reduce the average length of time in days between the day a patient requests an appointment and the third available appointment. The goal will be to decrease number of days to third next available appointment to zero days (same day) for primary care by DY5.

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Project Option 1.1.1- Establish More Primary Care Clinics: Pediatric Clinic Expansion - Northwest Houston Pediatric Clinic

Unique RHP Project Identification Number: 020834001.1.5

Performing Provider Name/TPI: Memorial Hermann Northwest Hospital/020834001

Project Description: 1.1/1.1.1: Using the strengths developed during their longstanding partnership, Memorial and The University of Texas Health Science Center at Houston (UTHSC-H) intend to work together to address the shortage of pediatric primary and specialty care in Region 3. In this project, Memorial will establish the Northwest Houston Pediatric Clinic, which will provide primary care for pediatric patients in an area of Harris County that is between Halls Bayou to the north, Beltway 8 to the west, I-10W and 610NW to the south, and the Hardy Toll Road to the east. Memorial has defined the service area for this clinic as a priority area for pediatric services, because it contains 14 of the 81 census tracts that make up the top 10% of all census tracts in Harris County with the greatest number of people below the age of 18 that are living below the federal poverty level (FPL). (The census tracts are 5333, 5331, 5321, 5320.01, 5307, 5223.01, 5221, 5214, 5206.02, 2217, 2216, 2215, 2214, and 2213.) The number of children living below the FPL in these 14 census tract areas is estimated to be approximately 15,415. Furthermore, these areas have particularly high numbers of Hispanics (64.6%), for whom language, as well as poverty, may pose a barrier to obtaining primary care for their children. Black/African Americans, another segment of the population that tend to be medically underserved, also make up a significant proportion of the population in these census tracts (20.4%). The service area for this clinic includes large populations with economic, cultural, language, and transportation barriers to receiving primary care. (All population statistics are from the U.S. Census Bureau, 2010 Census. Poverty statistics are from the U.S. Census Bureau, Small Area Estimates Branch. Release date: 11.2011. Table 1: 2010 Poverty and Median Income Estimates - Counties.) In order to address the unique needs of different communities in the greater Houston area, Memorial has chosen to establish a pediatric clinic in this area as an independent DSRIP project.

Using their longstanding partnership to provide quality healthcare as a base, Memorial will contract UTHSC-H to provide physician services to complement Memorial's investment in new technology, equipment and space to better provide pediatric services. Specifically, UTHSC-H will redirect pediatricians already on its staff who have the capacity to care for additional patients, recruit additional pediatricians, or increase residency programs to fill the need for additional pediatric specialists. UTHSC-H is uniquely positioned to attract and retain new physicians due to its accomplishments as a world-class academic and research institution. This additional service line will avoid duplication and draw on the strength of UTHSC-H's academic presence in the field of pediatric medicine, and will also benefit Memorial by increasing the quantity, quality, and scope of services provided at its facilities.

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Practically, Memorial will subcontract with UTHSC-H to provide physician and other services needed to implement this project. For example, Memorial will lease additional space to open the North Harris County clinic**.** This space will include additional consulting, exam and procedure rooms. Memorial will also subcontract with UTHSC-H to provide primary care providers and support staff to operationalize the project. For all services in which UTHSC-H is a subcontractor, Memorial will pay an agreed rate that is set in advance and represents fair market value for services negotiated in the ordinary course of business through an arms-length transaction.

Goal(s) and relationship to Regional goal(s):

Project goals:

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

This project meets the following Region 3 goals:

One of the goals of the region is to "Increase access to primary and specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their condition, regardless of where they live or their ability to pay". Expansion of primary care capacity certainly relates to this goal as it will make it easier for Memorial to provide care to underserved populations.

Challenges and how addressed:

This project faces three key challenges. First, Memorial must raise awareness and change existing patterns for seeking health care services for some patients. A second challenge is to raise awareness for the service delivery model offered by these new sites so that patients who currently don't have access to after-hours care learn that this type of care is available through a physician's clinic rather than turning to emergent or urgent care clinics. And finally, recruiting additional primary care providers and pediatric specialists in this competitive environment will be a challenge. Memorial will address these challenges by implementing other projects to reduce inappropriate ED use, educating patients on the benefits of primary care, and aggressively recruiting primary care providers by offering competitive salaries and other incentives to practice in the outlying clinics.

5-year expected outcome for provider and patients:

There will be shortening of waiting times for primary pediatric care appointments and increased uptake of primary pediatric care services in this specific service area, which will increase the percentage of patients who receive appropriate primary health care, including preventative services and regular monitoring for those patients with chronic illnesses.

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Starting Point/Baseline: Memorial has identified the targeted service area needing increased access to pediatric primary care. Since this will be a new clinic, the baseline will have to be established during DY3.

Rationale:

Reasons for selecting the project option: In 2010, Texas had 176 patient care physicians per 100,000 population and 70 primary care physicians per 100,000 population with a state ranking of 46 and 47, respectively (comparable ratios for US total are 219.5 and 90.5, respectively). From 2001 to 2011, the Texas physician workforce grew 32.3%, exceeding the population growth of 25.1%. Therefore, there is a significant need to expand primary care in order to facilitate delivery system reform.

Research has shown that access to primary care is associated with better health outcomes at less cost. Access to primary care ensures better preventive care and better management of chronic disease, with lack of access often resulting in more expensive care, received in hospitals and emergency departments (ED). For the fiscal year 2010, 10% of all potentially preventable hospitalizations (PPR) were ambulatory care sensitive. In 2009, 41% (390,945) of ED visits in Houston were primary care related (PCR), including non-urgent, primary care treatable, and primary care preventable, and for 26.8% (104,762) of these PCR visits, Medicaid was the payor. Getting more patients into primary care will help to reduce the use of this more costly care. Placing more primary care providers out in the communities will help to address transportation access barriers and the expansion of clinic service hours will provide a greater selection of available appointment times. By increasing primary care capacity, engaging more people in the primary care system, and avoiding inappropriate utilization of costly services, the community will experience better health outcomes and greater patient satisfaction.[79]

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

[79] PPR rate was from the Texas Health and Human Services Commission report on Potentially Preventable Readmissions in the Texas Medicaid Population, Fiscal year 2010, published January, 2012. The statistics for ED use were from the Houston Hospitals Emergency Department Use Study (January 1, 2009 through December 31, 2009), Final Report included in the 2010 Harris County Community Needs Assessment for Memorial Hermann.

Because UTHSC-H will IGT on behalf of Memorial for its successful implementation of delivery system improvements under the Waiver, this structure results in a payment from a private hospital to an entity that provides its IGT, which arguably raises questions regarding provider donations. Nonetheless, this collaboration is the most to effective and efficient structure to expand access to pediatric services to the community, and ensure overall improvement to the Region 3 delivery system. This collaboration is a natural progression of the existing relationship and the clinical strengths of Memorial and UTHSC-H. Memorial is the largest not-for-profit healthcare system in Texas and serves the greater Houston community through 12 hospitals, a vast network of affiliated physicians and numerous specialty programs and services. With over 4,000 medical staff members, 26 residency programs, 48 fellowship programs, and over 1,300 physicians in training, Memorial is dedicated to providing high quality health services in order to improve the health of the people in Southeast Texas. The mission of UTHSC-H is to educate health science professionals, discover and translate advances in the biomedical and social sciences, and model the best practices in clinical care and public health. UTHSC-H strives to improve the health of the public in the State of Texas through educating future public health practitioners and bringing evidence based public health practices to Texas. UTHSC-H's faculty of over 900 physicians in 80 specialties provide comprehensive care for patients while teaching 800 medical students and over 900 residents in over 60 accredited residency/fellowship programs.

Core Components:

Through the new North Houston Pediatric Clinic, we propose to:

a) Expand primary care clinic space

-Memorial will identify and lease appropriate space within the defined service area to establish the new clinic that includes reception, consulting, exam and procedure rooms, and will provide the necessary equipment and furnishings.

b) Expand primary care clinic hours

-UT Physicians will be contracted at fair market value to provide primary care physicians, advanced practice providers, and support staff to operate the clinic.

c) Expand primary care clinic staffing

-In addition to regular business hours, the clinic will operate with expanded evening and Saturday hours to increase access for individuals that are not able to leave their jobs for healthcare appointments, and to provide care for those needing urgent care services that can be accommodated in a primary care clinic.

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Unique community need identification number the project addresses:

CN1 – Primary Care

CN8 – High rates of inappropriate emergency department utilization

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

This project represents a significant improvement in Memorial's ability to deliver primary healthcare to babies, children, and adolescents. This new initiative proposes to add space, providers, support staff, and extended service hours in a location where economic and cultural barriers to receiving appropriate healthcare are indicative of a need for services that are conveniently located and available when needed. This project is an expansion of services in order to improve access to care.

Related Category 3 Outcome Measure(s):

OD-1 Primary Care and Chronic Disease Management IT-1.19 Antidepressant Medication Management - NQF 0105 (Standalone measure)

The management of antidepressant medication in children ages 6 and over who were discharged alive) from an acute inpatient setting (including acute care psychiatric facilities) with a principal mental health diagnosis: A) the acute phase treatment period consisting at least 84 days (12 weeks) of continuous treatment with antidepressant medication during the 114-day period following the IPSD (inclusive), and B) the continuation phase treatment period consisting of at least 180 days (6 months) of continuous treatment with antidepressant medication (Table AMM-D) during the 231-day period following the IPSD (inclusive).

OD-1 Primary Care and Chronic Disease Management IT-1.1 Third next available appointment (Non- standalone measure)

Reduce the average length of time in days between the day a patient makes a request for an appointment with a physician and the third available appointment for a new patient physical, routine exam, or return visit exam.

Reasons/rationale for selecting the outcome measure(s):

This project is specifically geared towards increasing primary care services for pediatric patients. If this population is receiving adequate levels of primary behavioral healthcare then the management of anti-depressant medication is expected to improve. Additionally, the immediate goal of the project is to allow greater access to primary care for pediatric patients—this should directly correlate to reduced wait times for available appointments. Therefore, this outcome measure is a reasonable gauge of the effectiveness of this project.

Relationship to Other Projects: This project is part of Memorial's larger plans to expand and develop primary care and specialty care services, while improving access to care. Expanding primary care supports/reinforces several of the Category 1 and 2 projects: increasing the number of physicians rotating through the primary care residency program will have a direct impact on Expanding Primary Care Capacity (1.2); this project not only will increase the number of available physicians to participate in medical homes (2.1), it will also ensure that they are trained in the medical home concept; this project reinforces the Redesign of Primary Care (2.3), the Redesign to Improve the Patient Experience (2.4).

Relationship to Other Performing Providers' Projects in the RHP: Children are the future of healthcare and will dictate the treatments needed as well as the cost of healthcare in future years so it is critical that they receive the access needed throughout their pediatric lives. The focus of pediatric specialty care is similar throughout the region with a concentrated focus in the Harris county proper geographic region and allows for the expansion of access to numerous specialties such as cardiology, neurology, ENT, and many more. The outcome measures focus to appropriate length of stay, per episode cost of care, and improved cost savings. The Region 3 Initiative grid allows for a cross reference of similar initiatives in our region. (addendum)

Plan for Learning Collaborative: Memorial will participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system.

Project Valuation: The valuation of each Memorial project takes into account the transformational impact of the project, the population served by the project (both number of people and complexity of patient needs), the alignment of the project with community needs, the magnitude of costs avoided or reduced by the project, the degree of collaboration involved in the project, and the sustainability of the project.

The expansion of primary care clinics will help address a substantial need in the community for increased access to primary care. It will also go a long way towards achieving the Waiver goal of improving outcomes while curbing the risk of healthcare costs, because primary care is one of the most cost effective methods to increase health outcomes.

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020834001.1.5	*OPTION 1.1.1*		*PEDIATRIC CLINIC EXPANSION*
Memorial Hermann Northwest Hospital			*020834001*
Related Category 3 Outcome Measure(s):	*020834001.3.6* *020834001.3.5*	**IT-1.19** **IT-1.1**	**Antidepressant Medication Management - NQF 0105 (Standalone measure)** **Third next available appointment (Non-standalone measure)**

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-1]: Expand existing primary care clinics Metric 1 [P-1.1]: Amount of additional space acquired to expand clinic services. Baseline/Goal: TBD Data Source: New primary care schedule and other UT Physicians' documents. Milestone 1 Estimated incentive payment: $ 2,238,923 **Milestone 2 [P-5]:** Hire additional primary care providers and staff Metric 1 [P-5.1]: Documentation of increased number of providers and staff. Baseline/Goal: TBD Data Source: UT Physicians' report, policy, contract or other documentation Milestone 2 Estimated incentive payment: $ 2,238,923	**Milestone 3 [P-4]:** Expand the hours of a primary care clinic, including evening and/or weekend hours Metric 1 [P-4.1]: Increased number of hours at primary care clinic over baseline Baseline/Goal: TBD Data Source: Clinic documentation Milestone 3 Estimated incentive payment: $ 4,886,557	**Milestone 4 [I-12]:** Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 [I-12.1]: Documentation of increased number of visits. Demonstrate improvement over prior reporting period. Goal: TBD Data Source: Registry, EHR, claims or other UT Physicians' source Milestone 4 Estimated incentive payment: $ 4,914,741	**Milestone 5 [I-11]:** Patient satisfaction with primary care services. Metric 1 [I-11.1]: Improved Patient satisfaction scores Goal: TBD Data Source: CG-CAHPS3 or other developed evidence based satisfaction assessment tool, available in formats and language to meet patient population. Milestone 5 Estimated incentive payment: $ 4,101,575
Year 2 Estimated Milestone Bundle Amount: $ 4,477,846	**Year 3 Estimated Milestone Bundle Amount: $ 4,886,557**	**Year 4 Estimated Milestone Bundle Amount: $ 4,914,741**	**Year 5 Estimated Milestone Bundle Amount: $ 4,101,575**

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020834001.1.5	*OPTION 1.1.1*			*PEDIATRIC CLINIC EXPANSION*
Memorial Hermann Northwest Hospital				*020834001*
Related Category 3 Outcome Measure(s):	*020834001.3.6* *020834001.3.5*	**IT-1.19** **IT-1.1**	**Antidepressant Medication Management - NQF 0105 (Standalone measure)** **Third next available appointment (Non-standalone measure)**	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**	
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $ 18,380,719				

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Memorial Medical Center

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Project Option 1.1.1, 1.1.2 and 1.9.2- Hospital Based Clinic – Improving Access to Care
Unique RHP Project ID: 137909111.1.1
Performing Provider Name/TPI: Memorial Medical Center / 137909111
Project Summary:
Provider:
Memorial Medical Center is a county-owned, 25 bed Critical Access Hospital and serves as the only hospital for Calhoun County. Located on the Gulf Coast, Memorial Medical Center serves 60% of the 21,382 County residents. With a tax base of $13,972,000, Memorial Medical Center was able to provide more than $8 million in charity care (includes uncompensated) during FY 2012.

Volume Statistics – 11 months Year to date 2011 - 2012	Patient Payer Mix	Patient/Community Demographics
Hospital admissions- 1056 Births (babies delivered)- 98 Emergency visits- 9084 Outpatient visits- 13,430 Laboratory procedures- 224,562	Medicaid and CHIP- 16.4% Medicare- 33.6% Commercial Insurance- 31.1% Uninsured, Charity, Indigent Care- 18.9%	Hispanic- 47.1% African American- 3.3% Caucasian- 44.4% Asian- 4.5% American Indian- 0.7%

Intervention(s):
This project will expand primary and specialty care services through a hospital-based clinic to a medically underserved area of rural Texas.

Need for the project:
The purpose is to provide access to both primary and specialty care services in an area where two-thirds of the population travels outside the service area for health care. Patients requiring specialty care must often drive long distances to see a provider, and may not receive services until the condition becomes critical. Patients needing primary care are unable to get appointments, delay care until it is more critical, and use the emergency room department for care that could have been provided in a physician's office.

Target Population:
All patients within the system with may benefit from this project (Medicaid and CHIP-16.4% / Medicare- 33.6%), specifically those with chronic diseases.

Category 1 or 2 expected patient benefits:
Over the course of this project, we will increase the total number of encounters for both primary care and specialty care services by 15% each by the end of DY 5. By doing so, we will improve the health of our clients by providing more timely access to care and coordinating treatment and follow-up care that isn't available when patients seek treatment through the Emergency Department.

Category 3 outcomes:
OD-6: Because the community we serve has an insufficient number of providers and patients are often unable to obtain appointments in a timely manner, the priority goal for this project is ensuring patients receive care when they need it and without significant delays, which will result in improved health outcomes and patient satisfaction. In DY5, patient experience at the Hospital Based Clinic shall have improved in deficient areas of timely care, appointments and information by 10% by the end of the waiver.

Project Options 1.1.4 – Other project option: Hospital based clinic improving access to primary and specialty care

Unique RHP Project Identification Number: 137909111.1.1
Performing Provider Name/TPI: Memorial Medical Center / 137909111

Project Description:

To increase the ability of Memorial Medical Center (MMC) to provide the "right care at the right time in the right setting," this project will expand access to primary and specialty care services through the establishment of a hospital-based clinic.

This initiative will provide critically needed services to a medically underserved area of rural Texas as identified in our Region's community needs assessment. To ensure patients have access to services at times that are convenient for them, are able to secure appointments with appropriate providers, and to reduce the inappropriate use of the hospital emergency department for non-urgent and primary care services, the clinic will offer extended and non-traditional hours of care.

Currently, the Region faces challenges providing both primary care and specialty care services to the community population. Every county in the region, including Calhoun County (the home of MMC) faces shortages of primary care, behavioral health care, and other specialty care providers, causing delays in care until medical care becomes an urgent need. Patients requiring specialty care must often drive long distances to see a provider, and may not receive services until the condition becomes critical. Patients needing primary care are unable to get appointments, delay care until it is more critical, and use the emergency room department for care that could have been provided in a physician's office. This creates unnecessary costs and burdens on the existing health care system, and may contribute to less healthy outcomes in patients. Attracting additional providers to the area is a challenge given the lack of clinical space, or access to specialty providers to whom they may refer their patients.

The operation of a hospital-based primary and specialty care clinic significantly enhances our existing delivery system by allowing us to meet a critical community need. Because these services will be provided by a clinic affiliated with the hospital, we also will be able to coordinate services provided to patients discharged from the hospital, improve our ability to ensure compliance with out-patient care instructions, and reduce readmissions. Studies have shown that integrating hospital and outpatient care is key to reducing readmissions and that strong relationships between hospitals and primary care providers improve patient outcomes.[80]

While we recognize this is an ambitious project, it is an important initiative that will significantly improve access to care for the patients in this Region MMC currently is unable to provide these critical services and has long recognized the need for a clinic. By creating a hospital-based clinic, patients will have access to a full-range of services not available in a stand-alone facility. Our plans will build on our existing experience in delivering high-quality health care, and will leverage the existing infrastructure and administrative services provided by MMC to provide a full-service clinic.

Goals and Relationship to Regional Goals:

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[80] Silow-Carroll, Sharon, Edwards, Jennifer N., Lashbrook, Aimee, *Reducing Hospital Readmissions: Lessons from Top Performing Hospitals.* The Commonwealth Fund, April 2011.

Through the creation and operation of a hospital-based clinic and hiring of primary and specialty care providers, this project will enable MMC to better meet the community and Region needs for health care services. The goals of this project are:

- Improve access to primary care providers and services;
- Improve access to specialty care providers and services;
- Reduce the need for clients to travel excessive distances for health care services;
- Increase the number of health care providers and services available to community residents;
- Reduce the inappropriate use of emergency rooms for non-urgent care;
- Provide access to care during non-traditional hours for patients who work, care for children, do not have transportation, or face other challenges that make it difficult for them to seek care during typical business hours;
- Improve health care outcomes by providing health care services that might not otherwise be available to residents and enabling patients to obtain more timely care before conditions become more serious and costly to treat;
- Reduce hospital readmissions by providing care coordination and patient follow-up when discharged from the hospital;
- Improve patient satisfaction by providing care in a more appropriate setting and reducing the wait time that typically accompanies visits to the emergency department.

While the Region has many specific objectives and improvement targets based on stakeholder input and community needs assessments, the over-arching goals that have guided many of our decisions include the following:

- Develop a regional approach to health care delivery that leverages and improves on existing programs and infrastructure, is responsive to patient needs throughout the entire region, and improves health care outcomes and patient satisfaction.
- Increase access to primary and specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their condition, regardless of where they live or their ability to pay.
- Transform health care delivery from a disease-focused model of episodic care to a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary or duplicative services, and builds on the accomplishments of our existing health care system, and
- Develop a culture of ongoing transformation and innovation that maximizes the use of technology and best-practices, facilitates regional collaboration and sharing, and engages patients, providers, and other stakeholders in the planning, implementation, and evaluation processes.

5-Year Expected Outcome for Provider and Patients:

Over the course of this project, we will establish a clinic that will provide both primary and specialty care services, and gradually increase the number of primary care and specialty care encounters so that the total number of encounters for both primary care and specialty services increase by 15% each by the end of Demonstration Year (DY) 5. By doing so, we will improve the health of our clients by providing more timely access to care and coordinating treatment and follow-up care that is not available when patients seek treatment through the emergency department. We also will improve patient satisfaction as patients will have a regular source for care that is less costly, more efficient, and better meets their health care needs. The project supports the Region's goals of ensuring residents have timely access to necessary health care

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services from an appropriate setting, within a reasonable distance, and receive the most cost-effective and appropriate treatment that enhances their ability to live healthy, productive lives.

Starting Point/Baseline:

No space currently exists for primary or specialty care providers. Therefore, the baseline for the number of patients and the number of clinics and participating providers begins at 0 in DY 2.

Rationale:

Memorial Medical Center (MMC) is located in Port Lavaca, Texas, which is located on the Gulf of Mexico between Corpus Christi and Houston. The city is in Calhoun County. Port Lavaca's population is approximately 11,500 and includes about 60% of the 21,381 county residents.[81] Memorial Medical Center is a county-owned, 25 bed Critical Access Hospital and serves as the only hospital for Calhoun County. Port Lavaca Clinic and Coastal Medical Clinic serve as the primary providers for outpatient services.

Like other counties in our Region, Calhoun County is a designated Medically Underserved Area for Primary Care, Mental Health Care, and Dental Care.[82] Due to further shortage of providers, an application was submitted in September 2012 for designation as a Health Professional Shortage Area. The most recent data from the Texas Medical Board shows Calhoun County has a total of 18 physicians, including seven in General Practice or Family Medicine, one Pediatrician, five who practice Internal Medicine, and two OB/GYNs.[83] However, since the study, five physicians have left the service area due to retirement, relocation and/or contract elimination.

MMC's primary service area is almost exclusive to the Port Lavaca zip code. The secondary service area includes the remainder of Calhoun County and the southwestern portion of adjacent Matagorda County. To better understand the community's needs and determine the steps MMC needs to take to adequately serve the region's patients, in 2010 MMC contracted with BR Healthcare Services, Inc. (BRHS) to conduct an analysis of MMC's current market, the primary and secondary service area, demographics, and outmigration.[84] The study found that 73% of patients served by MMC lived in the Port Lavaca zip code area, while 18% of patients lived in Calhoun County and Palacios. During the time period of the study, the patient population included 33.6% who are covered by Medicare; 16.4% who are covered by Medicaid; 31.1% who are insured by a commercial plan; and 18.9% who are uninsured, charity and indigent care patients.

At the time of the study, the MMC medical staff included 13 physicians. Twelve hold active statuses and one is Sr. Active.[85] Another 26 providers are "courtesy" or "consulting" staff. Of the 13 Active Staff physicians in 2010, all provided direct patient care or have full time offices in the area. The average age is 48 years. One Active Staff physician is over 60 years and is listed as Sr. Active.[86] Approximately 70% of the MMC physicians are concentrated in the age 45-60 range.

[81] Texas State Data Center, Texas Population 2010.

[82] U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Primary Care. August, 2012.

[83] Texas Medical Board, Physician Demographics by County and Specialty, January 2012. Note: the remaining 2 physician specialties are not noted in the Texas Medical Board data; Further, five physicians left service area since publication.

[84] BR Healthcare Services, Inc., Memorial Medical Center Market & Service Area Development Report, October, 2010.

[85] Since the time of the study, two primary care physicians have left the service area.

[86] BR Healthcare Services, Inc., 2010.

Using these current physician supply information and other data, the BRHS study conducted a Physician Needs Assessment utilizing four separate mathematical methodologies.[87] Three indexed physician demand for services and the fourth utilized National supply numbers. In assessing the physician supply needs for the community, the BRHS analysis reviewed various data and considered both current and future population needs. The results of the analysis concluded that community need currently exists for additional physicians in the following areas of care: 1) Family Practice; 2) Internal Medicine; 3) Pediatrics; 4) Cardiology (Non-invasive); 5) General Surgery; 6) Obstetrics/Gynecology; and 7) Orthopedic Surgery.

Due to various methodologies and data resources used in each of the studies, the range of providers needed varied, and is demonstrated in the following table.

Memorial Medical Center Physician Need Assessment							
		Need Assessment Methodology					
Specialty	**Current Number**	**GMENAC**	**Hicks & Glenn**	**Group Health**	**AMA**	**Need Avg.**	**Additional Physicians Needed**
Family Practice	6	7.04	6.93	8.72	5.7	7.1	1.1
Internal Medicine	4	5.94	3.63	4.1	8.78	5.6	1.6
Pediatrics	1	3.08	2.65	3.18	3.74	3.2	2.2
Cardiology	0	0.65	0.79	1.02	1.38	1.0	1.0
General Surgery	0	1.99	2.8	1.79	3.02	2.4	2.4
OB/GYN	1	2.03	2.28	2.31	2.82	2.4	1.4
Orthopedics	0	1.28	1.12	1.31	1.67	1.3	1.3

Project Components:

~~Through the establishment of a new clinic, we propose to meet all required core project components of 1.1.2 as described below.~~ Project option 1.1.4 does not have any core components. However, this project will meet the primary objectives, which is to establish more primary care clinics and improve access to specialty care. ~~For Project 1.1.2, we will meet all three components: a) Expand primary care clinic space; b) expand primary care clinic hours; and c) expand primary care clinic staffing.~~

Our clinic will provide both primary care and specialty care providers based on the needs identified for our community. The clinic will a) provide additional clinic space for primary care providers and patients; b) provide expanded clinic hours to ensure patients have access to care that fits within their schedule; and c) provide clinic staffing, including both providers and necessary administrative staff.

~~The operation of a hospital-based primary and specialty care clinic significantly enhances our existing delivery system by allowing us to meet a critical community need. Because these services will be provided by a clinic affiliated with the hospital, we also will be able to coordinate services provided to patients discharged from the hospital, improve our ability to ensure compliance with out-patient care instructions, and reduce readmissions. Studies have shown that integrating hospital and outpatient care is key to reducing readmissions and that strong relationships between hospitals and primary care providers improve patient outcomes.[88]~~

~~While we recognize this is an ambitious project, it is an important initiative that will significantly improve access to care for the patients in this Region MMC currently is unable to provide these critical services and has long recognized the need for a clinic. By creating a hospital-based clinic, patients will have access to a full-range of services not available in a stand-~~

[87] The physician demand was calculated based on the following studies: GMENAC, Hicks & Glenn, Group Health and U.S. Supply, *AMA Physician Characteristics and Distribution in the U.S.*

[88] Silow-Carroll, Sharon, Edwards, Jennifer N., Lashbrook, Aimee, *Reducing Hospital Readmissions: Lessons from Top Performing Hospitals.* The Commonwealth Fund, April 2011.

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~~alone facility. Our plans will build on our existing experience in delivering high-quality health care, and will leverage the existing infrastructure and administrative services provided by MMC to provide a full-service clinic.~~

Unique community need for identification numbers the project addresses:

- CN.1 – Inadequate access to primary care
- CN.2 – Inadequate access to specialty care

Challenges:

MMC has identified several challenges in developing this initiative, but is prepared to fully address each one of these in our implementation plan. One of the key challenges we face is attracting physicians to the clinic. To address this, our plan will include an outreach and marketing strategy to reach interested providers. Based on recommendations from BRHS, our expenditures in this area will be strategically prioritized to initially focus on the most critical physician needs. We will work with the local and state medical societies to publicize the new positions, as well as work with our Regional partners to identify potential candidates.

Another challenge will be educating clients to ensure they are aware of and utilize the new services. We will develop an education and outreach plan for the community, and will coordinate with local area providers to be sure residents are aware of the availability of the clinic. We will emphasize the availability of extended hours and will coordinate outreach with our emergency department and MMC administrative offices to inform and direct patients to the clinic when appropriate.

The population we serve also struggles with multiple chronic illnesses, including diabetes, chronic heart disease, COPD, and asthma, and has a high occurrence of behavioral health issues.[89] The creation of a new clinic will provide many of these underserved patients with access to care in a more timely manner, and will provide them with a local, accessible medical home. Studies have shown that obtaining primary care through a medical home reduces the number of hospital admissions, provides lower outpatient costs, reduces pharmaceutical costs, and improves health care outcomes.[90] To address the challenges of treating a wide range of medical problems and minimize potential complications, we will implement a process for ensuring our primary and specialty care providers work together to provide a coordinated approach to patient care. Clinic staff will also work closely with hospital staff to coordinate patient discharge planning and after-care, resulting in a reduction in hospital readmissions.[91] For services that may not be available from our specialists, we will utilize existing partnerships and develop new ones with providers in other counties for patient referrals.

We also know that the population we serve includes a large number of industrial shift workers, many of whom work non-traditional schedules that prevents them from obtaining care during normal clinic hours. This project will enable us to better serve this particular population by providing appointments during the extended hours. We will continually monitor the adequacy of those hours through patient surveys. If the client responses indicate changes are needed in clinic hours, we will reassess our options and, to the extent possible, adjust hours as necessary.

New Initiative for Provider:

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[89] County Health Rankings and Roadmaps, County Health Rankings 2012.

[90] Patient Centered Primary Care Collaborative. *Benefits of Implementing the Primary Care Patient-Centered Medical Home: A Review of Cost and Quality Results, 2012*.

[91] Silow-Carrol, et.al.

MMC currently operates a hospital that provides acute care, but does not provide access to primary and specialty care services. The operation of a hospital-based primary and specialty care clinic significantly enhances our existing delivery system by allowing us to meet a critical community need for care. Because these services will be provided by a clinic affiliated with the hospital, we will be able to coordinate services provided to patients discharged from the hospital, improve our ability to ensure compliance with out-patient care instructions, and reduce readmissions.

Related Category 3 Outcome Measure(s):

OD-6 Patient Satisfaction is the selected Category 3 Outcome Measure for this project. We intend to use the CG-CAHPS survey to improve our performance as measured by whether patients are (1) getting timely care, appointments and information. Obtaining patient feedback on our ability to provide the right care at the right time is critical to the success of this project and the internal operations of the clinic. This data will provide us with meaningful and objective information that will be used to determine whether our clinic has met patient expectations related to obtaining timely care and information, and will identify areas where we need to improve. Because the community we serve has an insufficient number of providers and patients are often unable to obtain appointments in a timely manner, the priority goal for this project is ensuring patients receive care when they need it and without significant delays, which will result in improved health outcomes and patient satisfaction. The CG-CAHPS survey is an effective tool for measuring our progress and will provide valuable information and feedback on our performance and areas where improvement is needed.

Plan for Learning Collaborative:

We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system. The learning collaborative meets our quality improvement milestone [P-1.1 and P-1.2].

Relationship to other Projects and other Performing Provider's Projects:

Primary Care/Ambulatory Care clinics are a top priority to Region 3 due to the acuity of the regional patient mix, population concentration, and lack of primary care access points for our patient base. The regional approach of collaboration as well as existing patient referral pattern relationships allowed our team to properly identify the community needs based on the necessity of population, uninsured, and medically underserved patient bases. This program is consistent with our region and similar to numerous initiatives in our RHP plan sharing both concepts as well as outcome measures focused to percent improvement over baseline of patient satisfaction scores, reduction of inappropriate ED utilization, and third next available appointment status. The Region 3 Initiative Grid attached as a RHP Plan addendum reflects a grid of relationship for all initiatives.

This project will support and coordinate with other projects designed to improve access to primary and specialty care (Projects 1.1 and 1.9), enhance service availability (1.12), redesign to improve patient experience (2.4), and enhance medical homes (2.1) Our participation in the Learning Collaborative will allow us to share information and promote the use of best practices.

Project Valuation:

When determining a value for expanding access to primary and specialty care through a hospital based clinic in Calhoun County, we first determined the priority of this initiative to our

community. Utilizing the Office of Extramural Research, National Institute of Health model, we identified the impact of this project as a high level. The insufficient access to these services in our area, results in patients' inability to locate a medical home; delayed diagnoses and treatment which leads to more serious health care conditions and higher costs; inappropriate utilization of emergency room facilities and higher costs; lack of care coordination and patient education. Further, in a 2010 BR Healthcare Services conducted a Market and Service Area Analysis that identified over 60% of Calhoun County residents sought medical treatment outside of the county. By providing access to care locally, an undue tax burden shall be offset reducing costs to local businesses and industry. Lower tax rates lend to business recruitment and workforce development adding to quality of life. Finally, we calculated the tangible expenses of space, utilities, technology, supplies, equipment, physician recruitment and staffing to determine the total project value. Living in rural Texas, we are painfully aware of the challenges to attract physicians to our area. Therefore, recruitment and salary packages must be competitive and access to health care resources plentiful to grow programs and patient satisfaction

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137909111.1.1	***1.1.4***	***N/A***	***OTHER OPTION: HOSPITAL BASED CLINIC IMPROVING ACCESS TO PRIMARY & SPECIALTY CARE***
Memorial Medical Center			*137909111*
Related Category 3 Outcome Measure(s):	*137909111.3.1*	*[3.IT-6.1.1]*	*Patient Satisfaction*
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1*[P-1]*: Establish additional/expand existing/relocate primary care clinic Metric 1 [P-1.1] Number of additional clinics or expanded hours or space Baseline: No space currently exists for primary care clinic/Goal: Establish space for two primary care providers. Data Source: Documentation of detailed expansion plans Milestone 1 Estimated Incentive Payment *(maximum amount):* $376,305 **Milestone 2** *[P-X1]:* Launch/expand a specialty clinic Metric 1 P-X1.1 Establish/expand specialty care clinic Baseline: No space currently exists for specialty care provider clinic/Goal: Establish space for two specialty care providers and services Data Source: Documentation of detailed expansion plans for specialty provider clinic space.	**Milestone 4** [P-5]: Train/hire additional primary care providers and staff Metric 1 [P-5.1]: Documentation of increased number of providers and staff and/or clinic sites. Baseline: No primary care providers/Goal: Recruit two primary care physicians and develop office staff Data Source: Hospital report and provider contracts Milestone 4 Estimated Incentive Payment *(maximum amount):* $261,712 **Milestone 5** *[P-X2]:* Increase number of specialist providers available for the high impact/most impacted medical specialties Metric 1 [P-X2.1]: Increase number of specialist providers in targeted specialties Baseline: No specialty care clinic providers/Goal: Recruit and hire orthopedic surgeon and develop	**Milestone 8** [I-X1]: : Increase number of specialist providers available for the high impact/most impacted medical specialties Metric 1 [I-X1.1]: Increase number of specialist providers in targeted specialties over baseline Goal: Recruit and hire General Surgeon and develop office staff Data Source: HR documents or other documentation demonstrating employed/contracted specialists Milestone 8 Estimated Incentive Payment *(maximum amount):* $246,626 **Milestone 9**[I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 [I-12.1]: Documentation of increased number of visits. Demonstrate improvement over prior reporting period. Baseline: No primary care patients are currently seen. Goal: 125 primary care visits per week. Data Source: Registry, EHR,	**Milestone 12**[I-X2]: Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 [I-X2.1]: Documentation of increased number of visits. Demonstrate improvement over prior reporting period. (baseline for DY4) Goal: Increase number of specialty visits by 15% over baseline in DY3) Data Source: Registry, EHR, claims or other provider source. Milestone 12 Estimated Incentive Payment *(maximum amount):* $222,662 **Milestone 13** [I-12]:Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 [I-12.1]: Documentation of increased number of visits. Demonstrate improvement over prior reporting period. Goal: Increase visits 10% over baseline. Data Source: Registry, EHR, claims or other Performing

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137909111.1.1	*1.1.4*	*N/A*	***OTHER OPTION: HOSPITAL BASED CLINIC IMPROVING ACCESS TO PRIMARY & SPECIALTY CARE***
Memorial Medical Center			*137909111*
Related Category 3 Outcome Measure(s):	*137909111.3.1*	*[3.IT-6.1.1]*	*Patient Satisfaction*
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 2 Estimated Incentive Payment *(maximum amount):* $138,153 **Milestone 3** [*P-1.1*]: Quality Improvement Milestone: Participate in at least bi-weekly interactions (meetings, conference calls, or webinars) with other providers and the RHP to promote collaborative learning around shared or similar projects. Metric 1 P-1.1 Number of bi-weekly meetings, conference calls, or webinars organized by RHP that the provider participated in. Data Source: Documentation of weekly or bi-weekly phone meetings, conference calls, or webinars including agendas for phone calls, slides from webinars, and/or meeting notes. Metric 2 P-1.2: Share challenges and solutions successfully during this bi-weekly interaction. Milestone 3 Estimated Incentive Payment *(maximum amount):* $50,000	office staff Data Source: HR documents or other documentation demonstrating employed/contracted specialists Milestone 5 Estimated Incentive Payment: $236,712 **Milestone 6** [P-4]: Expand the hours of primary care clinic, including evening and/or weekend hours Metric 1 [P-4.1]: Increased number of hours at primary and specialty clinic over baseline Baseline: Clinic currently is not operational/Goal: Establish baseline hours of operation Data Source: Clinic Documentation of clinical hours. Milestone 6 Estimated Incentive Payment: $105,857 **Milestone 7** [P-1]: Quality Improvement Milestone: Participate in at least bi-weekly interactions (meetings, conference calls, or webinars) with other providers and the RHP to promote collaborative learning around shared or similar projects. Metric 1 P-1.1 Number of bi-weekly	claims or other Performing Provider sources. Milestone 9 Estimated Incentive Payment: $214,417 **Milestone 10** [I-X2]: Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 [I-X2.1]: Documentation of increased number of visits. Demonstrate improvement over prior reporting period. Baseline: No specialty care patients are currently seen. Goal: 20 specialty care visits per week. Data Source: Registry, EHR, claims or other Performing Provider sources. Milestone 10 Estimated Incentive Payment: $150,000 **Milestone 11** [*P-1*]: Quality Improvement Milestone: Participate in at least bi-weekly interactions (meetings, conference calls, or webinars) with other providers and	Provider sources. Milestone 13 Estimated Incentive Payment: $293,705 **Milestone 14** [*P-1*]: Quality Improvement Milestone: Participate in at least bi-weekly interactions (meetings, conference calls, or webinars) with other providers and the RHP to promote collaborative learning around shared or similar projects. Metric 1 P-1.1 Number of bi-weekly meetings, conference calls, or webinars organized by RHP that the provider participated in. Data Source: Documentation of weekly or bi-weekly phone meetings, conference calls, or webinars including agendas for phone calls, slides from webinars, and/or meeting notes. Metric 2 P-1.2: Share challenges and solutions successfully during this bi-weekly interaction. Milestone 14 Estimated Incentive Payment *(maximum amount):* $50,000

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<table>
<tr><td>137909111.1.1</td><td>1.1.4</td><td>N/A</td><td colspan="2">OTHER OPTION: HOSPITAL BASED CLINIC IMPROVING ACCESS TO PRIMARY & SPECIALTY CARE</td></tr>
<tr><td colspan="4">Memorial Medical Center</td><td>137909111</td></tr>
<tr><td>Related Category 3 Outcome Measure(s):</td><td>137909111.3.1</td><td>[3.IT-6.1.1]</td><td colspan="2">Patient Satisfaction</td></tr>
<tr><th>Year 2
(10/1/2012 – 9/30/2013)</th><th>Year 3
(10/1/2013 – 9/30/2014)</th><th>Year 4
(10/1/2014 – 9/30/2015)</th><th colspan="2">Year 5
(10/1/2015 – 9/30/2016)</th></tr>
<tr><td></td><td>meetings, conference calls, or webinars organized by RHP that the provider participated in.

Data Source: Documentation of weekly or bi-weekly phone meetings, conference calls, or webinars including agendas for phone calls, slides from webinars, and/or meeting notes.
Metric 2 P-1.2: Share challenges and solutions successfully during this bi-weekly interaction.

Milestone 7 Estimated Incentive Payment: $50,000</td><td>the RHP to promote collaborative learning around shared or similar projects.
Metric 1 P-1.1 Number of bi-weekly meetings, conference calls, or webinars organized by RHP that the provider participated in.

Data Source: Documentation of weekly or bi-weekly phone meetings, conference calls, or webinars including agendas for phone calls, slides from webinars, and/or meeting notes.
Metric 2 P-1.2: Share challenges and solutions successfully during this bi-weekly interaction.

Milestone 11 Estimated Incentive Payment (maximum amount): $50,000</td><td colspan="2"></td></tr>
<tr><td>Year 2 Estimated Milestone Bundle Amount: $564,458</td><td>Year 3 Estimated Milestone Bundle Amount: $654,281</td><td>Year 4 Estimated Milestone Bundle Amount: $661,043</td><td colspan="2">Year 5 Estimated Milestone Bundle Amount: $566,367</td></tr>
<tr><td colspan="5">TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5):$2,446,149</td></tr>
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Mental Health and Mental Retardation Authority of Harris County

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Project Option 1.12 ENHANCE SERVICE AVAILABILITY OF APPROPRIATE LEVELS OF BEHAVIORAL HEALTH CARE: EXPANSION OF OUTPATIENT BEHAVIORAL HEALTH SERVICES FOR ADULTS WITH

SEVERE PSYCHIATRIC CONDITIONS (Northwest)

Unique RHP Project ID: 113180703.1.1

Performing Provider Name/TPI: MHMRA of Harris County / 113180703

Project Summary:

Provider: The Mental Health and Mental Retardation Authority (MHMRA) of Harris County is a public agency serving as the safety net provider for adults with serious mental illnesses, for children and adolescents with serious emotional disorders, for the developmentally delayed and for individuals experiencing acute psychiatric distress. MHMRA provides inpatient, residential and outpatient treatments, including psycho-therapy, case management and medication management for individuals. MHMRA serves more than 49,000 Harris County residents out of a culturally and ethnically diverse population of over 4.1 million. Of those individuals who received any agency service in FY12, 36.5% were medically indigent and 51.9% had Medicaid. Of those who received mental health services in FY12, such as those being proposed in this project, 55% were medically indigent and 34.9% had Medicaid.

Intervention(s): MHMRA will place one new treatment team which can serve about 500 consumers on an outpatient basis in the Northwest region of the city.

Need for the project: Estimates place approximately 78,000 adults with severe mental illness unable to access treatment from the public or private mental health systems in Harris County. The gap between service needs of seriously mentally ill adults in the county and available public service capacity is most evident in the current waiting list of 1,695 for ongoing outpatient service. MHMRA of Harris County routinely operates at or above its state mandated, contracted service capacity, averaging about 8,800 adult consumers served each month. At this level, however, access is inadequate for many who apply for service.

Target population: Seriously mentally ill adults in the Northwest region of Harris County currently unable to access mental health services. It is anticipated the program will provide service for about 500 patients.

Category 1 or 2 expected patient benefits:

- Increase utilization of services to 500 patients more than baseline by DY 5
- A 10% decrease from baseline in PES/HCPC admissions by DY5

Category 3 outcomes: MHMRA expects to increase one domain of patient satisfaction (TBD) by 10% from baseline by DY5.

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1.12 Enhance service availability of appropriate level of behavioral health care: Expansion of outpatient behavioral health services for adults with severe psychiatric conditions (Northwest)

RHP Project Number: 113180703.1.1
Performing Provider/TPI: Mental Health and Mental Retardation Authority of Harris County/ 113180703

Project Description:
The Mental Health and Mental Retardation Authority (MHMRA) of Harris County proposes to increase outpatient capacity to potentially eliminate the current wait list for services in this geographic area.

The Mental Health and Mental Retardation Authority (MHMRA) of Harris County is a public agency serving as the safety net provider for adults with serious mental illnesses, for children and adolescents with serious emotional disorders, for the developmentally delayed and for individuals experiencing acute psychiatric distress. MHMRA serves more than 49,000 Harris County residents out of a culturally and ethnically diverse population of over 4.1 million. Of those who received mental health services in FY12, such as those being proposed in this project, 55% were medically indigent and 34.9% had Medicaid. In an effort to provide needed services to the most critically ill population, MHMRA proposes to increase outpatient capacity by approximately 500 individuals potentially eliminating the current wait list for services in this geographic area. In order to address this issue we will choose to focus on project option 1.12.2: Expand the number of community based settings where behavioral health services may be delivered in underserved areas.

It is important to note that we are proposing four similar projects, each under the 1.12.2 umbrella, which would expand outpatient behavioral health services for adults in each of our existing clinics. Because the goals and rationale are identical, the narratives will be repetitive; however, each of the expansion programs serve unique geographical needs, and therefore, each of the projects are critical to addressing the community needs.

Goals and Relationship to Regional Goals:
Goals include improving access to community mental health services by establishing additional service providers (e.g., an additional treatment team) among existing MHMRA community clinics in Harris County. Specifically, we aspire to place one new treatment team in the Northwest region. Each treatment team can serve roughly 500 consumers.
The proposed project directly meets broad goals identified by the regional needs assessment. First, it improves and builds upon an existing program, which has shown positive gains in providing best-practices for patient-centered care. Furthermore, by providing enhanced, evidence-based services to patients the program will meet the regional goal set out above. Moreover, the program supports the regional goal of developing a culture of patient-centered care whereby the patient/consumer plays a more active role as a stakeholder.

Challenges:

Workforce limitations may provide staff recruitment challenges requiring significant lead time and advanced planning. Clinic managers will work closely with human resources and administration to ensure timely staffing of the proposed treatment teams.

Expected 5-year Outcomes:

1) Staffing of the new team: 1 Psychiatrist, 1 Nurse, 1 Clinical Team Leader, 4 Licensed Practitioners of the Healing Arts, 12 Rehabilitation Clinicians, 1 Administrative Assistant, 1 Clerical Support Staff, 1 Business Office Coordinator, and 1 HIT Staff.
2) Additional need is anticipated as initiatives to reduce 30-day re-hospitalizations, preventable emergency department visits, and jail recidivism, may create additional demand.
3) Provision of outpatient mental health service has been locally documented to reduce emergency psychiatric center visits by .37 visits per person per year; it has also has been shown to reduce public psychiatric hospital use by 1.66 bed days per person per year in a sample of 25,000 outpatients (served between the years 2005 and 2012).
4) Elimination of wait lists and improved geographic access can be expected to increase access to services, improved satisfaction, and decreased intensive service use. Reductions in intensive service (#3 and #4 above) use are firmly in line with regional project goals.

In order to measure the progress towards the stated goals, we have selected improvement metrics that measure increased utilization of behavioral health (I-11.1) and decreased emergency psychiatric service use (I-X).

Starting Point/Baseline:

As mentioned previously, 8,800 consumers are served among the four existing outpatient clinics. We seek to expand the provision of services by 1 team per current location, which would serve roughly 500 people per site, and add one additional team where the most need is determined. Current clinical space will be used in addition to redesigning available MHMRA space or seeking additional space as needed to house additional staff over the DSRIP period.

Rationale:

The community mental health system in Harris County has a limited capacity for service that is insufficient to the needs of its residents. The Mental Health Needs Council of Harris County has estimated that 153,000 of the 552,000 Harris County adults with mental illness have a severe mental illness (Depression, Bipolar Disorder, and Schizophrenia). These individuals are among the 96,200 Harris County adults who have no public (Medicaid or Medicare) or private health insurance and therefore, are totally dependent on the public mental health service system for treatment. In 2007, approximately 27,000 adults received services from the public mental health system; 18,200 of these were uninsured (a number representing only 19% of estimated need). By deduction, one can conclude that approximately 78,000 adults with severe mental illness failed to access treatment from the public or private mental health systems.

The gap between service needs of seriously mentally ill adults in the county and available public service capacity is most evident in the waiting list for ongoing outpatient service. MHMRA of Harris County routinely operates at or above its state mandated, contracted service

capacity, averaging about 8,800 adult consumers served each month. At this level, however, access is inadequate for many who apply for service.

On August 31 (2012), the MHMRA waitlist for adult mental health outpatient services rested at 1,695, a level that has persisted for several years. Further, tenure on the waiting list approached five months, an average of 149.16 days. The Northwest Clinic has the second highest proportion of patients in need, comprising 28.8% of consumers waiting for services.

The rationale for requesting funding for each project is based on the aforementioned need for additional mental health services in the county, and the existing waitlist. If MHMRA were to expand only one or two of the clinics, only 400-800 new consumers could be served and the waitlist would remain in effect. Additionally, it is expected that the need for mental health services will continue to grow, and therefore, limited expansion will simply not address the current needs of those on the waitlist or the community needs of those who initiated services with MHMRA.

Unique Community Need Identification numbers:

Specific community needs are also addressed through the proposed program:

- CN3-Inadequate access to Behavioral Health
- CN6- Inadequate access to treatment and services designed for special needs populations, including disabled, homeless, children and elderly
- CN9- High rates of preventable hospital readmissions

Expansion of outpatient behavioral health services will address the community needs above by providing greater access to behavioral health care, thereby offsetting the increased use of medical and psychiatric emergency services. Furthermore, a larger behavioral health workforce within MHMRA will provide more opportunities for collaboration between providers and for patient education. MHMRA clinicians already engage in a variety of community collaborations and education activities, despite their tremendous workload. With the addition of qualified behavioral health personnel, more services can be provided.

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

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

Reasons/rationale for selecting the outcome measures:

We believe patient satisfaction that addresses involvement in shared decision making, access to providers, and better communication with providers, will reduce chronic over-use of psychiatric emergency services and in general reduce cost and improve efficiency.

Relationship to other Projects:

The proposed project is similar to several MHMRA DSRIP proposals, including the expansion of outpatient behavioral health services within other clinics (113180703.1.4, 113180703.1.5, 113180703.1.6 and 113180703.1.7) and a project which enhances the intensity of behavioral outpatient services (113180703.1.2). Extending outpatient behavioral health specialty service and increasing the intensity of these services will together ultimately provide responsive, appropriate levels of care.

The behavioral health crisis in Region 3 is considerable and the proposed initiatives in our RHP plan will only imply a small impression into the overall community need for treatment, but is a good start. The outpatient focus of many RHP Plan initiatives will help numerous facilities focus to treating the patients in an ambulatory setting as well as continued navigation of services with a focus to keeping patients from the inpatient unit. This initiative is similar to many others in the

sense of the category of behavioral health. The Region 3 Initiative Grid attached in the addendum will show the relationship to other programs.

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

Plan for Learning Collaborative:

Consumer satisfaction with access outcomes will be assessed with input from consumer groups involving both patients and family members in the quality improvement loop. Similarly, rates of public psychiatric hospitalization will be presented to public psychiatric hospital representatives with an invitation for them to provide input on the improvement process.

Project Valuation:

In the effort to value the proposed project accurately, assistance was sought from H. Shelton Brown, Ph.D. of the UT Houston School of Public Health and Thomas Bohman, Ph.D. of the UT Austin Center for Social Work Research. Their consultation was limited to only the valuation section of this document. 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: The Texas Recommended Assessment Guidelines (Texas Department of State Health Services, 2011) established a utilization management scheme for matching patient need to service packages of varying intensities. To provide an approximation of the value of an outpatient behavioral health program, we will review studies related to each of the four service packages described below as "levels of care."

Level One: Medication only

Individuals receiving Service Package One (SP1) have been assessed to have relatively less severe symptomatology and functional impairment. Therefore, they receive medications only accompanied by service coordination. A study by Chouinard and Albright (1997) found that individuals receiving medications versus a placebo gained 7 times the quality-adjusted years than without medications (QALY = .125). The proportion of individuals recommended to Level One at MHMRA is 56.5%. Assuming the program would serve 100 persons in a year, the following formula shows the total valuation:

100	(persons served)
0.125	(QALY gained)
.565	(proportion of patients recommended to Level One)
× $50,000	(life year value)
= $353,125	Level 1 QALY Value

Level Two: Medication plus therapy

About 18.5% of patients at MHMRA are recommended to Level Two services based on moderately severe need accompanied by diagnoses of major depression. This service package includes cognitive psychotherapy for depressive disorders in addition to medications. Pyne et al. (2003) compared the cost-effectiveness of medication services to medication plus CBT for depression. Their randomized controlled trial yielded an incremental QALY of 0.041 for the addition of CBT. Assuming the program would serve 100 persons in a year, the following formula shows the total valuation:

100	(persons served)
0.041	(QALY gained)
.185	(proportion of patients recommended to Level 2)
× $50,000	(life year value)
= $37,925	Level 2 QALY Valuation

Level Three: Medications and skills training

About 24% of patients at MHMRA are recommended to Level Three services, based on higher severity symptom and functional skill impairment. This package includes medications and skills training. Barton and colleagues (2009) compared social recovery oriented cognitive behavioral therapy (SRCBT) for people diagnosed with psychosis compared to case management alone (CMA); they reported a mean incremental QALY gain of 0.035. Assuming the program would serve 100 persons in a year; the following formula shows the valuation:

100	(persons served)
0.035	(QALY gained)
0.24	(proportion of patients recommended to Level 3)
× $50,000	(life year value)
= $42,000	Level 3 QALY Value

Level Four: Assertive Community Treatment (ACT) for Persons with Serious Mental Illness

Of consumers referred for services, about 4.1% are recommended for ACT Team treatment. This level of care represents the highest intensity service intervention. A 2012 study reported the cost-effectiveness of assertive community treatment as part of integrated care versus standard care in patients with schizophrenia (Karow, Reimer, König, Heider, Bock & Huber 2012). Results indicated the ACT intervention yielded a QALY of 0.76, whereas the treatment as usual groups resulted in a QALY of 0.66. Since the treatment is being contrasted with wait list or not treatment, the full QALY (0.76) applies. The incremental QALY for the ACT group was 0.10. Assuming the program would serve 100 persons in a year the following formula shows the valuation:

100	(persons served)
0.76	(QALY gained)
0.041	Proportion of patients recommended to Level Four
× $50,000	(life year value)
= $155,800	Level 4 QALY Value

Hospitalizations
When compared to the year prior to outpatient treatment admission, MHMRA patients have averaged 1.66 fewer public psychiatric hospital bed days per person. Cost savings from these individuals from averting hospital services can be calculated as follows:

100	(persons served)
1.66	(average hospital bed days per person per year averted)
X$700	(cost of hospital day)
= $116,200	Costs saved from averted hospitalizations

Public Psychiatric Emergency Visits
When compared to the year prior to outpatient treatment admission, MHMRA patients have averaged 0.212 fewer public psychiatric emergency room visits per person. Cost savings from these individuals from averting these emergency services can be calculated as follows:

100	(persons served)
.212	(average emergency service visits per person per year averted)
X$705	(cost of hospital day)
= $14,946	Costs saved from averted hospitalizations

Mental Health Services in the County Jail
When compared to the year prior to outpatient treatment admission, MHMRA patients have averaged 0.05 fewer county jail incarcerations per person. Cost savings from averting these jail bookings can be calculated as follows:

100	(persons served)
.05	(average county jail incarcerations per person per year averted)
40.6	Average days incarcerated
X$130	(cost of jail day with mental health service)
= $26,390	Costs saved from averted hospitalizations

Valuation Summary: This valuation analysis shows that the intervention will have a positive value for participants who receive the intervention(s). Summing the estimated utilities of all four levels of care above, the expected value of this proposal is $746,386 per 100 people served per year.

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Unique Identifier: 113180703.1.1	RHP PP Reference Number: 1.12.2	Project Components: NA	Program Title: EXPANSION OF OUTPATIENT BEHAVIORAL HEALTH SERVICES FOR ADULTS WITH SEVERE PSYCHIATRIC CONDITIONS - NW
RHP Performing Provider: Mental Health and Mental Retardation Authority of Harris County			**TPI: 113180703**
Related Category 3 Measure(s): Patient Satisfaction		**IT-6.1**	**Percent improvement over baseline of patient satisfaction scores**
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1: P-2. Identify licenses, equipment requirements and other components needed to implement and operate options selected. **Metric 1: P-2.5.1** Develop a project plan and timeline detailing operational needs and equipment and components **Data Source:** Written Project Plan	**Milestone 3: P-6:** Establish behavioral health services in new community-based settings in underserved areas **Metric 1: P-6.1** Number of new community-based settings where behavioral health services are delivered **Data Source**: Project documentation and MHMRA records **Goals:** Provide documentation of patients being served by new treatment team	**Milestone 6: I-11:** Increased utilization of community behavioral healthcare **Metric 1: I-11.1** Percent utilization of community behavioral healthcare services. **Data Source**: MHMRA records **Goal:** Serve 250 patients more than baseline	**Milestone 8: I-11:** Increased utilization of community behavioral healthcare **Metric 1: I-11.1** Percent utilization of community behavioral healthcare services. **Data Source**: MHMRA records **Goal:** Serve 500 patients more than baseline
Estimated Incentive Payment: $1,493,333.075	**Estimated Incentive Payment: $1,094,430.09**	**Estimated Incentive Payment: $1,754,273.38**	**Estimated Incentive Payment: $1,694,950.12**

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Unique Identifier: 113180703.1.1	RHP PP Reference Number: 1.12.2	Project Components: NA	Program Title: EXPANSION OF OUTPATIENT BEHAVIORAL HEALTH SERVICES FOR ADULTS WITH SEVERE PSYCHIATRIC CONDITIONS - NW
RHP Performing Provider: Mental Health and Mental Retardation Authority of Harris County			**TPI: 113180703**
Related Category 3 Measure(s): Patient Satisfaction		**IT-6.1**	**Percent improvement over baseline of patient satisfaction scores**
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 2: P-4: Hire and train staff to operate and manage project **Metric 1: P-4.1**: Number of staff secured and trained **Data Source:** HR records **Goal:** hire staff for one additional treatment team	**Milestone 4:** I-11 Increased utilization of community behavioral healthcare **Metric 1:** I-11.1 Percent utilization of community behavioral healthcare services. **Data Source:** MHMRA records **Goal:** establish baseline	**Milestone 7:** I-X. Psychiatric Emergency Service (PES) Admissions and Inpatient Psych. Admissions **Metric 1:** I-X.1. Percent of individuals who were admitted to inpatient facilities. **Data Source:** MHMRA and HCPC records **Goal:** A 5% decrease from baseline in PES/HCPC admissions	**Milestone 9:** I-X. Psychiatric Emergency Service (PES) Admissions and Inpatient Psych. Admissions **Metric 1:** I-X.1. Percent of individuals who were admitted to inpatient facilities. **Data Source:** MHMRA and HCPC records **Goal:** A 10% decrease from baseline in PES/HCPC admissions
Estimated Incentive Payment: $1,493,333.075	**Estimated Incentive Payment: $1,094,430.09**	**Estimated Incentive Payment: $1,754,273.38**	**Estimated Incentive Payment: $1,694,950.12**

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Unique Identifier: 113180703.1.1	RHP PP Reference Number: 1.12.2	Project Components: NA	Program Title: EXPANSION OF OUTPATIENT BEHAVIORAL HEALTH SERVICES FOR ADULTS WITH SEVERE PSYCHIATRIC CONDITIONS - NW
RHP Performing Provider: Mental Health and Mental Retardation Authority of Harris County			**TPI: 113180703**
Related Category 3 Measure(s): Patient Satisfaction		**IT-6.1**	**Percent improvement over baseline of patient satisfaction scores**
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	Milestone 5: I-X. Psychiatric Emergency Service (PES) Admissions and Inpatient Psych. Admissions **Metric 1**: I-X.1. Percent of individuals who were admitted to inpatient facilities. **Data Source**: Psychiatric Emergency Services (PES) records are part of the MHMRA electronic record. Harris County Psychiatric Center (HCPC) is the local public psychiatric inpatient unit which maintains separate records **Goal:** Establish baseline		
	Estimated Incentive Payment: $1,094,430.09		
Year 2 Estimated Milestone Bundle Amount: $2,986,666.15	**Year 3 Estimated Milestone Bundle Amount: $3,283,290.27**	**Year 4 Estimated Milestone Bundle Amount: $3,508,546.76**	**Year 5 Estimated Milestone Bundle Amount: $3,389,900.24**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $13,168,403.42			

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Project Option 1.12 ENHANCE SERVICE AVAILABILITY OF APPROPRIATE LEVELS OF BEHAVIORAL HEALTH CARE: ENHANCING THE INTENSITY OF OUTPATIENT BEHAVIORAL HEALTH SERVICES FOR ADULTS WITH SEVERE PSYCHIATRIC CONDITIONS

Unique RHP Project ID: 113180703.1.2

Performing Provider Name/TPI: MHMRA of Harris County / 113180703

Project Summary:
Provider**:** The Mental Health and Mental Retardation Authority (MHMRA) of Harris County is a public agency serving as the safety net provider for adults with serious mental illnesses, for children and adolescents with serious emotional disorders, for the developmentally delayed and for individuals experiencing acute psychiatric distress. MHMRA provides inpatient, residential and outpatient treatments, including psycho-therapy, case management and medication management for individuals. MHMRA serves more than 49,000 Harris County residents out of a culturally and ethnically diverse population of over 4.1 million. Of those individuals who received any agency service in FY12, 36.5% were medically indigent and 51.9% had Medicaid. Of those who received mental health services in FY12, such as those being proposed in this project, 55% were medically indigent and 34.9% had Medicaid.

Intervention(s): The program will increase the number of available providers and treatment teams to address each of the under-resourced levels of care designated by the TRAG.

Need for the project: Currently, many individuals who are recommended for higher levels of service intensity (levels two, three, and four) are served at lower levels due to lack of resources. MHMRA is not sufficiently funded to serve its customers at the assessed levels of need. This project would aim to raise the level of care for these underserved individuals to the recommended appropriate levels indicated by the TRAG algorithm.

Target population: Currently there are 1,532 individuals who are underserved due to resource limitations. The overall project goal is to provide appropriate, recommended levels of behavioral health care to all MHMRA of Harris County patients who wish to receive this optimal level of care. In numerical terms, the project will reduce the number of patients who are underserved due to resource limitations from about 17% to 0% over the course of the proposed program expansion.

Category 1 or 2 expected patient benefits: By DY 5 MHMRA expects to:

- increase utilization up to 10% over baseline
- reduce canceled appointments or no shows by 10% from baseline.

Category 3 outcomes: MHMRA expects to increase one domain of patient satisfaction (TBD) by 10% from baseline by DY5.

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1.12 Enhance service availability of appropriate levels of behavioral health care: Enhancing the intensity of outpatient behavioral health services for adults with severe psychiatric conditions

<u>RHP Project Number:</u> 113180703.1.2
<u>Performing Provider/TPI:</u> Mental Health and Mental Retardation Authority of Harris County/ 113180703

Project Description:
The Mental Health and Mental Retardation Authority (MHMRA) of Harris County will enhance the intensity of outpatient behavioral health services for adults with severe psychiatric conditions by increasing the number of available providers and treatment teams to address each of the under-resourced levels of care.

The MHMRA of Harris County is a community mental health treatment organization in Houston, Texas. As the local mental health authority, the agency serves primarily indigent patients. Public mental health services for adults in Texas are provided within the structure of a state-wide utilization management scheme. This scheme is intended to provide the right type of service to the right person in the right amount. A pre-designed set of service packages, referred to as "levels of care", is matched to the consumer's rated level of functional and symptom severity. Using the assessment algorithm the Texas Recommended Assessment Guidelines (Department of State Health Services, 2011) MHMRA consumers are designated as falling into one of four levels of service. Due to resource limitations, MHMRA of Harris County currently under serves a number of its adult consumers, providing fewer services than recommended by the state guidelines.
In order to address the gap between recommended services and available resources we will choose a project option 1.12.4 "Other": Implement other evidence-based project to enhance service availability of appropriate levels of behavioral health care in an innovative manner not described in the project options above. Specifically, the program will increase the number of available providers and treatment teams to address each of the under-resourced levels of care designated by the TRAG.

Goals and Relationship to Regional Goals:
The overall project goal is to provide appropriate, recommended levels of behavioral health care to all MHMRA of Harris County patients who wish to receive this optimal level of care. In numerical terms, the project will reduce the number of patients who are underserved due to resource limitations from about 17% to 0% over the course of the proposed program expansion. The proposed project directly meets broad goals identified by the regional needs assessment. First, it improves and builds upon an existing program that has shown positive gains in providing best-practices for patient-centered care. Furthermore, by providing enhanced evidence-based services to patients, the program will meet the regional goal of improving responsiveness to the needs of the patient and increasing access to specialty behavioral health care. Moreover, the program supports the regional goal of developing a culture of patient-centered care whereby the patient/consumer plays a more active role as a stakeholder.

Challenges:
Workforce limitations may provide staff recruitment challenges which we will address by allowing significant lead time and advance planning.

5-Year Expected Outcome:
The 5 year outcomes of the proposed program include:
1) Reduction in intensive service use by individuals not receiving adequate care at a lower level
2) Increased functional improvement and satisfaction with services reported by patients
3) Increased access to specialty care for the underserved of Houston

Starting Point/Baseline:
Currently there are 1,532 individuals who are underserved due to resource limitations. Current clinical space will be used in addition to redesigning available MHMRA space or seeking additional space as needed to house additional staff over the DSRIP period.

Rationale:
Currently, many individuals who are recommended for higher levels of service intensity (levels two, three, and four) are served at lower levels due to lack of resources. MHMRA is not sufficiently funded to serve its customers at the assessed levels of need. This project would aim to raise the level of care for these underserved individuals to the recommended appropriate levels indicated by the TRAG algorithm. The five–year goals of this service enhancement would include reducing public emergency psychiatric center visits, reducing public psychiatric hospital admissions, reducing 30-day re-admissions, and reducing costs as reflected in in-patient bed days. These enhancements would be implemented at the four adult mental health outpatient clinics, each located within a geographic quadrant of Harris County.

Schnapp, Burruss, Hickey, Mortensen and Raffoul (2011) have demonstrated that under serving clients have negative consequences. In a study of over 5,300 MHMRA outpatients served in 2010 and 2011, those served at recommended levels averaged 0.68 fewer public emergency psychiatric center visits per person per year than their underserved counterparts; these customers were underserved due to resource limitations. This is an avoidable cost of $476 per year for each underserved patient.

A more recent analysis of 7,250 adult mental health outpatients, 27% of whom were underserved due to resource limitations, indicated a similar effect on public psychiatric hospitalizations. Those served at recommended appropriate levels logged 0.57 fewer public psychiatric hospital admissions per person per year, and averaged a reduction of more than seven hospital bed days per person per year. At $700 per bed day, savings amounted to $4,900 per person per year.

An estimate of need is based on a count of currently underserved individuals. At present, 1,532 adult mental health outpatients are underserved: 295 are recommended to Level Two, 1,132 recommended to Level Three, and 105 are recommended to Level Four. We propose to serve these individuals at recommended levels with the addition of 41 new staff FTE's (30 Rehab Techs, 8 Therapists and 3 Clinical Team Leaders).

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Milestones and Metrics:
In order to measure the progress towards the stated goals, we have chosen to focus on I-11 (I-11.1) increased utilization of community behavioral health care and I-13 (I-13.1) adherence to scheduled appointments - percent decrease in the number of canceled or no-show appointments as our improvement targets. If these metrics are met then it is a good indication that behavioral health services are being utilized by those in need.

Unique community need identification number the project addresses:
Specific community needs are also addressed through the proposed program:

- CN3-Inadequate access to Behavioral Health
- CN6- Inadequate access to treatment and services designed for special needs populations, including disabled, homeless, children and elderly
- CN9- High rates of preventable hospital readmissions

Related Category 3 Outcome Measure(s):
IT-6.1 Percent improvement over baseline of patient satisfaction scores
Expansion of outpatient behavioral health services will address the community needs above by providing greater access to behavioral health care, thereby offsetting the increased use of ER services. Furthermore, a larger behavioral health workforce within MHMRA will provide more opportunities for collaboration between providers and for patient education which will also be demonstrated by increased patient satisfaction. MHMRA clinicians already engage in a variety of community collaborations and education activities, despite their tremendous workload. With the addition of qualified behavioral health personnel, more services can be provided which will result in greater patient satisfaction.

Relationship to other Projects:
This project will interface with the expansion of the collaborative primary medical and behavioral health care and with integrating substance abuse treatment services into mental health services by referring individuals into the appropriate ongoing care alternative. The enhancement of services will also be augmented by the proposed expansion of behavioral health outpatient services intended to eliminate MHMRA's front-door wait list.

The behavioral health crisis in Region 3 is considerable and the proposed initiatives in our RHP plan will only imply a small impression into the overall community need for treatment, but is a good start. The outpatient focus of many RHP Plan initiatives will help numerous facilities focus to treating the patients in an ambulatory setting as well as continued navigation of services with a focus to keeping patients from the inpatient unit. This initiative is similar to many others in the sense of the category of behavioral health. The Region 3 Initiative Grid attached in the addendum will show the relationship to other programs.

Plan for Learning Collaborative:
We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and

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testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system.

Project Valuation:

In the effort to value the proposed project accurately, assistance was sought from H. Shelton Brown, Ph.D. of the UT Houston School of Public Health and Thomas Bohman, Ph.D. of the UT Austin Center for Social Work Research. Their consultation was limited to only the valuation section of this document. 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: Public mental health services for adults in Texas are provided within the structure of a state-wide utilization management scheme. This scheme is intended to provide the right type of service to the right person for the right amount. A pre-designed set of service packages, referred to as "levels of care," is matched to the consumer's rated level of functional and symptom severity. All MHMRA consumers are designated as falling into one of four levels of service. Due to resource limitations, MHMRA of Harris County currently underserves a number of its adult consumers, providing fewer services than recommended. Currently, individuals who are recommended for Levels Two, Three, and Four are underserved due to lack of resources. MHMRA is not funded at la level sufficient to the assessed needs of its customers. We will address consumers in these service levels one-by-one:

Level Two: Cognitive Behavior Therapy and Medication for Major Depression

At present, 295 MHMRA consumers with major depression are underserved due to resource limitations, receiving only medication and service coordination when cognitive behavior therapy (CBT) is a recommended service.

Schoenbaum et al. (2001) compared the cost-effectiveness of medication services to medication plus CBT for depression. Their randomized controlled trial yielded an incremental QALY of 0.0226 for the addition of CBT. Applying this estimate to the current population the value of enhancing services for these underserved individuals from Level Two can be calculated as follows:

295 (persons served)
0.0226 (QALY gained)
× $50,000 (life year value)
= $333,350 Level 2 QALY Value

Level Three: Skills Training with Optional Best Practice Services for Persons with Moderately Severe Schizophrenic and Manic Depressive Disorders

There are currently 1,132 MHMRA consumers receiving medication and service coordination services *without* recommended skills training services due to agency resource limitations. Barton and colleagues (2009) compared social recovery oriented cognitive behavioral therapy for people diagnosed with psychosis compared to case management alone (CMA). They reported a mean incremental QALY gain of 0.035. Applying this estimate to the current population the value of enhancing services for these underserved individuals from Level Three can be calculated as follows:

1,132 (persons served)
0.035 (QALY gained)
× $50,000 (life year value)
= $1,981,000 Level 3 QALY Value

Levels Two and Three Hospital Costs Averted

Local data indicate that "underserved" individuals require higher levels of public psychiatric hospital care. In a sample of 6,275 consumers studied over seven years, underserved consumers logged 0.819 additional hospital bed days per year. The increment in costs that could be averted with these interventions can be calculated as:

1,427 (persons served)
0.819 (psychiatric bed days gained)
× $700 (local bed day value)
= $818,099 Cost Savings- hospitalizations averted

Level Four: Assertive Community Treatment (ACT) for Persons with Serious Mental Illness

Of the MHMRA consumers who have been recommended for ACT Team treatment, 105 are currently served at lower levels of service intensity.

1) QALYs

A 2012 reported the cost-effectiveness of assertive community treatment as part of integrated care versus standard care in patients with schizophrenia (Karow, Reimer, König, Heider, Bock & Huber ...2012). Results indicated the ACT intervention yielded a QALY of 0.76, whereas the treatment as usual groups resulted in a QALY of 0.66. The incremental QALY for the ACT group was 0.10. Applying this estimate to the current population the value of enhancing services for these underserved individuals from Level Four can be calculated as follows:

105	(persons served)
0.10	(QALY gained)

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× $50,000	(life year value)
= $525,000	Level 4 QALY Value

2) 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. We identified several relevant cost-effectiveness studies. Essock and colleagues (1998) found that societal costs for participants who joined the study when they were out of the hospital were $29,013 (2012 US dollars) per year compared to the comparison group ($24,581; Essock and colleagues reported costs over 18 months; they are pro-rated to 12 here.) However, for participants who joined the study while in the hospital, ACT participants had lower costs of $57,743 compared with standard treatment participants ($84,959). The net gain assuming equal patients of each type would be $27,216.

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 $12,291 (2012 US dollars) per client per year in 1999/2000, while the direct cost for an inpatient day in the adult psychiatry ward was $296. 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 (days) × $296 = $13,852. The net difference between ACT and treatment as usual was $1,562. 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.

Lehman (1999) examined the cost-effectiveness of ACT versus standard care and found that the overall average cost per ACT client was $24,385 (2012 US dollars) less than the cost per client per year for treatment as usual ($78,659 cost per ACT client versus $103,044 cost per client for treatment as usual).

The average gain across all studies was $17,721. If we were to value the program based on cost saving the total valuation would be:

105	(persons served)
× $17,721	(cost savings)
= $1,860,705	Level 4 Cost Savings

Total Value

Combining the estimates for each of the three service packages and for averted hospital costs, one arrives at a total as follows:

$333,350	Level 2 QALY Value
$1,981,000	Level 3 QALY Value
$818,099	Levels 2 & 3 Cost Savings
$525,000	Level 4 QALY
+ $1,860,705	Level 4 Cost Savings
$5,518,154	**Total Estimated Value**

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Unique Identifier: 113180703.1.2	RHP PP Reference Number: 1.12.4	Project Components: N/A	Program Title: ENHANCING THE INTENSITY OF OUTPATIENT BEHAVIORAL HEALTH SERVICES FOR ADULTS WITH SEVERE PSYCHIATRIC CONDITIONS
RHP Performing Provider: Mental Health and Mental Retardation Authority of Harris County			**TPI: 113180703**
Related Category 3 Measure(s): Patient satisfaction		**IT-6.1**	**Percent improvement over baseline of patient satisfaction scores**
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1: P-2: Identify licenses, equipment requirements and other components needed to implement and operate options selected **Metric 1: P-2.1** Develop a project plan and timeline detailing the operational needs, training , equipment and components **Data Source:** Project Plan	**Milestone 4: P-4:** Hire and train staff to operate and manage first treatment team **Metric 1: P-4.1** Number of staff secured and trained **Data Source:** HR records **Goal:** hire staff for one additional treatment team	**Milestone 7**: **P-4:** Hire and train staff to operate and manage first treatment team **Metric 1: P-4.1** Number of staff secured and trained Data Source: HR records **Goal**: hire staff for one additional treatment team	**Milestone 10: P-4:** Hire and train staff to operate and manage first treatment team **Metric 1: P-4.1** Number of staff secured and trained Data Source: HR records **Goal:** hire staff for one additional treatment team
Estimated Incentive Payment: $1,472,060.81	**Estimated Incentive Payment: $1,618,260.20**	**Estimated Incentive Payment: $1,729,284.07**	**Estimated Incentive Payment: $1,670,805.86**

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Unique Identifier: 113180703.1.2	RHP PP Reference Number: 1.12.4	Project Components: N/A	Program Title: ENHANCING THE INTENSITY OF OUTPATIENT BEHAVIORAL HEALTH SERVICES FOR ADULTS WITH SEVERE PSYCHIATRIC CONDITIONS
RHP Performing Provider: Mental Health and Mental Retardation Authority of Harris County			TPI: 113180703
Related Category 3 Measure(s): Patient satisfaction		IT-6.1	Percent improvement over baseline of patient satisfaction scores

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 2: P-6: Establish behavioral health services in new community-based settings in underserved areas **Metric 1: P-6.1** Number of new community-based settings where behavioral health services are delivered **Data Source:** Project Plan, licenses and permits **Goals:** Establish behavioral health service in the Northeast quadrant of Harris County	**Milestone 5: P-9**: Review project data and respond to it every week with tests of new ideas, practices, tools, or solutions **Metric 1: P-9.1** Number of new ideas, practices, tools, or solutions tested by each provider. **Data Source:** Brief description of the idea, practice, tool, or solution tested by each provider each week, weekly management meeting notes **Goal:** continuously identify areas of improvement	**Milestone 8: I-11:** Increased utilization of community behavioral healthcare **Metric 1: I-11.1** Percent utilization of community behavioral healthcare services.a. Number receiving services from mobile clinics after access expansion by the total number receiving servicesc. **Data source:** Claims data and encounter data from community behavioral health sites and expanded transportation programs. **Goal:** Increase 5% over baseline for those receiving services	**Milestone 11: I-11.** Increased utilization of community behavioral healthcare **Metric 1: I-11.1** Percent utilization of community behavioral healthcare services.a. Number receiving services from mobile clinics after access expansion by the total number receiving servicesc. **Data source:** Claims data and encounter data from community behavioral health sites and expanded transportation programs. **Goal:** Increase 10% over baseline for those receiving services
Estimated Incentive Payment: $1,472,060.81	**Estimated Incentive Payment: $1,618,260.20**	**Estimated Incentive Payment: $1,729,284.07**	**Estimated Incentive Payment: $1,670,805.86**

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Unique Identifier: 113180703.1.2	**RHP PP Reference Number: 1.12.4**	**Project Components: N/A**	**Program Title: ENHANCING THE INTENSITY OF OUTPATIENT BEHAVIORAL HEALTH SERVICES FOR ADULTS WITH SEVERE PSYCHIATRIC CONDITIONS**
RHP Performing Provider: Mental Health and Mental Retardation Authority of Harris County			**TPI: 113180703**
Related Category 3 Measure(s): Patient satisfaction		**IT-6.1**	**Percent improvement over baseline of patient satisfaction scores**

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 3: P-4:Hire and train staff to operate and manage first treatment team **Metric 1: P-4.1:** Number of staff secured and trained Data Source: HR records **Goal:** hire staff for one additional treatment team	**Milestone 6: I-11:** Increased utilization of community behavioral healthcare **Metric 1: I-11.1:** Percent utilization of community behavioral healthcare services.a. Number receiving services from mobile clinics after access expansion by the total number receiving services **Data source**: MHMRA claims data and encounter data **Goal:** Measure baseline for those receiving services	**Milestone 9: I-13:** Adherence to scheduled appointments **Metric 1: I-13.1** Percent decrease in the number of canceled or no-show appointments. **Data Source**: Clinical records **Goal**: measure baseline	**Milestone 12: I-13**: Adherence to scheduled appointments **Metric 1: I-13.1** Percent decrease in the number of canceled or no-show appointments. **Data Source:** Clinical records **Goal**: decrease no-shows by 5% from baseline
Estimated Incentive Payment: $1,472,060.82	**Estimated Incentive Payment: $1,618,260.20**	**Estimated Incentive Payment: $1,729,284.08**	**Estimated Incentive Payment: $1,670,805.87**
Year 2 Est. Bundle Amount: $4,416,182.44	**Year 3 Est. Bundle Amount: $4,854,780.60**	**Year 4 Est. Bundle Amount: $5,187,852.22**	**Year 5 Est. Bundle Amount: $5,012,417.59**
TOTAL EST. INCENTIVE PAYMENTS FOR 4-DY: $19,471,232.85			

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Project Option 1.9 EXPAND SPECIALTY CARE CAPACITY:
IDD SPECIALIZED TREATMENT AND REHABILITATIVE SERVICES (STARS)

Unique RHP Project ID: 113180703.1.3

Performing Provider Name/TPI: MHMRA of Harris County / 113180703

Provider: The Mental Health and Mental Retardation Authority (MHMRA) of Harris County is public agency serving as the safety net provider for adults with serious mental illnesses, for children and adolescents with serious emotional disorders, for the developmentally delayed and for individuals experiencing acute psychiatric distress. MHMRA provides inpatient, residential and outpatient treatments, including psycho-therapy, case management and medication management for individuals. MHMRA serves about 49,000 Harris County residents out of a culturally and ethnically diverse population of over 4.1 million. Of those individuals who received services in FY12, 60.0% were medically indigent and 32% had Medicaid.

Intervention(s): The primary goal of the project is to expand capacity for the current specialized behavioral health services provided to people with Intellectual and Developmental Disabilities (IDD) and/or Autism Spectrum Disorders (ASD) and co-occurring mental illness by adding additional staff.

Need for the project: Approximately 106,494 Harris County residents are diagnosed with an intellectual and developmental disability; 24,000 with autism spectrum disorder; and of people in these groups, 38,700 are dually diagnosed with co-occurring mental illness. Like the rest of the state, a behavioral health service for these individuals is a specialty that is lacking in Harris County. In response to this service gap, MHMRA developed a specialty outpatient clinic for people with co-occurring disorders; however, the need far exceeds the capacity of the current clinic.

Target population: The target population for this service will be the waiting list of over 900 people for clinic services in addition to any other referrals for individuals with co-morbid mental health and IDD diagnoses. It is anticipated the program will provide service for about 477 patients.

Category 1 or 2 expected patient benefits: Increase specialty care clinic volume to 30% more over baseline by DY5 (I-23.1).

Category 3 outcomes: MHMRA expects to increase one domain of patient satisfaction (TBD) by 10% from baseline by DY5.

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1.9 Expand Specialty Care Capacity: 1.9.2 - IDD Specialized Treatment and Rehabilitation Services (STARS)

RHP Project Number: 113180703.1.3
Performing Provider/TPI: Mental Health and Mental Retardation Authority of Harris County/ 113180703

Project Description:
The Mental Health and Mental Retardation Authority (MHMRA) proposes to improve access to specialty care for children and adults with co-occurring psychiatric/behavioral and Intellectual and Development Disabilities (IDD) by expanding services and staffing.

MHMRA is a community mental health treatment organization in Houston, Texas. As the local mental health authority, the agency serves primarily indigent patients. The proposed project seeks to expand outpatient specialty services for children and adults with complex co-occurring psychiatric/behavioral and Intellectual and Developmental Disabilities (IDD) or Autism Spectrum Disorders (ASD). This project meets the Delivery System Incentive Reform Payment (DSRIP) Pool 1115(a) waiver component 1.9, Enhance service availability to appropriate levels of care— option 1.9.2 Improve access to specialty care.

Goals and Relationship to Regional Goals:
The primary goal of the project is to expand capacity for specialized behavioral health services to people with Intellectual and Developmental Disabilities (IDD) and/or Autism Spectrum Disorders (ASD) and co-occurring mental illness. Additionally, it is hoped patient satisfaction will improve. These goals are consistent with the regional goals and community needs discussed below.
Regional Goals:
The project will increase access to specialty care in Harris County and will transform behavioral healthcare for the target population by providing timely, coordinated clinical care. When the behavioral health needs of people with IDD/ASD and mental illness are not treated until a crisis occurs, resulting interventions focus on episodic, emergent care without adequate coordination of aftercare. The project will provide coordinated care to prevent crises or resolve them with successful transition into stable maintenance. Furthermore, by increasing training capacity for new professionals, this project will develop a skilled workforce to multiply community options and improve access to treatment while improving satisfaction and behavioral health outcomes for the target population.

Challenges:
One of the challenges will be hiring and training the appropriate level of staff to provide increased access and service to the targeted population. The proposed project will develop the workforce of clinicians who are competent to work with the target population and are comfortable doing so. MHMRA will continue to build upon existing partnerships with local universities, medical schools, public and private Medicaid providers and other agencies to develop clinicians who are skilled and willing to treat people with IDD/ASD, thereby growing an ever-expanding pool of competent community providers. The contractual agreements between MHMRA and medical schools and universities are already in place to provide internships and

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practicum opportunities to students and residents in child psychiatry, psychology, nursing, and social work. The results of pre/post surveys of training for child psychiatry residents show that there is a consistent increase in both content knowledge related to IDD and subjective comfort level with evaluation/treatment of persons with co-morbid IDD and psychiatric illness following the training rotation offered by MHMRA's IDD Division. Expansion of the clinic will allow MHMRA to reach a larger pool of clinicians and provide training stipends to encourage greater participation.

5-Year Expected Outcome for Provider and Patients:
MHMRA expects to see an increase in utilization of specialty care services for as many as 550 patients in DY4 to 622 patients by DY5.

Starting Point/Baseline:
The STARS clinic serves approximately 400 people with IDD/ASD and co-occurring mental illness are annually through outpatient clinic services. In an analysis conducted in 2006, the agency noted a 97% reduction in hospitalization rate, which represents a cost savings for the community and provides patient care in less restrictive settings. The clinic is staffed with one Psychiatrist, two Licensed Clinical Psychologists, one LCSW, one LVN, one RN, one Board Certified Behavior Analyst and one LPC/Director. All of these clinicians specialize in co-occurring mental illness and developmental disabilities. Current clinical space will be used in addition to redesigning available MHMRA space or seeking additional space as needed to house additional staff over the DSRIP period.

Rationale:
The existence of co-occurring mental illness in people with IDD/ASD has been widely recognized; however, treatment of psychiatric conditions in this population is still in its infancy, with unremarkable treatment outcomes. Poor treatment outcomes include more frequent psychiatric hospitalizations; longer admissions and later identification in the psychiatric event, resulting in higher levels of care. Furthermore, studies examining the treatment of co-occurring disorders report that mental health clinicians, including psychiatrists, psychologists, social workers, nurses and other disciplines, are rarely formally trained to treat people with IDD/ASD and MI. Lack of exposure to people with developmental disabilities causes clinicians to shy away from these patients; and when they do become involved, they intervene later in the course of the disease process and tend to use medication for sedating purposes and not in accordance with the person's mental illness.

Texas has documented similar concerns. In May 2011, the directors of IDD programs in MHMRs across Texas were queried about the resources in their areas for responding to behavioral crises. Across the state they reported a lack of skilled clinicians and also noted psychiatric hospitals often refused inpatient services to individuals with co-morbid IDD and psychiatric illness in crisis because they lacked expertise in the population. Conversely, when admitted, they had extended inpatient stays with little improvement in behavioral functioning. With no other alternative in Texas, communities turn to institutional care in State Supported Living Centers (formerly called State Schools) to manage and treat these individuals. This is an expensive choice. The current annual cost for a person with IDD in a state supported living center is $177,624.

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Harris County also has documented similar needs. Approximately 106,494 Harris County residents are diagnosed with an intellectual and developmental disability; 24,000 with autism spectrum disorder; and of people in these groups, 38,700 are dually diagnosed with co-occurring mental illness. Like the rest of the state, a behavioral health service for these individuals is a specialty that is lacking in Harris County. In response to this service gap, MHMRA developed a specialty outpatient clinic for people with co-occurring disorders; however, the need far exceeds the capacity of the current clinic. MHMRA has a waiting list of over 900 people for clinic services, yet the current capacity remains at 400. MHMRA of Harris County proposes to expand an innovative outpatient option, the Specialized Treatment and Rehabilitative Services (STARS) clinic, to provide behavioral medicine and behavioral support services to create a safety net for people with IDD/ASD and co-occurring mental illness who reside in Harris County. The existing STARS clinic has been in operation for over 20 years with outpatient services that include assessment, parent/caregiver training, casework, medication management and education, and skills training to address the behavioral health needs of persons with dual diagnoses of IDD/ASD and mental illness, and whose needs exceed the capacity and expertise of the existing mental health system. However, the demand for services far exceeds the clinic's capacity.

STARS is a unique clinic with highly skilled clinicians and IDD/ASD specialists who work together to achieve positive outcomes for people with serious behavioral and/or mental health problems. Clinicians and specialty paraprofessionals provide traditional therapies adapted for people with IDD/ASD and mental illness, family interventions and in-home applied behavior analysis training for families. The proposed expansion would add one psychiatrist, two clinical psychologists, two behavior analysts, one RN, two team leaders and clerical supports to extend the safety net to private providers who are unable to find expertise among available clinicians in Harris County.

Project Components:

Through the expansion of specialty care services project, we propose to meet all required project components listed below and believe that the selected milestones and metrics relate to the project components.

a) Increase service availability with extended hours
b) Increase number of specialty clinic locations
c) Implement transparent, standardized referrals across the system
d) Conduct quality improvement for project using methods such as rapid cycle improvement

Milestones and Metrics:

The goals are consistent with the regional goals and community needs discussed above. Furthermore, the improvement metrics chosen for this project (I-23.1: Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services) will determine the progress MHMRA is making to meet our stated goals.

Unique community need identification number the project addresses:

Expansion of the STARS clinic will address the following community needs:

- CN3-Inadequate access to Behavioral Health
- CN6- Inadequate access to treatment and services designed for special needs populations, including disabled, homeless, children and elderly
- CN9- High rates of preventable hospital readmissions

- CN18- Insufficient access to integrated care programs for behavioral health and physical health conditions

Related Category 3 Outcome Measure(s):
IT 6.1 Percent improvement over baseline of patient satisfaction scores for one domain of patient satisfaction.

Rationale for selecting the outcome measures:
Harris County MHMRA proposes to expand an innovative outpatient option, the Specialized Treatment and Rehabilitative Services (STARS) clinic, to provide behavioral medicine and behavioral support services to create a safety net for people with IDD/ASD and co-occurring mental illness who reside in Harris County. This program is a unique clinic with highly skilled clinicians and IDD/ASD specialists who work together to achieve positive outcomes for people with serious behavioral and/or mental health problems. Clinicians and specialty paraprofessionals provide traditional therapies adapted for people with IDD/ASD and mental illness, family interventions and in-home applied behavior analysis training for families. These services allow for the best opportunity for patient satisfaction as they provide the appropriate level of care for this critical population.

Relationship to Other Projects:
This proposed project has activities related to the following MHMRA proposals: IDD Consultation and Liaison Service and IDD/ASD Wrap-around and In-home Services.

The behavioral health crisis in Region 3 is considerable and the proposed initiatives in our RHP plan will only imply a small impression into the overall community need for treatment, but is a good start. The outpatient focus of many RHP Plan initiatives will help numerous facilities focus to treating the patients in an ambulatory setting as well as continued navigation of services with a focus to keeping patients from the inpatient unit. This initiative is similar to many others in the sense of the category of behavioral health. The Region 3 Initiative Grid attached in the addendum will show the relationship to other programs.

Plan for Learning Collaborative:
We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system.

Project Valuation:
In the effort to value the proposed project accurately, assistance was sought from H. Shelton Brown, Ph.D. of the UT Houston School of Public Health and Thomas Bohman, Ph.D. of the UT Austin Center for Social Work Research. Their consultation was limited to only the valuation section of this document. 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

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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: Expansion of the current STARS-ABA program will provide resources for the 900 currently awaiting services. About 40% of the average population of IDD/ASD patients has a comorbid psychiatric diagnosis, most commonly depression, psychosis or ADHD. Many dually diagnosed individuals are within the mild to moderate range of intellectual impairment, making CBT a viable treatment. Due to resource limitations, many are receiving only medication and service coordination when cognitive behavior therapy (CBT) is a recommended service.

Schoenbaum et al. (2001) compared the cost-effectiveness of medication services to medication plus CBT for depression. Their randomized controlled trial yielded an incremental QALY of 0.0226 for the addition of CBT. Applying this estimate to the current population the value of enhancing services for these underserved individuals can be calculated as follows:

100	(persons served)
0.40	(percent with comorbid disorders)
0.0226	(QALY gained)
x $50,000	(life year value)
$45,200	**QALY Value**

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. We did identify a benefit-cost study that is related.

MHMRA's existing STARS clinic sees approximately 400 people with IDD/ASD and co-occurring mental illness annually through outpatient clinic services. Estimates have put the rate of co-occurring mental health problems, such as depression and schizophrenia among this population as high as 40% making the treatment of these individuals more complex and costly (Lai, Hung, Lin, Chien & Lin, 2011; Tsakanikos, Sturmey, Costello, Holt & Bouras, 2007). After the implementation of this service in 1999, the inpatient hospitalization rate was 97% lower for individuals who received services in the following fiscal year. The average cost of inpatient hospitalization in the Harris County Hospital District is $700 per day, with an average length of

stay for IDD/AS patients of 11.89 days (SD=8.13, N=524). Based on these findings the cost savings can be calculated as follows:

.05	(percent hospitalized prior to treatment)
100	(persons served)
0.97	(percent of hospital reduction)
11.89	(average IDD patient length of stay)
x $700	(average inpatient cost per diem)
$40,366	Cost Savings: Hospitalization

Since hospital costs are included in the alternative method presented below, these costs are not separately claimed in the valuation.

Alternative Cost Offset Estimation

An additional study provides evidence that additional costs will be reduced by the implementation of specific behavioral treatments, such as ABA to the IDD/ASD population. The effectiveness of ABA has been well documented. By using a randomized, single-blind controlled study that compared treatment as usual with the use of a specialized team, similar to the proposed STARS program, in addition to treatment as usual, significant cost savings and improvements were noted on the Lethargy and Hyperactivity subscales (p<.008) of the Aberrant Behavior Checklist (Hassiotis, Robotham, Canagasabey, Romeo, Langridge, Blizard, Murad & .King, 2009). This study also found that at the end of a 6 month trial the costs for the treatment group were £2200 UK ($3,525 US) less than for the control when cost offset was calculated for increased community supports by the control group. When applied to 100 served individuals, a savings of **$352,500 per 100 served.**

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 ($45,200 QALY-based estimate plus $352,500 cost offset estimation) $397,700 per 100 people served per year.**

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Unique Identifier: 113180703.1.3	RHP PP Reference Number: 1.9.2	Project Components: 1.9.2 a-d	Program Title: IDD SPECIALIZED TREATMENT AND REHABILITATIVE SERVICES (STARS)
RHP Performing Provider: Mental Health and Mental Retardation Authority of Harris County			**TPI: 113180703**
Related Category 3 Measure(s): Patient Satisfaction		**IT-6.1**	**Percent improvement over baseline of patient satisfaction scores**
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1: P-21 Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects **Metric 1:** P-21.2 Implement the "raise the floor" improvement initiatives established at the semiannual meeting. **Data Source**: written documentation	**Milestone 5:** P-21 Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects **Metric 2** P-21.2 Implement the "raise the floor" improvement initiatives established at the semiannual meeting. **Data Source:** written documentation	**Milestone 9: P-21** Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects **Metric 1 P-21.1** Participate in semi-annual face-to-face meetings or seminars organized by the RHP. **Data Source:** written documentation	**Milestone 11: P-21** Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects **Metric 1 P-21.1** Participate in semi-annual face-to-face meetings or seminars organized by the RHP. **Data Source:** written documentation
Estimated Incentive Payment: $379,548.40	**Estimated Incentive Payment: $416,993.68**	**Estimated Incentive Payment: $891,238.99**	**Estimated Incentive Payment: $861,083.56**

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Unique Identifier: 113180703.1.3	RHP PP Reference Number: 1.9.2	Project Components: 1.9.2 a-d	Program Title: IDD SPECIALIZED TREATMENT AND REHABILITATIVE SERVICES (STARS)
RHP Performing Provider: Mental Health and Mental Retardation Authority of Harris County			**TPI: 113180703**
Related Category 3 Measure(s): Patient Satisfaction		**IT-6.1**	**Percent improvement over baseline of patient satisfaction scores**
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 2: **P-19**. Participate in at least bi-weekly interactions with other providers and the RHP to promote collaborative learning around shared or similar projects. **Metric 2: P-19.1** Number of bi-weekly RHP meetings MHMRA participated in **Data Source:** Documentation of weekly or bi-weekly interactions	**Milestone 6:** P-19 Participate in at least bi-weekly interactions (meetings, conference calls, or webinars) with other providers and the RHP to promote collaborative learning around shared or similar projects **Metric 6** P-19.1 Number of bi-weekly RHP meetings MHMRA participated in **Data Source:** Written Documentation	**Milestone 10:** **I-**23: Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services. **Metric 10**: I-23.1: Documentation of increased number of visits. **Data Source:** Registry, EHR, claims or other Performing Provider source **Goal:** Demonstrate 15% improvement over baseline.	**Milestone 10:** I-23: Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services. **Metric 10:** I-23.1: Documentation of increased number of visits. **Data Source:** Registry, EHR, claims or other Performing Provider source **Goal:** Demonstrate 30% improvement over baseline.
Estimated Incentive Payment: $379,548.40	**Estimated Incentive Payment: $416,993.68**	**Estimated Incentive Payment: $891,238.98**	**Estimated Incentive Payment: $861,083.56**

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Unique Identifier: 113180703.1.3	RHP PP Reference Number: 1.9.2	Project Components: 1.9.2 a-d	Program Title: IDD SPECIALIZED TREATMENT AND REHABILITATIVE SERVICES (STARS)
RHP Performing Provider: Mental Health and Mental Retardation Authority of Harris County			**TPI: 113180703**
Related Category 3 Measure(s): Patient Satisfaction		**IT-6.1**	**Percent improvement over baseline of patient satisfaction scores**
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Milestone 3 P-1: Conduct specialty care gap assessment based on community need **Metric 3**: P-1.1. Documentation of gap assessment. **Data source**: Needs Assessment **Goal**: establish baseline of community needs	**Milestone 7:** Collect baseline data for wait times, backlog, and/or return appointments in specialties **Metric 7:** P-3.1. Establish baseline for performance indicators a. Numerator: TBD by the Performing Provider b. Denominator: TBD by the Performing Provider **Data Source**: Anasazi, client records **Baseline:** current documentation of waitlist needs to be revised for stated goals **Goal**: establish baseline wait times	**N/A**	**N/A**
Estimated Incentive Payment: $379,548.40	**Estimated Incentive Payment: $416,993.68**	**N/A**	**N/A**

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<tr><td>Unique Identifier: 113180703.1.3</td><td>RHP PP Reference Number: 1.9.2</td><td colspan="2">Project Components:
1.9.2 a-d</td><td colspan="2">Program Title: IDD SPECIALIZED TREATMENT AND REHABILITATIVE SERVICES (STARS)</td></tr>
<tr><td colspan="5">RHP Performing Provider: Mental Health and Mental Retardation Authority of Harris County</td><td>TPI: 113180703</td></tr>
<tr><td colspan="2">Related Category 3 Measure(s): Patient Satisfaction</td><td>IT-6.1</td><td colspan="3">Percent improvement over baseline of patient satisfaction scores</td></tr>
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(10/1/2012 – 9/30/2013)</td><td>Year 3
(10/1/2013 – 9/30/2014)</td><td colspan="2">Year 4
(10/1/2014 – 9/30/2015)</td><td colspan="2">Year 5
(10/1/2015 – 9/30/2016)</td></tr>
<tr><td>Milestone 4: P-11: Launch/expand a specialty care clinic
Metric 4: P- 11.1: Establish/expand STARS specialty care clinics
a. Number of patients served by specialty care clinic
Data Source: Documentation of new/expanded specialty care clinic</td><td>Milestone 8: P-5: Provide reports on the number of days to process referrals and/or wait time
from receipt of referral to actual referral appointment
Metric 8 : Generate and provide reports on average referral process time and/or time to appointment
Data Source: EHR, Anasazi
Baseline: establish current baseline</td><td colspan="2">N/A</td><td colspan="2">N/A</td></tr>
<tr><td>Estimated Incentive Payment:
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$416,993.68</td><td colspan="2">N/A</td><td colspan="2">N/A</td></tr>
<tr><td>Year 2 Est. Bundle Amount:
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$1,667,974.73</td><td colspan="2">Year 4 Est. Bundle Amount:
$1,782,477.97</td><td colspan="2">Year 5 Est. Bundle Amount:
$1,722,167.12</td></tr>
<tr><td colspan="6">TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $6,690,813.44</td></tr>
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References

Hassiotis, A., Robotham, D., Canagasabey, A., Romeo, R., Langridge, D., Blizard, R., Murad, S. & King, M. (2009). Randomized, single-blind, controlled trial of a specialist behavior therapy team for challenging behavior in adults with intellectual disabilities. *Journal of the American Medical Association, 166,* 1278-1285.

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Schoenbaum, M., Unützer, J., Sherbourne, C., Duan, N., Rubenstein, L., Miranda, J. & ... Wells, K. (2001). Cost-effectiveness of practice-initiated quality improvement for depression: Results of a randomized controlled trial. *Journal of the American Medical Association, 286,* 1325-1330.

Tsakanikos, E., Sturmey, P., Costello, H., Holt, G. & Bouras, N. (2007). Referral trends in mental health services for adults with intellectual disability and autism spectrum disorders. *Autism*, *11*, 9-17.

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Project Option 1.12 ENHANCE SERVICE AVAILABILITY OF APPROPRIATE LEVELS OF BEHAVIORAL HEALTH CARE: EXPANSION OF OUTPATIENT BEHAVIORAL HEALTH SERVICES FOR ADULTS WITH SEVERE PSYCHIATRIC CONDITIONS (Northeast)

Unique RHP Project ID: 113180703.1.4

Performing Provider Name/TPI: MHMRA of Harris County / 113180703

Provider**:** The Mental Health and Mental Retardation Authority (MHMRA) of Harris County is a public agency serving as the safety net provider for adults with serious mental illnesses, for children and adolescents with serious emotional disorders, for the developmentally delayed and for individuals experiencing acute psychiatric distress. MHMRA provides inpatient, residential and outpatient treatments, including psycho-therapy, case management and medication management for individuals. MHMRA serves more than 49,000 Harris County residents out of a culturally and ethnically diverse population of over 4.1 million. Of those individuals who received any agency service in FY12, 36.5% were medically indigent and 51.9% had Medicaid. Of those who received mental health services in FY12, such as those being proposed in this project, 55% were medically indigent and 34.9% had Medicaid.

Intervention(s): MHMRA will place one new treatment team which can serve about 500 consumers on an outpatient basis in the Northeast region of the city.

Need for the project: Estimates place approximately 78,000 adults with severe mental illness unable to access treatment from the public or private mental health systems in Harris County. The gap between service needs of seriously mentally ill adults in the county and available public service capacity is most evident in the current waiting list of 1,695 for ongoing outpatient service. MHMRA of Harris County routinely operates at or above its state mandated, contracted service capacity, averaging about 8,800 adult consumers served each month. At this level, however, access is inadequate for many who apply for service.

Target population: Seriously mentally ill adults in the Northeast region of Harris County currently unable to access mental health services. It is anticipated the program will provide service for about 500 patients.

Category 1 or 2 expected patient benefits:

- Increase utilization of services to 500 patients more than baseline by DY 5
- A 10% decrease from baseline in PES/HCPC admissions by DY5

Category 3 outcomes: MHMRA expects to increase one domain of patient satisfaction (TBD) by 10% from baseline by DY5.

1.12 Enhance service availability of appropriate level of behavioral health care: Expansion of outpatient behavioral health services for adults with severe psychiatric conditions (Northeast)

RHP Project Number: 113180703.1.4
Performing Provider/TPI: Mental Health and Mental Retardation Authority of Harris County/ 113180703

Project Description:
The Mental Health and Mental Retardation Authority (MHMRA) of Harris County proposes to increase outpatient capacity to potentially eliminate the current wait list for services in this geographic area.

The Mental Health and Mental Retardation Authority (MHMRA) of Harris County is a public agency serving as the safety net provider for adults with serious mental illnesses, for children and adolescents with serious emotional disorders, for the developmentally delayed and for individuals experiencing acute psychiatric distress. MHMRA serves more than 49,000 Harris County residents out of a culturally and ethnically diverse population of over 4.1 million. Of those who received mental health services in FY12, such as those being proposed in this project, 55% were medically indigent and 34.9% had Medicaid. In an effort to provide needed services to the most critically ill population, MHMRA proposes to increase outpatient capacity by approximately 500 individuals potentially eliminating the current wait list for services in this geographic area. In order to address this issue we will choose to focus on project option 1.12.2: Expand the number of community based settings where behavioral health services may be delivered in underserved areas.

It is important to note that we are proposing four similar projects, each under the 1.12.2 umbrella, which would expand outpatient behavioral health services for adults in each of our existing clinics. Because the goals and rationale are identical, the narratives will be repetitive; however, each of the expansion programs serve unique geographical needs, and therefore, each of the projects are critical to addressing the community needs.

Goals and Relationship to Regional Goals:
Goals include improving access to community mental health services by establishing additional service providers (e.g., an additional treatment team) among existing MHMRA community clinics in Harris County. Specifically, we aspire to place one new treatment team in the Northeast region. Each treatment team can serve roughly 500 consumers.
The proposed project directly meets broad goals identified by the regional needs assessment. First, it improves and builds upon an existing program, which has shown positive gains in providing best-practices for patient-centered care. Furthermore, by providing enhanced, evidence-based services to patients the program will meet the regional goal set out above. Moreover, the program supports the regional goal of developing a culture of patient-centered care whereby the patient/consumer plays a more active role as a stakeholder.

Challenges:

Workforce limitations may provide staff recruitment challenges requiring significant lead time and advanced planning. Clinic managers will work closely with human resources and administration to ensure timely staffing of the proposed treatment teams.

Expected 5-year Outcomes:

5) Staffing of the new team: 1 Psychiatrist, 1 Nurse, 1 Clinical Team Leader, 4 Licensed Practitioners of the Healing Arts, 12 Rehabilitation Clinicians, 1 Administrative Assistant, 1 Clerical Support Staff, 1 Business Office Coordinator, and 1 HIT Staff.
6) Additional need is anticipated as initiatives to reduce 30-day re-hospitalizations, preventable emergency department visits, and jail recidivism, may create additional demand.
7) Provision of outpatient mental health service has been locally documented to reduce emergency psychiatric center visits by .37 visits per person per year; it has also has been shown to reduce public psychiatric hospital use by 1.66 bed days per person per year in a sample of 25,000 outpatients (served between the years 2005 and 2012).
8) Elimination of wait lists and improved geographic access can be expected to increase access to services, improved satisfaction, and decreased intensive service use. Reductions in intensive service (#3 and #4 above) use are firmly in line with regional project goals.

In order to measure the progress towards the stated goals, we have selected improvement metrics that measure increased utilization of behavioral health (I-11.1) and decreased emergency psychiatric service use (I-X).

Starting Point/Baseline:

As mentioned previously, 8,800 consumers are served among the four existing outpatient clinics. We seek to expand the provision of services by 1 team per current location, which would serve roughly 500 people per site, and add one additional team where the most need is determined. Current clinical space will be used in addition to redesigning available MHMRA space or seeking additional space as needed to house additional staff over the DSRIP period.

Rationale:

The community mental health system in Harris County has a limited capacity for service that is insufficient to the needs of its residents. The Mental Health Needs Council of Harris County has estimated that 153,000 of the 552,000 Harris County adults with mental illness have a severe mental illness (Depression, Bipolar Disorder, and Schizophrenia). These individuals are among the 96,200 Harris County adults who have no public (Medicaid or Medicare) or private health insurance and therefore, are totally dependent on the public mental health service system for treatment. In 2007, approximately 27,000 adults received services from the public mental health system; 18,200 of these were uninsured (a number representing only 19% of estimated need). By deduction, one can conclude that approximately 78,000 adults with severe mental illness failed to access treatment from the public or private mental health systems.

The gap between service needs of seriously mentally ill adults in the county and available public service capacity is most evident in the waiting list for ongoing outpatient service. MHMRA of Harris County routinely operates at or above its state mandated, contracted service

capacity, averaging about 8,800 adult consumers served each month. At this level, however, access is inadequate for many who apply for service.

On August 31 (2012), the MHMRA waitlist for adult mental health outpatient services rested at 1,695, a level that has persisted for several years. Further, tenure on the waiting list approached five months, an average of 149.16 days. The majority of consumers on the MHMRA waitlist (31.1%) reside in the Northeast section of town.

The rationale for requesting funding for each project is based on the aforementioned need for additional mental health services in the county, and the existing waitlist. If MHMRA were to expand only one or two of the clinics, only 400-800 new consumers could be served and the waitlist would remain in effect. Additionally, it is expected that the need for mental health services will continue to grow, and therefore, limited expansion will simply not address the current needs of those on the waitlist or the community needs of those who initiated services with MHMRA.

Unique Community Need Identification numbers:

Specific community needs are also addressed through the proposed program:

- CN3-Inadequate access to Behavioral Health
- CN6- Inadequate access to treatment and services designed for special needs populations, including disabled, homeless, children and elderly
- CN9- High rates of preventable hospital readmissions

Expansion of outpatient behavioral health services will address the community needs above by providing greater access to behavioral health care, thereby offsetting the increased use of medical and psychiatric emergency services. Furthermore, a larger behavioral health workforce within MHMRA will provide more opportunities for collaboration between providers and for patient education. MHMRA clinicians already engage in a variety of community collaborations and education activities, despite their tremendous workload. With the addition of qualified behavioral health personnel, more services can be provided.

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

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

Reasons/rationale for selecting the outcome measures:

We believe patient satisfaction that addresses involvement in shared decision making, access to providers, and better communication with providers, will reduce chronic over-use of psychiatric emergency services and in general reduce cost and improve efficiency.

By enhancing service availability of appropriate levels of outpatient behavioral health care we will address the community needs. Also providing greater access to behavioral health care and the addition of qualified behavioral health care professionals will allow for the provision of more services, great patient satisfaction and improved patient outcomes.

Relationship to other Projects:

The proposed project is similar to several MHMRA DSRIP proposals, including the expansion of outpatient behavioral health services within other clinics (113180703.1.1, 113180703.1.5, 113180703.1.6 and 113180703.1.7) and a project which enhances the intensity of behavioral outpatient services (113180703.1.2). Extending outpatient behavioral health specialty service and increasing the intensity of these services will together ultimately provide responsive, appropriate levels of care.

The behavioral health crisis in Region 3 is considerable and the proposed initiatives in our RHP plan will only imply a small impression into the overall community need for treatment, but is a good start. The outpatient focus of many RHP Plan initiatives will help numerous facilities focus to treating the patients in an ambulatory setting as well as continued navigation of services with a focus to keeping patients from the inpatient unit. This initiative is similar to many others in the sense of the category of behavioral health. The Region 3 Initiative Grid attached in the addendum will show the relationship to other programs.

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

Plan for Learning Collaborative:

Consumer satisfaction with access outcomes will be assessed with input from consumer groups involving both patients and family members in the quality improvement loop. Similarly, rates of public psychiatric hospitalization will be presented to public psychiatric hospital representatives with an invitation for them to provide input on the improvement process.

Project Valuation:

In the effort to value the proposed project accurately, assistance was sought from H. Shelton Brown, Ph.D. of the UT Houston School of Public Health and Thomas Bohman, Ph.D. of the UT Austin Center for Social Work Research. Their consultation was limited to only the valuation section of this document. 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: The Texas Recommended Assessment Guidelines (Texas Department of State Health Services, 2011) established a utilization management scheme for matching patient need to service packages of varying intensities. To provide an approximation of the value of an outpatient behavioral health program, we will review studies related to each of the four service packages described below as "levels of care."

Level One: Medication only

Individuals receiving Service Package One (SP1) have been assessed to have relatively less severe symptomatology and functional impairment. Therefore, they receive medications only accompanied by service coordination. A study by Chouinard and Albright (1997) found that individuals receiving medications versus a placebo gained 7 times the quality-adjusted years than without medications (QALY = .125). The proportion of individuals recommended to Level One at MHMRA is 56.5%. Assuming the program would serve 100 persons in a year, the following formula shows the total valuation:

100	(persons served)
0.125	(QALY gained)
.565	(proportion of patients recommended to Level One)
× $50,000	(life year value)
= $353,125	Level 1 QALY Value

Level Two: Medication plus therapy

About 18.5% of patients at MHMRA are recommended to Level Two services based on moderately severe need accompanied by diagnoses of major depression. This service package includes cognitive psychotherapy for depressive disorders in addition to medications. Pyne et al. (2003) compared the cost-effectiveness of medication services to medication plus CBT for depression. Their randomized controlled trial yielded an incremental QALY of 0.041 for the addition of CBT. Assuming the program would serve 100 persons in a year, the following formula shows the total valuation:

100	(persons served)
0.041	(QALY gained)
.185	(proportion of patients recommended to Level 2)
× $50,000	(life year value)
= $37,925	Level 2 QALY Valuation

Level Three: Medications and skills training

About 24% of patients at MHMRA are recommended to Level Three services, based on higher severity symptom and functional skill impairment. This package includes medications and skills training. Barton and colleagues (2009) compared social recovery oriented cognitive behavioral therapy (SRCBT) for people diagnosed with psychosis compared to case management alone (CMA); they reported a mean incremental QALY gain of 0.035. Assuming the program would serve 100 persons in a year; the following formula shows the valuation:

100	(persons served)
0.035	(QALY gained)
0.24	(proportion of patients recommended to Level 3)
× $50,000	(life year value)
= $42,000	Level 3 QALY Value

Level Four: Assertive Community Treatment (ACT) for Persons with Serious Mental Illness

Of consumers referred for services, about 4.1% are recommended for ACT Team treatment. This level of care represents the highest intensity service intervention. A 2012 study reported the cost-effectiveness of assertive community treatment as part of integrated care versus standard care in patients with schizophrenia (Karow, Reimer, König, Heider, Bock & Huber 2012). Results indicated the ACT intervention yielded a QALY of 0.76, whereas the treatment as usual groups resulted in a QALY of 0.66. Since the treatment is being contrasted with wait list or not treatment, the full QALY (0.76) applies. The incremental QALY for the ACT group was

0.10. Assuming the program would serve 100 persons in a year the following formula shows the valuation:

100	(persons served)
0.76	(QALY gained)
0.041	Proportion of patients recommended to Level Four
× $50,000	(life year value)
= $155,800	Level 4 QALY Value

Hospitalizations
When compared to the year prior to outpatient treatment admission, MHMRA patients have averaged 1.66 fewer public psychiatric hospital bed days per person. Cost savings from these individuals from averting hospital services can be calculated as follows:

100	(persons served)
1.66	(average hospital bed days per person per year averted)
X$700	(cost of hospital day)
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When compared to the year prior to outpatient treatment admission, MHMRA patients have averaged 0.212 fewer public psychiatric emergency room visits per person. Cost savings from these individuals from averting these emergency services can be calculated as follows:

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Mental Health Services in the County Jail
When compared to the year prior to outpatient treatment admission, MHMRA patients have averaged 0.05 fewer county jail incarcerations per person. Cost savings from averting these jail bookings can be calculated as follows:

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Valuation Summary: This valuation analysis shows that the intervention will have a positive value for participants who receive the intervention(s). Summing the estimated utilities of all four levels of care above, the expected value of this proposal is $746,386 per 100 people served per year.

Unique Identifier: 113180703.1.4	RHP PP Reference Number: 1.12.2	Project Components: NA	Program Title: EXPANSION OF OUTPATIENT BEHAVIORAL HEALTH SERVICES FOR ADULTS WITH SEVERE PSYCHIATRIC CONDITIONS - NE
RHP Performing Provider: Mental Health and Mental Retardation Authority of Harris County			TPI: 113180703
Related Category 3 Measure(s): Patient Satisfaction		IT-6.1	Percent improvement over baseline of patient satisfaction scores
Year 2 (10/1/2012 – 9/30/2013)	**Year 3** (10/1/2013 – 9/30/2014)	**Year 4** (10/1/2014 – 9/30/2015)	**Year 5** (10/1/2015 – 9/30/2016)
Milestone 1: P-2. Identify licenses, equipment requirements and other components needed to implement and operate options selected. **Metric 1: P-2.5.1** Develop a project plan and timeline detailing operational needs and equipment and components **Data Source:** Written Project Plan	**Milestone 3: P-6:** Establish behavioral health services in new community-based settings in underserved areas **Metric 1: P-6.1** Number of new community-based settings where behavioral health services are delivered **Data Source**: Project documentation and MHMRA records **Goals:** Provide documentation of patients being served by new treatment team	**Milestone 6: I-11:** Increased utilization of community behavioral healthcare **Metric 1: I-11.1** Percent utilization of community behavioral healthcare services. **Data Source**: MHMRA records **Goal:** Serve 250 patients more than baseline	**Milestone 8: I-11:** Increased utilization of community behavioral healthcare **Metric 1: I-11.1** Percent utilization of community behavioral healthcare services. **Data Source**: MHMRA records **Goal:** Serve 500 patients more than baseline
Estimated Incentive Payment: $1,493,333.075	**Estimated Incentive Payment: $1,094,430.09**	**Estimated Incentive Payment: $1,754,273.38**	**Estimated Incentive Payment: $1,694,950.12**

Unique Identifier: 113180703.1.4	RHP PP Reference Number: 1.12.2	Project Components: NA	Program Title: EXPANSION OF OUTPATIENT BEHAVIORAL HEALTH SERVICES FOR ADULTS WITH SEVERE PSYCHIATRIC CONDITIONS - NE
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Related Category 3 Measure(s): Patient Satisfaction		**IT-6.1**	**Percent improvement over baseline of patient satisfaction scores**
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 2: P-4: Hire and train staff to operate and manage project **Metric 1: P-4.1**: Number of staff secured and trained **Data Source:** HR records **Goal:** hire staff for one additional treatment team	**Milestone 4:** I-11 Increased utilization of community behavioral healthcare **Metric 1:** I-11.1 Percent utilization of community behavioral healthcare services. **Data Source:** MHMRA records **Goal:** establish baseline	**Milestone 7:** I-X. Psychiatric Emergency Service (PES) Admissions and Inpatient Psych. Admissions **Metric 1:** I-X.1. Percent of individuals who were admitted to inpatient facilities. **Data Source:** MHMRA and HCPC records **Goal:** A 5% decrease from baseline in PES/HCPC admissions	**Milestone 9:** I-X. Psychiatric Emergency Service (PES) Admissions and Inpatient Psych. Admissions **Metric 1:** I-X.1. Percent of individuals who were admitted to inpatient facilities. **Data Source:** MHMRA and HCPC records **Goal:** A 10% decrease from baseline in PES/HCPC admissions
Estimated Incentive Payment: $1,493,333.075	**Estimated Incentive Payment: $1,094,430.09**	**Estimated Incentive Payment: $1,754,273.38**	**Estimated Incentive Payment: $1,694,950.12**

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RHP Performing Provider: Mental Health and Mental Retardation Authority of Harris County			**TPI: 113180703**
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Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	Milestone 5: I-X. Psychiatric Emergency Service (PES) Admissions and Inpatient Psych. Admissions **Metric 1**: I-X.1. Percent of individuals who were admitted to inpatient facilities. **Data Source**: Psychiatric Emergency Services (PES) records are part of the MHMRA electronic record. Harris County Psychiatric Center (HCPC) is the local public psychiatric inpatient unit which maintains separate records **Goal:** Establish baseline		
	Estimated Incentive Payment: $1,094,430.09		
Year 2 Estimated Milestone Bundle Amount: $2,986,666.15	**Year 3 Estimated Milestone Bundle Amount: $3,283,290.27**	**Year 4 Estimated Milestone Bundle Amount: $3,508,546.76**	**Year 5 Estimated Milestone Bundle Amount: $3,389,900.24**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $13,168,403.42			

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Project Option 1.12 ENHANCE SERVICE AVAILABILITY OF APPROPRIATE LEVELS OF BEHAVIORAL HEALTH CARE: EXPANSION OF OUTPATIENT BEHAVIORAL HEALTH SERVICES FOR ADULTS WITH SEVERE PSYCHIATRIC CONDITIONS (Southwest)
Unique RHP Project ID: 113180703.1.5

Performing Provider Name/TPI: MHMRA of Harris County / 113180703

Provider: The Mental Health and Mental Retardation Authority (MHMRA) of Harris County is a public agency serving as the safety net provider for adults with serious mental illnesses, for children and adolescents with serious emotional disorders, for the developmentally delayed and for individuals experiencing acute psychiatric distress. MHMRA provides inpatient, residential and outpatient treatments, including psycho-therapy, case management and medication management for individuals. MHMRA serves more than 49,000 Harris County residents out of a culturally and ethnically diverse population of over 4.1 million. Of those individuals who received any agency service in FY12, 36.5% were medically indigent and 51.9% had Medicaid. Of those who received mental health services in FY12, such as those being proposed in this project, 55% were medically indigent and 34.9% had Medicaid.

Intervention(s): MHMRA will place one new treatment team which can serve about 500 consumers on an outpatient basis in the Southwest region of the city.

Need for the project: Estimates place approximately 78,000 adults with severe mental illness unable to access treatment from the public or private mental health systems in Harris County. The gap between service needs of seriously mentally ill adults in the county and available public service capacity is most evident in the current waiting list of 1,695 for ongoing outpatient service. MHMRA of Harris County routinely operates at or above its state mandated, contracted service capacity, averaging about 8,800 adult consumers served each month. At this level, however, access is inadequate for many who apply for service.

Target population: Seriously mentally ill adults in the Southwest region of Harris County currently unable to access mental health services. It is anticipated the program will provide service for about 500 patients.

Category 1 or 2 expected patient benefits:

- Increase utilization of services to 500 patients more than baseline by DY 5
- A 10% decrease from baseline in PES/HCPC admissions by DY5

Category 3 outcomes: MHMRA expects to increase one domain of patient satisfaction (TBD) by 10% from baseline by DY5.

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1.12 Enhance service availability of appropriate level of behavioral health care: Expansion of outpatient behavioral health services for adults with severe psychiatric conditions (Southwest)

RHP Project Number: 113180703.1.5
Performing Provider/TPI: Mental Health and Mental Retardation Authority of Harris County/ 113180703

Project Description:
The Mental Health and Mental Retardation Authority (MHMRA) of Harris County proposes to increase outpatient capacity to potentially eliminate the current wait list for services in this geographic area.

The Mental Health and Mental Retardation Authority (MHMRA) of Harris County is a public agency serving as the safety net provider for adults with serious mental illnesses, for children and adolescents with serious emotional disorders, for the developmentally delayed and for individuals experiencing acute psychiatric distress. MHMRA serves more than 49,000 Harris County residents out of a culturally and ethnically diverse population of over 4.1 million. Of those who received mental health services in FY12, such as those being proposed in this project, 55% were medically indigent and 34.9% had Medicaid. In an effort to provide needed services to the most critically ill population, MHMRA proposes to increase outpatient capacity by approximately 500 individuals potentially eliminating the current wait list for services in this geographic area. In order to address this issue we will choose to focus on project option 1.12.2: Expand the number of community based settings where behavioral health services may be delivered in underserved areas.

It is important to note that we are proposing four similar projects, each under the 1.12.2 umbrella, which would expand outpatient behavioral health services for adults in each of our existing clinics. Because the goals and rationale are identical, the narratives will be repetitive; however, each of the expansion programs serve unique geographical needs, and therefore, each of the projects are critical to addressing the community needs.

Goals and Relationship to Regional Goals:
Goals include improving access to community mental health services by establishing additional service providers (e.g., an additional treatment team) among existing MHMRA community clinics in Harris County. Specifically, we aspire to place one new treatment team in the Southwest region. Each treatment team can serve roughly 500 consumers.
The proposed project directly meets broad goals identified by the regional needs assessment. First, it improves and builds upon an existing program, which has shown positive gains in providing best-practices for patient-centered care. Furthermore, by providing enhanced, evidence-based services to patients the program will meet the regional goal set out above. Moreover, the program supports the regional goal of developing a culture of patient-centered care whereby the patient/consumer plays a more active role as a stakeholder.

Challenges:

Workforce limitations may provide staff recruitment challenges requiring significant lead time and advanced planning. Clinic managers will work closely with human resources and administration to ensure timely staffing of the proposed treatment teams.

Expected 5-year Outcomes:

9) Staffing of the new team: 1 Psychiatrist, 1 Nurse, 1 Clinical Team Leader, 4 Licensed Practitioners of the Healing Arts, 12 Rehabilitation Clinicians, 1 Administrative Assistant, 1 Clerical Support Staff, 1 Business Office Coordinator, and 1 HIT Staff.
10) Additional need is anticipated as initiatives to reduce 30-day re-hospitalizations, preventable emergency department visits, and jail recidivism, may create additional demand.
11) Provision of outpatient mental health service has been locally documented to reduce emergency psychiatric center visits by .37 visits per person per year; it has also has been shown to reduce public psychiatric hospital use by 1.66 bed days per person per year in a sample of 25,000 outpatients (served between the years 2005 and 2012).
12) Elimination of wait lists and improved geographic access can be expected to increase access to services, improved satisfaction, and decreased intensive service use. Reductions in intensive service (#3 and #4 above) use are firmly in line with regional project goals.

In order to measure the progress towards the stated goals, we have selected improvement metrics that measure increased utilization of behavioral health (I-11.1) and decreased emergency psychiatric service use (I-X).

Starting Point/Baseline:
As mentioned previously, 8,800 consumers are served among the four existing outpatient clinics. We seek to expand the provision of services by 1 team per current location, which would serve roughly 500 people per site, and add one additional team where the most need is determined. Current clinical space will be used in addition to redesigning available MHMRA space or seeking additional space as needed to house additional staff over the DSRIP period.

Rationale:
The community mental health system in Harris County has a limited capacity for service that is insufficient to the needs of its residents. The Mental Health Needs Council of Harris County has estimated that 153,000 of the 552,000 Harris County adults with mental illness have a severe mental illness (Depression, Bipolar Disorder, and Schizophrenia). These individuals are among the 96,200 Harris County adults who have no public (Medicaid or Medicare) or private health insurance and therefore, are totally dependent on the public mental health service system for treatment. In 2007, approximately 27,000 adults received services from the public mental health system; 18,200 of these were uninsured (a number representing only 19% of estimated need). By deduction, one can conclude that approximately 78,000 adults with severe mental illness failed to access treatment from the public or private mental health systems.

The gap between service needs of seriously mentally ill adults in the county and available public service capacity is most evident in the waiting list for ongoing outpatient service. MHMRA of Harris County routinely operates at or above its state mandated, contracted service

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capacity, averaging about 8,800 adult consumers served each month. At this level, however, access is inadequate for many who apply for service.

On August 31 (2012), the MHMRA waitlist for adult mental health outpatient services rested at 1,695, a level that has persisted for several years. Further, tenure on the waiting list approached five months, an average of 149.16 days. The Southwest clinic has 17.9% of the waitlist. The rationale for requesting funding for each project is based on the aforementioned need for additional mental health services in the county, and the existing waitlist. If MHMRA were to expand only one or two of the clinics, only 400-800 new consumers could be served and the waitlist would remain in effect. Additionally, it is expected that the need for mental health services will continue to grow, and therefore, limited expansion will simply not address the current needs of those on the waitlist or the community needs of those who initiated services with MHMRA.

Unique Community Need Identification numbers:

Specific community needs are also addressed through the proposed program:

- CN3-Inadequate access to Behavioral Health
- CN6- Inadequate access to treatment and services designed for special needs populations, including disabled, homeless, children and elderly
- CN9- High rates of preventable hospital readmissions

Expansion of outpatient behavioral health services will address the community needs above by providing greater access to behavioral health care, thereby offsetting the increased use of medical and psychiatric emergency services. Furthermore, a larger behavioral health workforce within MHMRA will provide more opportunities for collaboration between providers and for patient education. MHMRA clinicians already engage in a variety of community collaborations and education activities, despite their tremendous workload. With the addition of qualified behavioral health personnel, more services can be provided.

Related Category 3 Outcome Measure(s):

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

Reasons/rationale for selecting the outcome measures:

We believe patient satisfaction that addresses involvement in shared decision making, access to providers, and better communication with providers, will reduce chronic over-use of psychiatric emergency services and in general reduce cost and improve efficiency.

Relationship to other Projects:

The proposed project is similar to several MHMRA DSRIP proposals, including the expansion of outpatient behavioral health services within other clinics (113180703.1.1, 113180703.1.4, 113180703.1.6 and 113180703.1.7) and a project which enhances the intensity of behavioral outpatient services (113180703.1.2). Extending outpatient behavioral health specialty service and increasing the intensity of these services will together ultimately provide responsive, appropriate levels of care.

The behavioral health crisis in Region 3 is considerable and the proposed initiatives in our RHP plan will only imply a small impression into the overall community need for treatment, but is a good start. The outpatient focus of many RHP Plan initiatives will help numerous facilities focus to treating the patients in an ambulatory setting as well as continued navigation of services with a focus to keeping patients from the inpatient unit. This initiative is similar to

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many others in the sense of the category of behavioral health. The Region 3 Initiative Grid attached in the addendum will show the relationship to other programs.

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

Plan for Learning Collaborative:

Consumer satisfaction with access outcomes will be assessed with input from consumer groups involving both patients and family members in the quality improvement loop. Similarly, rates of public psychiatric hospitalization will be presented to public psychiatric hospital representatives with an invitation for them to provide input on the improvement process.

Project Valuation:

In the effort to value the proposed project accurately, assistance was sought from H. Shelton Brown, Ph.D. of the UT Houston School of Public Health and Thomas Bohman, Ph.D. of the UT Austin Center for Social Work Research. Their consultation was limited to only the valuation section of this document. 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.

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100 (persons served)
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100 (persons served)
0.035 (QALY gained)
0.24 (proportion of patients recommended to Level 3)
× $50,000 (life year value)
= $42,000 Level 3 QALY Value

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100	(persons served)
0.76	(QALY gained)
0.041	Proportion of patients recommended to Level Four
× $50,000	(life year value)
= $155,800	Level 4 QALY Value

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X$130	(cost of jail day with mental health service)
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Valuation Summary: This valuation analysis shows that the intervention will have a positive value for participants who receive the intervention(s). Summing the estimated utilities of all four levels of care above, the expected value of this proposal is $746,386 per 100 people served per year.

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Unique Identifier: 113180703.1.5	RHP PP Reference Number: 1.12.2	Project Components: NA	Program Title: EXPANSION OF OUTPATIENT BEHAVIORAL HEALTH SERVICES FOR ADULTS WITH SEVERE PSYCHIATRIC CONDITIONS - SW
RHP Performing Provider: Mental Health and Mental Retardation Authority of Harris County		**TPI: 113180703**	
Related Category 3 Measure(s): Patient Satisfaction		**IT-6.1**	**Percent improvement over baseline of patient satisfaction scores**
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1: P-2. Identify licenses, equipment requirements and other components needed to implement and operate options selected. **Metric 1: P-2.5.1** Develop a project plan and timeline detailing operational needs and equipment and components **Data Source:** Written Project Plan	**Milestone 3: P-6:** Establish behavioral health services in new community-based settings in underserved areas **Metric 1: P-6.1** Number of new community-based settings where behavioral health services are delivered **Data Source**: Project documentation and MHMRA records **Goals:** Provide documentation of patients being served by new treatment team	**Milestone 6: I-11:** Increased utilization of community behavioral healthcare **Metric 1: I-11.1** Percent utilization of community behavioral healthcare services. **Data Source**: MHMRA records **Goal:** Serve 250 patients more than baseline	**Milestone 8: I-11:** Increased utilization of community behavioral healthcare **Metric 1: I-11.1** Percent utilization of community behavioral healthcare services. **Data Source**: MHMRA records **Goal:** Serve 500 patients more than baseline
Estimated Incentive Payment: $1,493,333.075	**Estimated Incentive Payment: $1,094,430.09**	**Estimated Incentive Payment: $1,754,273.38**	**Estimated Incentive Payment: $1,694,950.12**

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Unique Identifier: 113180703.1.5	RHP PP Reference Number: 1.12.2	Project Components: NA	Program Title: EXPANSION OF OUTPATIENT BEHAVIORAL HEALTH SERVICES FOR ADULTS WITH SEVERE PSYCHIATRIC CONDITIONS - SW
RHP Performing Provider: Mental Health and Mental Retardation Authority of Harris County		**TPI: 113180703**	
Related Category 3 Measure(s): Patient Satisfaction		**IT-6.1**	**Percent improvement over baseline of patient satisfaction scores**
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 2: P-4: Hire and train staff to operate and manage project **Metric 1: P-4.1**: Number of staff secured and trained **Data Source:** HR records **Goal:** hire staff for one additional treatment team	**Milestone 4:** I-11 Increased utilization of community behavioral healthcare **Metric 1:** I-11.1 Percent utilization of community behavioral healthcare services. **Data Source:** MHMRA records **Goal:** establish baseline	**Milestone 7:** I-X. Psychiatric Emergency Service (PES) Admissions and Inpatient Psych. Admissions **Metric 1:** I-X.1. Percent of individuals who were admitted to inpatient facilities. **Data Source:** MHMRA and HCPC records **Goal:** A 5% decrease from baseline in PES/HCPC admissions	**Milestone 9:** I-X. Psychiatric Emergency Service (PES) Admissions and Inpatient Psych. Admissions **Metric 1:** I-X.1. Percent of individuals who were admitted to inpatient facilities. **Data Source:** MHMRA and HCPC records **Goal:** A 10% decrease from baseline in PES/HCPC admissions
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RHP Performing Provider: Mental Health and Mental Retardation Authority of Harris County		**TPI: 113180703**	
Related Category 3 Measure(s): Patient Satisfaction		**IT-6.1**	**Percent improvement over baseline of patient satisfaction scores**
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
	Milestone 5: I-X. Psychiatric Emergency Service (PES) Admissions and Inpatient Psych. Admissions **Metric 1**: I-X.1. Percent of individuals who were admitted to inpatient facilities. **Data Source**: Psychiatric Emergency Services (PES) records are part of the MHMRA electronic record. Harris County Psychiatric Center (HCPC) is the local public psychiatric inpatient unit which maintains separate records **Goal:** Establish baseline		
	Estimated Incentive Payment: $1,094,430.09		
Year 2 Estimated Milestone Bundle Amount: $2,986,666.15	**Year 3 Estimated Milestone Bundle Amount: $3,283,290.27**	**Year 4 Estimated Milestone Bundle Amount: $3,508,546.76**	**Year 5 Estimated Milestone Bundle Amount: $3,389,900.24**
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Project Option 1.12 ENHANCE SERVICE AVAILABILITY OF APPROPRIATE LEVELS OF BEHAVIORAL HEALTH CARE: EXPANSION OF OUTPATIENT BEHAVIORAL HEALTH SERVICES FOR ADULTS WITH SEVERE PSYCHIATRIC CONDITIONS (Southeast)

Unique RHP Project ID: 113180703.1.6

Performing Provider Name/TPI: MHMRA of Harris County / 113180703

Provider**:** The Mental Health and Mental Retardation Authority (MHMRA) of Harris County is a public agency serving as the safety net provider for adults with serious mental illnesses, for children and adolescents with serious emotional disorders, for the developmentally delayed and for individuals experiencing acute psychiatric distress. MHMRA provides inpatient, residential and outpatient treatments, including psycho-therapy, case management and medication management for individuals. MHMRA serves more than 49,000 Harris County residents out of a culturally and ethnically diverse population of over 4.1 million. Of those individuals who received any agency service in FY12, 36.5% were medically indigent and 51.9% had Medicaid. Of those who received mental health services in FY12, such as those being proposed in this project, 55% were medically indigent and 34.9% had Medicaid.

Intervention(s): MHMRA will place one new treatment team which can serve about 500 consumers on an outpatient basis in the Southeast region of the city.

Need for the project: Estimates place approximately 78,000 adults with severe mental illness unable to access treatment from the public or private mental health systems in Harris County. The gap between service needs of seriously mentally ill adults in the county and available public service capacity is most evident in the current waiting list of 1,695 for ongoing outpatient service. MHMRA of Harris County routinely operates at or above its state mandated, contracted service capacity, averaging about 8,800 adult consumers served each month. At this level, however, access is inadequate for many who apply for service.

Target population: Seriously mentally ill adults in the Southeast region of Harris County currently unable to access mental health services. It is anticipated the program will provide service for about 500 patients.

Category 1 or 2 expected patient benefits:

- Increase utilization of services to 500 patients more than baseline by DY 5
- A 10% decrease from baseline in PES/HCPC admissions by DY5

Category 3 outcomes: MHMRA expects to increase one domain of patient satisfaction (TBD) by 10% from baseline by DY5.

1.12 Enhance service availability of appropriate level of behavioral health care: Expansion of outpatient behavioral health services for adults with severe psychiatric conditions (Southeast)

RHP Project Number: 113180703.1.6
Performing Provider/TPI: Mental Health and Mental Retardation Authority of Harris County/ 113180703

Project Description:
The Mental Health and Mental Retardation Authority (MHMRA) of Harris County proposes to increase outpatient capacity to potentially eliminate the current wait list for services in this geographic area.

The Mental Health and Mental Retardation Authority (MHMRA) of Harris County is a public agency serving as the safety net provider for adults with serious mental illnesses, for children and adolescents with serious emotional disorders, for the developmentally delayed and for individuals experiencing acute psychiatric distress. MHMRA serves more than 49,000 Harris County residents out of a culturally and ethnically diverse population of over 4.1 million. Of those who received mental health services in FY12, such as those being proposed in this project, 55% were medically indigent and 34.9% had Medicaid. In an effort to provide needed services to the most critically ill population, MHMRA proposes to increase outpatient capacity by approximately 500 individuals potentially eliminating the current wait list for services in this geographic area. In order to address this issue we will choose to focus on project option 1.12.2: Expand the number of community based settings where behavioral health services may be delivered in underserved areas.

It is important to note that we are proposing four similar projects, each under the 1.12.2 umbrella, which would expand outpatient behavioral health services for adults in each of our existing clinics. Because the goals and rationale are identical, the narratives will be repetitive; however, each of the expansion programs serve unique geographical needs, and therefore, each of the projects are critical to addressing the community needs.

Goals and Relationship to Regional Goals:
Goals include improving access to community mental health services by establishing additional service providers (e.g., an additional treatment team) among existing MHMRA community clinics in Harris County. Specifically, we aspire to place one new treatment team in the Southeast region. Each treatment team can serve roughly 500 consumers.
The proposed project directly meets broad goals identified by the regional needs assessment. First, it improves and builds upon an existing program, which has shown positive gains in providing best-practices for patient-centered care. Furthermore, by providing enhanced, evidence-based services to patients the program will meet the regional goal set out above. Moreover, the program supports the regional goal of developing a culture of patient-centered care whereby the patient/consumer plays a more active role as a stakeholder.

Challenges:

Workforce limitations may provide staff recruitment challenges requiring significant lead time and advanced planning. Clinic managers will work closely with human resources and administration to ensure timely staffing of the proposed treatment teams.

Expected 5-year Outcomes:

13) Staffing of the new team: 1 Psychiatrist, 1 Nurse, 1 Clinical Team Leader, 4 Licensed Practitioners of the Healing Arts, 12 Rehabilitation Clinicians, 1 Administrative Assistant, 1 Clerical Support Staff, 1 Business Office Coordinator, and 1 HIT Staff.
14) Additional need is anticipated as initiatives to reduce 30-day re-hospitalizations, preventable emergency department visits, and jail recidivism, may create additional demand.
15) Provision of outpatient mental health service has been locally documented to reduce emergency psychiatric center visits by .37 visits per person per year; it has also has been shown to reduce public psychiatric hospital use by 1.66 bed days per person per year in a sample of 25,000 outpatients (served between the years 2005 and 2012).
16) Elimination of wait lists and improved geographic access can be expected to increase access to services, improved satisfaction, and decreased intensive service use. Reductions in intensive service (#3 and #4 above) use are firmly in line with regional project goals.

In order to measure the progress towards the stated goals, we have selected improvement metrics that measure increased utilization of behavioral health (I-11.1) and decreased emergency psychiatric service use (I-X).

Starting Point/Baseline:

As mentioned previously, 8,800 consumers are served among the four existing outpatient clinics. We seek to expand the provision of services by 1 team per current location, which would serve roughly 500 people per site, and add one additional team where the most need is determined. Current clinical space will be used in addition to redesigning available MHMRA space or seeking additional space as needed to house additional staff over the DSRIP period.

Rationale:

The community mental health system in Harris County has a limited capacity for service that is insufficient to the needs of its residents. The Mental Health Needs Council of Harris County has estimated that 153,000 of the 552,000 Harris County adults with mental illness have a severe mental illness (Depression, Bipolar Disorder, and Schizophrenia). These individuals are among the 96,200 Harris County adults who have no public (Medicaid or Medicare) or private health insurance and therefore, are totally dependent on the public mental health service system for treatment. In 2007, approximately 27,000 adults received services from the public mental health system; 18,200 of these were uninsured (a number representing only 19% of estimated need). By deduction, one can conclude that approximately 78,000 adults with severe mental illness failed to access treatment from the public or private mental health systems.

The gap between service needs of seriously mentally ill adults in the county and available public service capacity is most evident in the waiting list for ongoing outpatient service. MHMRA of Harris County routinely operates at or above its state mandated, contracted service

capacity, averaging about 8,800 adult consumers served each month. At this level, however, access is inadequate for many who apply for service.

On August 31 (2012), the MHMRA waitlist for adult mental health outpatient services rested at 1,695, a level that has persisted for several years. Further, tenure on the waiting list approached five months, an average of 149.16 days. The Southeast clinic accounts for 21.3% of the current waitlist. The rationale for requesting funding for each project is based on the aforementioned need for additional mental health services in the county, and the existing waitlist. If MHMRA were to expand only one or two of the clinics, only 400-800 new consumers could be served and the waitlist would remain in effect. Additionally, it is expected that the need for mental health services will continue to grow, and therefore, limited expansion will simply not address the current needs of those on the waitlist or the community needs of those who initiated services with MHMRA.

Unique Community Need Identification numbers:

Specific community needs are also addressed through the proposed program:

- CN3-Inadequate access to Behavioral Health
- CN6- Inadequate access to treatment and services designed for special needs populations, including disabled, homeless, children and elderly
- CN9- High rates of preventable hospital readmissions

Expansion of outpatient behavioral health services will address the community needs above by providing greater access to behavioral health care, thereby offsetting the increased use of medical and psychiatric emergency services. Furthermore, a larger behavioral health workforce within MHMRA will provide more opportunities for collaboration between providers and for patient education. MHMRA clinicians already engage in a variety of community collaborations and education activities, despite their tremendous workload. With the addition of qualified behavioral health personnel, more services can be provided.

Related Category 3 Outcome Measure(s):

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

Reasons/rationale for selecting the outcome measures:

We believe patient satisfaction that addresses involvement in shared decision making, access to providers, and better communication with providers, will reduce chronic over-use of psychiatric emergency services and in general reduce cost and improve efficiency.

Relationship to other Projects:

The proposed project is similar to several MHMRA DSRIP proposals, including the expansion of outpatient behavioral health services within other clinics (113180703.1.1, 113180703.1.4, 113180703.1.5 and 113180703.1.7) and a project which enhances the intensity of behavioral outpatient services (113180703.1.2). Extending outpatient behavioral health specialty service and increasing the intensity of these services will together ultimately provide responsive, appropriate levels of care.

The behavioral health crisis in Region 3 is considerable and the proposed initiatives in our RHP plan will only imply a small impression into the overall community need for treatment, but is a good start. The outpatient focus of many RHP Plan initiatives will help numerous facilities focus to treating the patients in an ambulatory setting as well as continued navigation of services with a focus to keeping patients from the inpatient unit. This initiative is similar to many others in the

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sense of the category of behavioral health. The Region 3 Initiative Grid attached in the addendum will show the relationship to other programs.

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

Plan for Learning Collaborative:

Consumer satisfaction with access outcomes will be assessed with input from consumer groups involving both patients and family members in the quality improvement loop. Similarly, rates of public psychiatric hospitalization will be presented to public psychiatric hospital representatives with an invitation for them to provide input on the improvement process.

Project Valuation:

In the effort to value the proposed project accurately, assistance was sought from H. Shelton Brown, Ph.D. of the UT Houston School of Public Health and Thomas Bohman, Ph.D. of the UT Austin Center for Social Work Research. Their consultation was limited to only the valuation section of this document. 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: The Texas Recommended Assessment Guidelines (Texas Department of State Health Services, 2011) established a utilization management scheme for matching patient need to service packages of varying intensities. To provide an approximation of the value of an outpatient behavioral health program, we will review studies related to each of the four service packages described below as "levels of care."

Level One: Medication only

Individuals receiving Service Package One (SP1) have been assessed to have relatively less severe symptomatology and functional impairment. Therefore, they receive medications only accompanied by service coordination. A study by Chouinard and Albright (1997) found that individuals receiving medications versus a placebo gained 7 times the quality-adjusted years than without medications (QALY = .125). The proportion of individuals recommended to Level One at MHMRA is 56.5%. Assuming the program would serve 100 persons in a year, the following formula shows the total valuation:

100	(persons served)
0.125	(QALY gained)
.565	(proportion of patients recommended to Level One)
× $50,000	(life year value)
= $353,125	Level 1 QALY Value

Level Two: Medication plus therapy

About 18.5% of patients at MHMRA are recommended to Level Two services based on moderately severe need accompanied by diagnoses of major depression. This service package includes cognitive psychotherapy for depressive disorders in addition to medications. Pyne et al. (2003) compared the cost-effectiveness of medication services to medication plus CBT for depression. Their randomized controlled trial yielded an incremental QALY of 0.041 for the addition of CBT. Assuming the program would serve 100 persons in a year, the following formula shows the total valuation:

100	(persons served)
0.041	(QALY gained)
.185	(proportion of patients recommended to Level 2)
× $50,000	(life year value)
= $37,925	Level 2 QALY Valuation

Level Three: Medications and skills training

About 24% of patients at MHMRA are recommended to Level Three services, based on higher severity symptom and functional skill impairment. This package includes medications and skills training. Barton and colleagues (2009) compared social recovery oriented cognitive behavioral therapy (SRCBT) for people diagnosed with psychosis compared to case management alone (CMA); they reported a mean incremental QALY gain of 0.035. Assuming the program would serve 100 persons in a year; the following formula shows the valuation:

100	(persons served)
0.035	(QALY gained)
0.24	(proportion of patients recommended to Level 3)
× $50,000	(life year value)
= $42,000	Level 3 QALY Value

Level Four: Assertive Community Treatment (ACT) for Persons with Serious Mental Illness

Of consumers referred for services, about 4.1% are recommended for ACT Team treatment. This level of care represents the highest intensity service intervention. A 2012 study reported the cost-effectiveness of assertive community treatment as part of integrated care versus standard care in patients with schizophrenia (Karow, Reimer, König, Heider, Bock & Huber 2012). Results indicated the ACT intervention yielded a QALY of 0.76, whereas the treatment as usual groups resulted in a QALY of 0.66. Since the treatment is being contrasted with wait list or not treatment, the full QALY (0.76) applies. The incremental QALY for the ACT group was 0.10. Assuming the program would serve 100 persons in a year the following formula shows the valuation:

100	(persons served)
0.76	(QALY gained)
0.041	Proportion of patients recommended to Level Four
× $50,000	(life year value)
= $155,800	Level 4 QALY Value

Hospitalizations
When compared to the year prior to outpatient treatment admission, MHMRA patients have averaged 1.66 fewer public psychiatric hospital bed days per person. Cost savings from these individuals from averting hospital services can be calculated as follows:

100	(persons served)
1.66	(average hospital bed days per person per year averted)
X$700	(cost of hospital day)
= $116,200	Costs saved from averted hospitalizations

Public Psychiatric Emergency Visits
When compared to the year prior to outpatient treatment admission, MHMRA patients have averaged 0.212 fewer public psychiatric emergency room visits per person. Cost savings from these individuals from averting these emergency services can be calculated as follows:

100	(persons served)
.212	(average emergency service visits per person per year averted)
X$705	(cost of hospital day)
= $14,946	Costs saved from averted hospitalizations

Mental Health Services in the County Jail
When compared to the year prior to outpatient treatment admission, MHMRA patients have averaged 0.05 fewer county jail incarcerations per person. Cost savings from averting these jail bookings can be calculated as follows:

100	(persons served)
.05	(average county jail incarcerations per person per year averted)
40.6	Average days incarcerated
X$130	(cost of jail day with mental health service)
= $26,390	Costs saved from averted hospitalizations

Valuation Summary: This valuation analysis shows that the intervention will have a positive value for participants who receive the intervention(s). Summing the estimated utilities of all four levels of care above, the expected value of this proposal is $746,386 per 100 people served per year.

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Unique Identifier: 113180703.1.6	RHP PP Reference Number: 1.12.2	Project Components: NA	Program Title: EXPANSION OF OUTPATIENT BEHAVIORAL HEALTH SERVICES FOR ADULTS WITH SEVERE PSYCHIATRIC CONDITIONS - SE
RHP Performing Provider: Mental Health and Mental Retardation Authority of Harris County		**TPI: 113180703**	
Related Category 3 Measure(s): Patient Satisfaction		**IT-6.1**	**Percent improvement over baseline of patient satisfaction scores**
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RHP Performing Provider: Mental Health and Mental Retardation Authority of Harris County		**TPI: 113180703**	
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Project Option 1.12 ENHANCE SERVICE AVAILABILITY OF APPROPRIATE LEVELS OF BEHAVIORAL HEALTH CARE: EXPANSION OF OUTPATIENT BEHAVIORAL HEALTH SERVICES FOR ADULTS WITH SEVERE PSYCHIATRIC CONDITIONS (Need based)

Unique RHP Project ID: 113180703.1.7

Performing Provider Name/TPI: MHMRA of Harris County / 113180703

Project Summary:

Provider**:** The Mental Health and Mental Retardation Authority (MHMRA) of Harris County is public agency serving as the safety net provider for adults with serious mental illnesses, for children and adolescents with serious emotional disorders, for the developmentally delayed and for individuals experiencing acute psychiatric distress. MHMRA provides inpatient, residential and outpatient treatments, including psycho-therapy, case management and medication management for individuals. MHMRA serves about 49,000 Harris County residents out of a culturally and ethnically diverse population of over 4.1 million. Of those individuals who received services in FY12, 60.0% were medically indigent and 32% had Medicaid.

Intervention(s): MHMRA aspires to place one new treatment team in the region of the city in the most need of additional services. Each treatment team can serve roughly 500 consumers.

Need for the project: Estimates place approximately 78,000 adults with severe mental illness unable to access treatment from the public or private mental health systems in Harris County. The gap between service needs of seriously mentally ill adults in the county and available public service capacity is most evident in the current waiting list of 1,641 for ongoing outpatient service. MHMRA of Harris County routinely operates at or above its state mandated, contracted service capacity, averaging about 8,800 adult consumers served each month. At this level, however, access is inadequate for many who apply for service.

Target population: Seriously mentally ill adults in an area of Harris County to be determined who are currently unable to access mental health services. It is anticipated the program will provide service for about 500 patients.

Category 1 or 2 expected patient benefits:

- Increase utilization of services to 500 patients more than baseline by DY5.
- A 10% decrease from baseline in psychiatric emergency service admissions (e.g., PES/HCPC) by DY5.

Category 3 outcomes: MHMRA expects to increase one domain of patient satisfaction (TBD) by 10% from baseline by DY5.

1.12 Enhance service availability of appropriate level of behavioral health care: Expansion of outpatient behavioral health services for adults with severe psychiatric conditions (region to be determined according to need)

RHP Project Number: 113180703.1.7
Performing Provider/TPI: Mental Health and Mental Retardation Authority of Harris County/ 113180703

Project Description:
The Mental Health and Mental Retardation Authority (MHMRA) of Harris County proposes to increase outpatient capacity to potentially eliminate the current wait list for services in this geographic area. (Region to be determined according to need)

The Mental Health and Mental Retardation Authority (MHMRA) of Harris County is a public agency serving as the safety net provider for adults with serious mental illnesses, for children and adolescents with serious emotional disorders, for the developmentally delayed and for individuals experiencing acute psychiatric distress. MHMRA serves more than 49,000 Harris County residents out of a culturally and ethnically diverse population of over 4.1 million. Of those who received mental health services in FY12, such as those being proposed in this project, 55% were medically indigent and 34.9% had Medicaid. In an effort to provide needed services to the most critically ill population, MHMRA proposes to increase outpatient capacity by approximately 500 individuals potentially eliminating the current wait list for services in this geographic area. In order to address this issue we will choose to focus on project option 1.12.2: Expand the number of community based settings where behavioral health services may be delivered in underserved areas.

It is important to note that we are proposing four similar projects, each under the 1.12.2 umbrella, which would expand outpatient behavioral health services for adults in each of our existing clinics. Because the goals and rationale are identical, the narratives will be repetitive; however, each of the expansion programs serve unique geographical needs, and therefore, each of the projects are critical to addressing the community needs.

Goals and Relationship to Regional Goals:
Goals include improving access to community mental health services by establishing additional service providers (e.g., an additional treatment team) among existing MHMRA community clinics in Harris County. Specifically, we aspire to place one new treatment team in a location to be determined based on need. Each treatment team can serve roughly 500 consumers.
The proposed project directly meets broad goals identified by the regional needs assessment. First, it improves and builds upon an existing program, which has shown positive gains in providing best-practices for patient-centered care. Furthermore, by providing enhanced, evidence-based services to patients the program will meet the regional goal set out above. Moreover, the program supports the regional goal of developing a culture of patient-centered care whereby the patient/consumer plays a more active role as a stakeholder.

Challenges:

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Workforce limitations may provide staff recruitment challenges requiring significant lead time and advanced planning. Clinic managers will work closely with human resources and administration to ensure timely staffing of the proposed treatment teams.

Expected 5-year Outcomes:

17) Staffing of the new team: 1 Psychiatrist, 1 Nurse, 1 Clinical Team Leader, 4 Licensed Practitioners of the Healing Arts, 12 Rehabilitation Clinicians, 1 Administrative Assistant, 1 Clerical Support Staff, 1 Business Office Coordinator, and 1 HIT Staff.
18) Additional need is anticipated as initiatives to reduce 30-day re-hospitalizations, preventable emergency department visits, and jail recidivism, may create additional demand.
19) Provision of outpatient mental health service has been locally documented to reduce emergency psychiatric center visits by .37 visits per person per year; it has also has been shown to reduce public psychiatric hospital use by 1.66 bed days per person per year in a sample of 25,000 outpatients (served between the years 2005 and 2012).
20) Elimination of wait lists and improved geographic access can be expected to increase access to services, improved satisfaction, and decreased intensive service use. Reductions in intensive service (#3 and #4 above) use are firmly in line with regional project goals.

In order to measure the progress towards the stated goals, we have selected improvement metrics that measure increased utilization of behavioral health (I-11.1) and decreased emergency psychiatric service use (I-X).

Starting Point/Baseline:

As mentioned previously, 8,800 consumers are served among the four existing outpatient clinics. We seek to expand the provision of services by 1 team per current location, which would serve roughly 500 people per site, and add one additional team where the most need is determined. Current clinical space will be used in addition to redesigning available MHMRA space or seeking additional space as needed to house additional staff over the DSRIP period.

Rationale:

The community mental health system in Harris County has a limited capacity for service that is insufficient to the needs of its residents. The Mental Health Needs Council of Harris County has estimated that 153,000 of the 552,000 Harris County adults with mental illness have a severe mental illness (Depression, Bipolar Disorder, and Schizophrenia). These individuals are among the 96,200 Harris County adults who have no public (Medicaid or Medicare) or private health insurance and therefore, are totally dependent on the public mental health service system for treatment. In 2007, approximately 27,000 adults received services from the public mental health system; 18,200 of these were uninsured (a number representing only 19% of estimated need). By deduction, one can conclude that approximately 78,000 adults with severe mental illness failed to access treatment from the public or private mental health systems.

The gap between service needs of seriously mentally ill adults in the county and available public service capacity is most evident in the waiting list for ongoing outpatient service. MHMRA of Harris County routinely operates at or above its state mandated, contracted service

capacity, averaging about 8,800 adult consumers served each month. At this level, however, access is inadequate for many who apply for service.

On August 31 (2012), the MHMRA waitlist for adult mental health outpatient services rested at 1,695, a level that has persisted for several years. Further, tenure on the waiting list approached five months, an average of 149.16 days. At this time, MHMRA is proposing four separate DSRIP projects that will provide additional services in each of the existing outpatient clinics and one project that will determine the area of greatest need to establish an additional team. The fifth clinic will be opened based on the regional needs of MHMRA consumers.

The rationale for requesting funding for each project is based on the aforementioned need for additional mental health services in the county, and the existing waitlist. If MHMRA were to expand only one or two of the clinics, only 400-800 new consumers could be served and the waitlist would remain in effect. Additionally, it is expected that the need for mental health services will continue to grow, and therefore, limited expansion will simply not address the current needs of those on the waitlist or the community needs of those who initiated services with MHMRA.

Unique Community Need Identification numbers:

Specific community needs are also addressed through the proposed program:

- CN3-Inadequate access to Behavioral Health
- CN6- Inadequate access to treatment and services designed for special needs populations, including disabled, homeless, children and elderly
- CN9- High rates of preventable hospital readmissions

Expansion of outpatient behavioral health services will address the community needs above by providing greater access to behavioral health care, thereby offsetting the increased use of medical and psychiatric emergency services. Furthermore, a larger behavioral health workforce within MHMRA will provide more opportunities for collaboration between providers and for patient education. MHMRA clinicians already engage in a variety of community collaborations and education activities, despite their tremendous workload. With the addition of qualified behavioral health personnel, more services can be provided.

Related Category 3 Outcome Measure(s):

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

Reasons/rationale for selecting the outcome measures:

We believe patient satisfaction that addresses involvement in shared decision making, access to providers, and better communication with providers, will reduce chronic over-use of psychiatric emergency services and in general reduce cost and improve efficiency.

Relationship to other Projects:

The proposed project is similar to several MHMRA DSRIP proposals, including the expansion of outpatient behavioral health services within other clinics (113180703.1.1, 113180703.1.4, 113180703.1.5 and 113180703.1.6) and a project which enhances the intensity of behavioral outpatient services (113180703.1.2). Extending outpatient behavioral health specialty service and increasing the intensity of these services will together ultimately provide responsive, appropriate levels of care.

The behavioral health crisis in Region 3 is considerable and the proposed initiatives in our RHP plan will only imply a small impression into the overall community need for treatment,

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but is a good start. The outpatient focus of many RHP Plan initiatives will help numerous facilities focus to treating the patients in an ambulatory setting as well as continued navigation of services with a focus to keeping patients from the inpatient unit. This initiative is similar to many others in the sense of the category of behavioral health. The Region 3 Initiative Grid attached in the addendum will show the relationship to other programs.

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

Plan for Learning Collaborative:

Consumer satisfaction with access outcomes will be assessed with input from consumer groups involving both patients and family members in the quality improvement loop. Similarly, rates of public psychiatric hospitalization will be presented to public psychiatric hospital representatives with an invitation for them to provide input on the improvement process.

Project Valuation:

In the effort to value the proposed project accurately, assistance was sought from H. Shelton Brown, Ph.D. of the UT Houston School of Public Health and Thomas Bohman, Ph.D. of the UT Austin Center for Social Work Research. Their consultation was limited to only the valuation section of this document. 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: The Texas Recommended Assessment Guidelines (Texas Department of State Health Services, 2011) established a utilization management scheme for matching patient need to service packages of varying intensities. To provide an approximation of the value of an outpatient behavioral health program, we will review studies related to each of the four service packages described below as "levels of care."

Level One: Medication only

Individuals receiving Service Package One (SP1) have been assessed to have relatively less severe symptomatology and functional impairment. Therefore, they receive medications only accompanied by service coordination. A study by Chouinard and Albright (1997) found that individuals receiving medications versus a placebo gained 7 times the quality-adjusted years than

without medications (QALY = .125). The proportion of individuals recommended to Level One at MHMRA is 56.5%. Assuming the program would serve 100 persons in a year, the following formula shows the total valuation:

100	(persons served)
0.125	(QALY gained)
.565	(proportion of patients recommended to Level One)
× $50,000	(life year value)
= $353,125	Level 1 QALY Value

Level Two: Medication plus therapy

About 18.5% of patients at MHMRA are recommended to Level Two services based on moderately severe need accompanied by diagnoses of major depression. This service package includes cognitive psychotherapy for depressive disorders in addition to medications. Pyne et al. (2003) compared the cost-effectiveness of medication services to medication plus CBT for depression. Their randomized controlled trial yielded an incremental QALY of 0.041 for the addition of CBT. Assuming the program would serve 100 persons in a year, the following formula shows the total valuation:

100	(persons served)
0.041	(QALY gained)
.185	(proportion of patients recommended to Level 2)
× $50,000	(life year value)
= $37,925	Level 2 QALY Valuation

Level Three: Medications and skills training

About 24% of patients at MHMRA are recommended to Level Three services, based on higher severity symptom and functional skill impairment. This package includes medications and skills training. Barton and colleagues (2009) compared social recovery oriented cognitive behavioral therapy (SRCBT) for people diagnosed with psychosis compared to case management alone (CMA); they reported a mean incremental QALY gain of 0.035. Assuming the program would serve 100 persons in a year; the following formula shows the valuation:

100	(persons served)
0.035	(QALY gained)
0.24	(proportion of patients recommended to Level 3)
× $50,000	(life year value)
= $42,000	Level 3 QALY Value

Level Four: Assertive Community Treatment (ACT) for Persons with Serious Mental Illness

Of consumers referred for services, about 4.1% are recommended for ACT Team treatment. This level of care represents the highest intensity service intervention. A 2012 study reported the cost-effectiveness of assertive community treatment as part of integrated care versus standard care in patients with schizophrenia (Karow, Reimer, König, Heider, Bock & Huber 2012). Results indicated the ACT intervention yielded a QALY of 0.76, whereas the treatment as usual groups resulted in a QALY of 0.66. Since the treatment is being contrasted with wait list or

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not treatment, the full QALY (0.76) applies. The incremental QALY for the ACT group was 0.10. Assuming the program would serve 100 persons in a year the following formula shows the valuation:

100 (persons served)
0.76 (QALY gained)
0.041 Proportion of patients recommended to Level Four
× $50,000 (life year value)
= $155,800 Level 4 QALY Value

Hospitalizations

When compared to the year prior to outpatient treatment admission, MHMRA patients have averaged 1.66 fewer public psychiatric hospital bed days per person. Cost savings from these individuals from averting hospital services can be calculated as follows:

100 (persons served)
1.66 (average hospital bed days per person per year averted)
X$700 (cost of hospital day)
= $116,200 Costs saved from averted hospitalizations

Public Psychiatric Emergency Visits

When compared to the year prior to outpatient treatment admission, MHMRA patients have averaged 0.212 fewer public psychiatric emergency room visits per person. Cost savings from these individuals from averting these emergency services can be calculated as follows:

100 (persons served)
.212 (average emergency service visits per person per year averted)
X$705 (cost of hospital day)
= $14,946 Costs saved from averted hospitalizations

Mental Health Services in the County Jail

When compared to the year prior to outpatient treatment admission, MHMRA patients have averaged 0.05 fewer county jail incarcerations per person. Cost savings from averting these jail bookings can be calculated as follows:

100 (persons served)
.05 (average county jail incarcerations per person per year averted)
40.6 Average days incarcerated
X$130 (cost of jail day with mental health service)
= $26,390 Costs saved from averted hospitalizations

Valuation Summary: This valuation analysis shows that the intervention will have a positive value for participants who receive the intervention(s). Summing the estimated utilities of all four levels of care above, the expected value of this proposal is $746,386 per 100 people served per year.

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Unique Identifier: 113180703.1.7	RHP PP Reference Number: 1.12.2	Project Components: NA	Program Title: EXPANSION OF OUTPATIENT BEHAVIORAL HEALTH SERVICES FOR ADULTS WITH SEVERE PSYCHIATRIC CONDITIONS - NEEDS BASED
RHP Performing Provider: Mental Health and Mental Retardation Authority of Harris County		**TPI: 113180703**	
Related Category 3 Measure(s): Patient Satisfaction		**IT-6.1**	**Percent improvement over baseline of patient satisfaction scores**
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Milestone 1: P-2. Identify licenses, equipment requirements and other components needed to implement and operate options selected. **Metric 1: P-2.5.1** Develop a project plan and timeline detailing operational needs and equipment and components **Data Source:** Written Project Plan	**Milestone 3: P-6:** Establish behavioral health services in new community-based settings in underserved areas **Metric 1: P-6.1** Number of new community-based settings where behavioral health services are delivered **Data Source**: Project documentation and MHMRA records **Goals:** Provide documentation of patients being served by new treatment team	**Milestone 6: I-11:** Increased utilization of community behavioral healthcare **Metric 1: I-11.1** Percent utilization of community behavioral healthcare services. **Data Source**: MHMRA records **Goal:** Serve 250 patients more than baseline	**Milestone 8: I-11:** Increased utilization of community behavioral healthcare **Metric 1: I-11.1** Percent utilization of community behavioral healthcare services. **Data Source**: MHMRA records **Goal:** Serve 500 patients more than baseline
Estimated Incentive Payment: $1,493,333.075	**Estimated Incentive Payment: $1,094,430.09**	**Estimated Incentive Payment: $1,754,273.38**	**Estimated Incentive Payment: $1,694,950.12**

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Unique Identifier: 113180703.1.7	RHP PP Reference Number: 1.12.2	Project Components: NA	Program Title: EXPANSION OF OUTPATIENT BEHAVIORAL HEALTH SERVICES FOR ADULTS WITH SEVERE PSYCHIATRIC CONDITIONS - NEEDS BASED
RHP Performing Provider: Mental Health and Mental Retardation Authority of Harris County		**TPI: 113180703**	
Related Category 3 Measure(s): Patient Satisfaction		**IT-6.1**	**Percent improvement over baseline of patient satisfaction scores**
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 2: P-4: Hire and train staff to operate and manage project **Metric 1: P-4.1**: Number of staff secured and trained **Data Source:** HR records **Goal:** hire staff for one additional treatment team	**Milestone 4:** I-11 Increased utilization of community behavioral healthcare **Metric 1:** I-11.1 Percent utilization of community behavioral healthcare services. **Data Source:** MHMRA records **Goal:** establish baseline	**Milestone 7:** I-X. Psychiatric Emergency Service (PES) Admissions and Inpatient Psych. Admissions **Metric 1:** I-X.1. Percent of individuals who were admitted to inpatient facilities. **Data Source:** MHMRA and HCPC records **Goal:** A 5% decrease from baseline in PES/HCPC admissions	**Milestone 9:** I-X. Psychiatric Emergency Service (PES) Admissions and Inpatient Psych. Admissions **Metric 1:** I-X.1. Percent of individuals who were admitted to inpatient facilities. **Data Source:** MHMRA and HCPC records **Goal:** A 10% decrease from baseline in PES/HCPC admissions
Estimated Incentive Payment: $1,493,333.075	**Estimated Incentive Payment: $1,094,430.09**	**Estimated Incentive Payment: $1,754,273.38**	**Estimated Incentive Payment: $1,694,950.12**

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Unique Identifier: 113180703.1.7	RHP PP Reference Number: 1.12.2	Project Components: NA	Program Title: EXPANSION OF OUTPATIENT BEHAVIORAL HEALTH SERVICES FOR ADULTS WITH SEVERE PSYCHIATRIC CONDITIONS - NEEDS BASED
RHP Performing Provider: Mental Health and Mental Retardation Authority of Harris County		**TPI: 113180703**	
Related Category 3 Measure(s): Patient Satisfaction		**IT-6.1**	**Percent improvement over baseline of patient satisfaction scores**
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	Milestone 5: I-X. Psychiatric Emergency Service (PES) Admissions and Inpatient Psych. Admissions **Metric 1**: I-X.1. Percent of individuals who were admitted to inpatient facilities. **Data Source**: Psychiatric Emergency Services (PES) records are part of the MHMRA electronic record. Harris County Psychiatric Center (HCPC) is the local public psychiatric inpatient unit which maintains separate records **Goal:** Establish baseline		
	Estimated Incentive Payment: $1,094,430.09		
Year 2 Estimated Milestone Bundle Amount: $2,986,666.15	**Year 3 Estimated Milestone Bundle Amount: $3,283,290.27**	**Year 4 Estimated Milestone Bundle Amount: $3,508,546.76**	**Year 5 Estimated Milestone Bundle Amount: $3,389,900.24**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $13,168,403.42			

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Mental Health and Mental Retardation Authority of Harris County

Pass 2

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Project Option 1.13.1: Develop and implement crisis stabilization services to address the identified gaps in the current community crisis system- Interim Care Clinic

RHP Project ID: 113180703.1.8 / Pass 2
Provider / TPI: Mental Health and Mental Retardation Authority of Harris County / 113180703

Project Summary:

Provider:
The Mental Health and Mental Retardation Authority (MHMRA) of Harris County is public agency serving as the safety net provider for adults with serious mental illnesses, for children and adolescents with serious emotional disorders, for the developmentally delayed and for individuals experiencing acute psychiatric distress. MHMRA provides inpatient, residential and outpatient treatments, including psycho-therapy, case management and medication management for individuals. MHMRA serves more than 49,000 Harris County residents out of a culturally and ethnically diverse population of over 4.1 million. Of those individuals who received any agency service in FY12, 36.5% were medically indigent and 51.9% had Medicaid. Of those who received psychiatric emergency services in FY12, such as those being proposed in this project, 59.3% were medically indigent and 28.7% had Medicaid.

Intervention(s):
The Interim Care Clinic (ICC) is designed to provide initial evaluation and treatment in a single visit. The clinic will include extended evening hours and availability seven days a week.

Need for the project:
Although MHMRA routinely operates at or above its state mandated, contracted service capacity, averaging about 8,800 adult consumers served each month, there remains a significant waiting list for services. As of August 31, 2012 the waitlist for adult mental health outpatient services rested at 1,695, a level that has persisted for several years. Furthermore, tenure on the waiting list approached five months, an average of 149.16 days.

Target population:
The program targets individuals presenting at the MHMRA Psychiatric Emergency Service (PES) voluntarily, who are not in acute crisis, but who are in urgent need of assessment and treatment to avoid further deterioration of their psychiatric condition. It is anticipated the program will provide service for about 1100 patients.

Category 1 or 2 expected patient benefits:
MHMRA will:

- decrease inpatient admissions by 10% from baseline
- increase cost savings amount by amount TBD

Category 3 outcomes:
MHMRA expects to increase one domain of patient satisfaction (TBD) by 10% from baseline by DY5.

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1.13.1- Develop and implement crisis stabilization services to address the identified gaps in the current community crisis system: Interim Care Clinic

RHP Project Number: 113180703.1.8 / Pass 2

Provider/TPI: Mental Health and Mental Retardation Authority of Harris County/ 113180703

The Mental Health and Mental Retardation Authority (MHMRA) of Harris County is public agency serving as the safety net provider for adults with serious mental illnesses, for children and adolescents with serious emotional disorders, for the developmentally delayed and for individuals experiencing acute psychiatric distress. MHMRA provides inpatient, residential and outpatient treatments, including psycho-therapy, case management and medication management for individuals. MHMRA serves more than 49,000 Harris County residents out of a culturally and ethnically diverse population of over 4.1 million. Of those individuals who received any agency service in FY12, 36.5% were medically indigent and 51.9% had Medicaid. Of those who received psychiatric emergency services in FY12, such as those being proposed in this project, 59.3% were medically indigent and 28.7% had Medicaid. With regard to income, 88% report family size and annual income placing them at or below 133% of 2012 Federal Poverty Level Guidelines. Only 5.2% of the agency's clientele report incomes above 100% of FPL. Harris County's ethnic diversity is reflected in the population served. Agency consumers self-describe the following ethnic backgrounds: African-Americans (34.5%), Anglos (27.1%), persons of Hispanic heritage (26.6%), Asian-Americans (2.8%) and those reporting other ethnicities (0.4%).

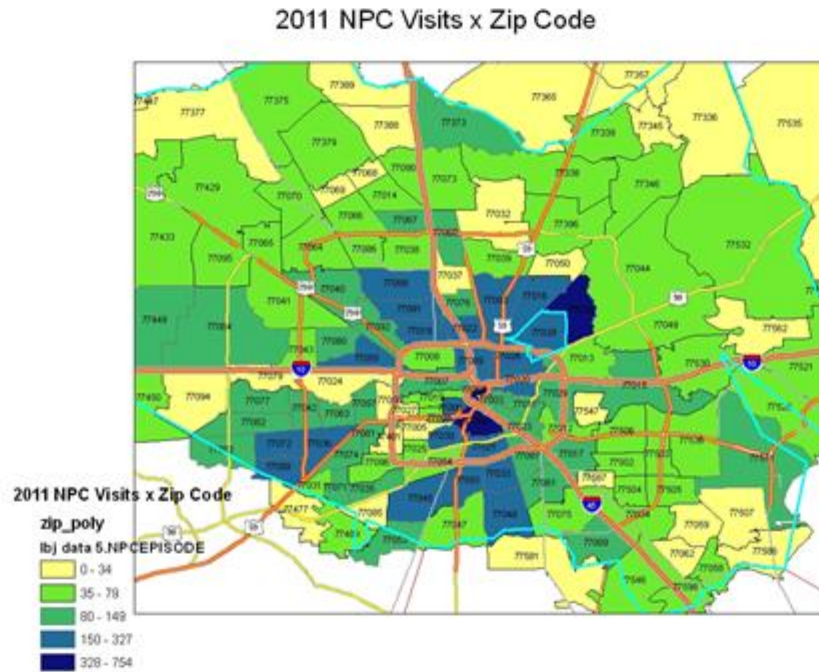
Project Description: The Interim Care Clinic (ICC) is designed to provide initial evaluation and treatment to individuals presenting at the MHMRA Psychiatric Emergency Service (PES) voluntarily, who are not in acute crisis, but who are in urgent need of assessment and treatment to avoid further deterioration of their psychiatric condition. These individuals are diverted from admission to the PES and offered a same day evaluation with an interim care clinic psychiatrist. The clinic is designed to be a single visit clinic and no return or follow-up appointments are given, although patients my return if needed. The project proposes to have the clinic available seven days a week, including extended evening hours.

Project Goals: The goals are to provide a community-based alternative for urgent psychiatric care, reduce unnecessary inpatient hospitalizations, reduce general hospital emergency room admissions for behavioral health emergencies, improve access to treatment for individuals in crisis, and utilize the least restrictive means of stabilizing and treating consumers.

Anticipated Challenges: The primary challenge is linkage to ongoing care. This challenge will be addressed through stakeholder meetings with other behavioral health care providers and expansion of outpatient behavioral health services. Additionally, linkage is addressed in other MHMRA DSRIP proposals.

The 5-year expected outcome(s): The expected 5 year outcome is to have a fully functional interim care clinic capable of serving up to 300 patients a month. Additionally, we expect to see a decrease in crisis services for patients receiving ICC services. Although they may be in urgent need, they may be stabilized prior to an emergent episode, and thus remain in the community. These goals are consistent with the regional and community needs as discussed below.

Table 1. Neuropsychiatric (Emergency) Center Visits by Zip Code of Residence



<u>Baseline:</u> There is currently no publicly funded interim care service provided through MHMRA of Harris County. Individuals who are in urgent need of psychiatric assessment and treatment are treated in the MHMRA Psychiatric Emergency Service (PES) located at Neuropsychiatric Center (NPC). Due to the overwhelming need for these services, the current PES has often been forced for health and safety reasons and elevated risk, to delay registration of those seeking voluntary admission to the program, or to divert law enforcement to other scarce psychiatric resources in the community. An interim care clinic would allow a portion of those seeking voluntary treatment to be directed to a less expense and restrictive alternative.

<u>Rationale:</u> While MHMRA has implemented several crisis alternatives, there is still an overwhelming need to provide psychiatric evaluation and treatment for those in urgent need. The current MHMRA Psychiatric Emergency Services has seen a marked increase in admissions since 2008. In 2008 there were 10,998 admissions; in 2011 that number rose to 16,334 admissions, an increase of 49%. The number brought to the unit by law enforcement also increased by 42% during that same time frame. The only other public hospital psychiatric crisis access is through Ben Taub Hospital. For a population of 4.2 million people, two access points are not adequate to fill the need to address both urgent and emergent crisis services.

Below is a map of the visits to the MHMRA Psychiatric Emergency Service located at NPC. The gap between service needs of seriously mentally ill adults in the county and available public service capacity is most evident in the waiting list for ongoing outpatient service. MHMRA of Harris County routinely operates at or above its state mandated, contracted service capacity, averaging about 8,800 adult consumers served each month. At this level, however, access is poor for many who apply for service. On August 31, the waitlist for adult mental health outpatient services rested at 1,695, a level that has persisted for several years. Further, tenure on the waiting list approached five months, an average of 149.16 days.

1.13.1 Core Components

In order to develop such a program, the following option (1.13.1) and core components were chosen:

a) Convene community stakeholders who can support the development of psychiatric urgent care services to update the gap analysis of the current community crisis system and revise a specific action plan to address identified gaps.
   - In progress. MHMRA convenes regularly with Harris County Psychiatric Center in a Joint Quality Council. MHMRA is also a member of the Harris County Mental Health Needs Council, where issues pertaining to gaps and needs of the community are discussed. Also, a pilot project resulted in outcomes that indicate an Interim Care Clinic can have a significant impact on reduction of penetration further into costly emergency services. .

b) Analyze the current system of crisis stabilization services available in the community including capacity of each service, current utilization patterns, eligibility criteria and discharge criteria for each service.
   - Already completed. MHMRA produces monthly reports on crisis stabilization services available within the agency, and has eligibility criteria and discharge criteria for each service.

c) Assess the behavioral health needs of patients currently receiving crisis services in the jails, EDs, or psychiatric hospitals. Determine the types and volume of services needed to resolve crises in community-based settings. Then update the gap analysis that will result in a data-driven plan to further refine the crisis stabilization initiative of interim care clinics that will meet the behavioral health needs of the patients. This will build upon the DSHS Crisis Redesign process.
   - A recent pilot project resulted in outcomes that indicate an Interim Care Clinic can have a significant impact on reduction of penetration further into costly emergency services.

d) Explore potential crisis alternative service models and determine an acceptable and feasible program design for implementation.

- This has already been done through DSHS Crisis Redesign and through a pilot project that resulted in positive outcomes on hospital diversion by utilizing an Interim Care model.

e) Review the intervention(s) impact on access to and quality of behavioral health crisis stabilization services and identify "lessons learned," opportunities to scale all or part of the intervention(s) to a broader patient population, and identify key challenges associated with expansion of the intervention(s), including special considerations for safety-net populations
   - To be completed. MHMRA will work with the outcomes department and key stakeholders to review impact and access, identify challenges and refine the intervention strategies.

Regional and Community Needs: This project directly meets broad goals identified by the regional needs assessment. First, it improves on existing programs and infrastructure by filling a void that is unmet by existing psychiatric outpatient clinics and psychiatric emergency services. Second, it increases access to specialty care services by providing treatment in an additional Houston location. The program also offers a preventative, patient-centered approach that provides brief psychiatric care to those in urgent need. The proposed program will also complement the regional need to develop a culture of "best practices" whereby the patient plays a more active role as a stakeholder by completing patient satisfaction surveys.

Unique Community Need Identification numbers: The Interim Care Clinic will address the following community needs:

- CN2-Insuffcient Access to Behavioral Health
- CN5- Integrated Care for Behavioral Health
- CN12- Improved Access to Patient Education
- CN14-Reduction of ER Services

The metrics chosen to assess our progress toward meeting our overall goals were specifically designed to measure the reduction in PES/HCPC use and the costs associated with meeting such a goal (see Milestone and Metrics chart).

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

IT-6.1 Percent improvement over baseline of patient satisfaction scores

Reasons/rationale for selecting the outcome measure:

Measurement of patient satisfaction is a key indicator of patient-centered care and has been targeted as a quality indicator by national organizations dedicated to improvement in patient outcomes, e.g. the National Council for Quality Assurance. Furthermore, if patients and their family are satisfied with services then we can assume they are being provided for adequately. On

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the other hand, if patients are dissatisfied having an avenue to express their concerns is important to empowering our clients.

Relationship to other Projects: At this time there is not enough information available from the RHP to describe how this project may or may not be related to other RHP DSRIP proposals. However, the proposed project is similar to several MHMRA DSRIP proposals, including the expansion of the Crisis Residential Unit, expansion of the Chronic Consumer Stabilization Initiative. All three proposals seek to expand psychiatric stabilization while reducing inpatient admissions. It is hoped that many of the Interim Care patients could access these less restrictive and more appropriate care levels in lieu of hospitalization. Also, this project will interface with the expansion of outpatient mental health clinic services, the collaborative primary medical and behavioral health care, and with integrating substance abuse treatment services into mental health services by referring individuals into the appropriate ongoing care alternative.

Relationship to other Projects in the RHP: Numerous community needs assessments reflect an extreme need for behavioral health services to include outpatient treatment centers, crisis stabilization units, inpatient beds, and much more. The lack of funding as well as complexity of the regions patient base has limited the amount of behavioral health treatments available to our region and continues to drive cost in emergent and inpatient situations. The Crisis Stabilization Unit has a direct correlation to all behavioral health programs recommended in the RHP plan and will be a focus of two of the largest Local Mental Health Authorities of our region. Both CSU's share the outcome measures of mental health admissions & readmissions, and improvement of patient satisfaction scores. The Region 3 Initiative Grid attached in the addendum reflects the direct relationships of this initiative.

Plan for Learning Collaborative: We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region’s healthcare system.

Project Valuation: In the effort to value the proposed project accurately, assistance was sought from H. Shelton Brown, Ph.D. of the UT Houston School of Public Health and Thomas Bohman, Ph.D. of the UT Austin Center for Social Work Research. Their consultation was limited to only the valuation section of this document. 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

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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: When comparing this expansion of Interim Care Clinic capacity to current service strategies, the project can best be likened to an innovative model for delivering medication only services, a strategy most similar to Level One of the current utilization management scheme. Individuals receiving service package one care are often prescribed psychotropic medication, but do not receive therapy. One QALY-related study (Chouinard & Albright, 1997) found individuals with schizophrenia receiving medications versus a placebo gained, on average, seven times the quality-adjusted years than without medications (QALY = .087). Furthermore, Schoenbaum, M., Miranda, J., Sherbourne, C., Duan, N., & Wells, K. (2004 found depressed patients who received medications improved to an average QALY of .0148 compared to those with no medications. Averaging these QALYs together results in a QALY of .0509 for receiving medications compared to not receiving medications.

Assuming the program would serve 100 patients a year:

100	(persons served)
0.0509	(QALY gained)
× $50,000	(life year value)
= $254,500	**Level 1 QALY Value**

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. We used local information to describe cost-savings. In the year prior to contact with the interim clinic there were a total of 52 hospitalizations at HCPC and 453 individuals admitted to NPC. After the first interim clinic visit, no HCPC or NPC visits were logged by this sample. Care at the Interim Care Clinic produced a reduction in hospitalizations at

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HCPC by 4.7% and NPC visits by 50.8%. Based on this information we can calculate the cost savings as follows:

100	Number of Consumers Served
.047	Percent of Reduction in Hospitalization
10.25	Average length of stay at HCPC
x $700	Per diem cost of HCPC
$33,722.50	**Hospital Savings 1**

100	Number of Emergency Psychiatric Visits
0.508	Percent of Reduction in Emergency Psychiatric Visits
x $700	Per visit cost: Psychiatric Emergency Care
$35,560.00	**Hospital Savings 2**

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 **$323,783** per 100 patients served based on the QALY estimate and cost savings (**$254,500+ 33,722.50** + **$35,560.00**). This concludes the valuation for the proposed project.

Unique Identifier: 113180703.1.8	RHP PP Reference Number: 1.13.1	Project Components: 1.13.1a, 1.13.1b, 1.13.1c, 1.13.1d, 1.13.1e	Program Title: INTERIM CARE CLINIC
RHP Performing Provider: Mental Health and Mental Retardation Authority of Harris County		**TPI: 113180703**	
Related Category 3 Outcome Measure(s): Patient Satisfaction Survey	**113180703.3.15**	**Improvement Target: Percent improvement over baseline of patient satisfaction scores**	**1.13.1: Develop and Implement Crisis Stabilization**
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Milestone 1: P-2: Review mapping and gap analysis of current crisis system **Metric 1: P.2.1** Produce a written analysis of community needs for crisis services. **Data Source**: Written plan	**Milestone 3: P-4:** Hire and train staff to implement the interim care clinic **Metric 3**: P-4.1 Number of staff hired. **Goal:** At least 50% of staff will be hired/ trained by the end of Y3. **Data Source:** Human Resource Records	**Milestone 6: P-6.** Evaluate and continuously improve crisis services **Metric 6: P-6.1.** Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles **Data Source:** Quarterly Reports	**Milestone 9: P-12.** Evaluate and continuously improve crisis services **Metric 9: P-6.1.** Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles **Data Source:** Quarterly Reports
Estimated Incentive Payment:	**Estimated Incentive Payment:**	**Estimated Incentive Payment:**	**Estimated Incentive Payment:**
$1,393,792.72	**$1,042,845.82**	**$1,128,505.53**	**$1,086,483.64**
Milestone 2: P-3: Develop implementation plans for needed psychiatric interim care clinic capacity	**Milestone 4: P-5:** Review and refine administration of operational protocols and clinical guidelines for an interim care clinic	**Milestone 7: I-X.** Psychiatric Emergency Service (PES) Readmissions and Inpatient Public Hospital Admissions **Metric 7: I-X.1**	**Milestone 10: I-X**. Psychiatric Emergency Service (PES) Readmissions and Inpatient Public Hospital Admissions **Metric :10 I-X.1**

Unique Identifier: 113180703.1.8	RHP PP Reference Number: 1.13.1	Project Components: 1.13.1a, 1.13.1b, 1.13.1c, 1.13.1d, 1.13.1e	Program Title: INTERIM CARE CLINIC
RHP Performing Provider: Mental Health and Mental Retardation Authority of Harris County		**TPI: 113180703**	
Related Category 3 Outcome Measure(s): Patient Satisfaction Survey	**113180703.3.15**	**Improvement Target: Percent improvement over baseline of patient satisfaction scores**	**1.13.1: Develop and Implement Crisis Stabilization**
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Metric 2: P-3.1 Produce data-driven written action plan for development of specific interim care clinic capacity based on gap analysis and assessment of needs. **Data Source:** Written plan	**Metric 4: P-5.1** Completion of policies and procedures.**Data Source:** Written policy and operations manuals.	Number of inpatient admissions at PES/HCPC **Goal:** decrease inpatient admissions by 5% from baseline a. Numerator: number of patients receiving ICC services admitted to PES/HCPC b. Denominator: The number of patients **Data Source:** MHMRA and public psych hospital records	Number of inpatient admissions at PES/HCPC **Goal:** decrease inpatient admissions by 10% from baseline a. Numerator: number of patients receiving ICC services admitted to PES/HCPC b. Denominator: The number of patients **Data Source:** MHMRA and public psych hospital records
Estimated Incentive Payment:	**Estimated Incentive Payment: $**	**Estimated Incentive Payment: $**	**Estimated Incentive Payment: $**
$1,393,792.72	**$1,042,845.83**	**$1,128,505.53**	**$1,086,483.64**
N/A	**Milestone 5: I-X.** Psychiatric Emergency Service (PES) Readmissions and Inpatient Public Hospital Admissions	**Milestone 8: I-11.** Costs avoided by using lower cost settings **Metric: 8: I-11.1** Costs avoided by comparing utilization of lower cost	**Milestone 11: I-11.** Costs avoided by using lower cost settings **Metric: 11**: I-11.1 Costs avoided by comparing utilization of lower cost

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Unique Identifier: 113180703.1.8	RHP PP Reference Number: 1.13.1	Project Components: 1.13.1a, 1.13.1b, 1.13.1c, 1.13.1d, 1.13.1e	Program Title: INTERIM CARE CLINIC
RHP Performing Provider: Mental Health and Mental Retardation Authority of Harris County		**TPI: 113180703**	
Related Category 3 Outcome Measure(s): Patient Satisfaction Survey	**113180703.3.15**	**Improvement Target: Percent improvement over baseline of patient satisfaction scores**	**1.13.1: Develop and Implement Crisis Stabilization**
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
	Metric 5: I-X.1 Number of inpatient admissions at PES/HCPC for ICC **Goal:** Establish baseline **Data Source:** MHMRA and public psych hospital records	alternative settings with higher cost settings (ICC versus PES/inpatient hospitals) a. Numerator: average cost of services for ICC patients b. Denominator: Total average cost for crisis care to individuals in the regional partnership study area. **GOAL:** establish baseline cost savings **Data Source:** Records from MHMRA, public hospital, & jail	alternative settings with higher cost settings (ICC versus PES/inpatient hospitals) a. Numerator: Average cost of services for ICC patients b. Denominator: Total average cost for crisis care to individuals in the regional partnership study area. **GOAL:** increase cost savings amount TBD **Data Source:** Records from MHMRA, public hospital, & jail
N/A	**Estimated Incentive Payment:**	**Estimated Incentive Payment:**	**Estimated Incentive Payment:**
N/A	**$1,042,845.83**	**$1,128,505.54**	**$1,086,483.65**
Year 2 Est. Bundle Amount:2,787,585.44	**Year 3 Est. Bundle Amount: $3,128,537.48**	**Year 4 Est. Bundle Amount: $3,385,516.60**	**Year 5 Est. Bundle Amount: $3,259,450.93**

Unique Identifier: 113180703.1.8	**RHP PP Reference Number: 1.13.1**	**Project Components: 1.13.1a, 1.13.1b, 1.13.1c, 1.13.1d, 1.13.1e**	**Program Title: INTERIM CARE CLINIC**
RHP Performing Provider: Mental Health and Mental Retardation Authority of Harris County		**TPI: 113180703**	
Related Category 3 Outcome Measure(s): Patient Satisfaction Survey	**113180703.3.15**	**Improvement Target: Percent improvement over baseline of patient satisfaction scores**	**1.13.1: Develop and Implement Crisis Stabilization**
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
TOTAL EST. INCENTIVE PAYMENTS FOR 4-DY: $12,561,090.45			

Mental Health and Mental Retardation Authority of Harris County

Pass 3

Project Option 1.12 ENHANCE SERVICE AVAILABILITY OF APPROPRIATE LEVELS OF BEHAVIORAL HEALTH CARE: Clubhouse

RHP Project ID: 113180703.1.9 / Pass 3
Provider / TPI: Mental Health and Mental Retardation Authority of Harris County / 113180703

Project Summary:
Provider: The Mental Health and Mental Retardation Authority (MHMRA) of Harris County is public agency serving as the safety net provider for adults with serious mental illnesses, for children and adolescents with serious emotional disorders, for the developmentally delayed and for individuals experiencing acute psychiatric distress. We will be contracting St. Joseph's House to provide psychosocial rehabilitative services. St Joseph House is an accredited Clubhouse and adheres to the standards of the International Center for Clubhouse Development (ICCD).

Intervention(s): The intervention is the ICCD Clubhouse Model, which is a day treatment program for psychosocial rehabilitation of adults diagnosed with a serious and persistent, chronically disabling mental health problem.

Need for the project: Estimates place approximately 78,000 adults with severe mental illness unable to access treatment from the public or private mental health systems in Harris County. The gap between service needs of seriously mentally ill adults in the county and available public service capacity is most evident in the current waiting list of 1,641 for ongoing outpatient service. MHMRA of Harris County routinely operates at or above its state mandated, contracted service capacity, averaging about 8,800 adult consumers served each month. At this level, however, access is inadequate for many who apply for service. At present, St. Joseph House is the sole provider of service of this type in Harris County. The current St. Joseph House capacity is limited to 60 active members.

Target population: Seriously mentally ill adults in Harris County with social and vocational functional impairments.

Category 1 or 2 expected patient benefits:

- Increase utilization of services to 209 patients more than baseline by DY5.
- A 10% decrease from baseline in intensive psychiatric and jail service admissions/bookings (i.e. psychiatric hospital, psychiatric emergency department, jail) by DY5.

Category 3 outcomes: MHMRA expects to increase one domain of patient satisfaction (TBD) by 10% from baseline by DY5.

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

RHP Project Number: 113180703.1.9/Pass 3

Provider/TPI: Mental Health and Mental Retardation Authority of Harris County/ 113180703

Project Description:

The Mental Health and Mental Retardation Authority (MHMRA) of Harris County is public agency serving as the safety net provider for adults with serious mental illnesses, for children and adolescents with serious emotional disorders, for the developmentally delayed and for individuals experiencing acute psychiatric distress. MHMRA provides inpatient, residential and outpatient treatments, including psycho-therapy, case management and medication management for individuals. MHMRA serves more than 49,000 Harris County residents out of a culturally and ethnically diverse population of over 4.1 million. Of those individuals who received any agency service in FY12, 36.5% were medically indigent and 51.9% had Medicaid. Of those who received psychiatric emergency services in FY12, such as those being proposed in this project, 59.3% were medically indigent and 28.7% had Medicaid. With regard to income, 88% report family size and annual income placing them at or below 133% of 2012 Federal Poverty Level Guidelines. Only 5.2% of the agency's clientele report incomes above 100% of FPL. Harris County's ethnic diversity is reflected in the population served. Agency consumers self-describe the following ethnic backgrounds: African-Americans (34.5%), Anglos (27.1%), persons of Hispanic heritage (26.6%), Asian-Americans (2.8%) and those reporting other ethnicities (0.4%).

MHMRA will be contracting with St. Joseph House to provide psychosocial rehab services. St Joseph House is an accredited Clubhouse and adheres to the standards of the International Center for Clubhouse Development (ICCD). The ICCD Clubhouse Model is a day treatment program for rehabilitating adults diagnosed with a serious and persistent mental health problem. The goal of the program is to contribute to the recovery of individuals through use of a therapeutic environment that includes responsibilities within the Clubhouse (e.g., clerical duties, reception, food service, transportation, financial services), as well as through outside employment, education, meaningful relationships, housing, and an overall improved quality of life. Individuals who participate in the Clubhouse are called "members." Fundamental elements of their participation include openness and choice in type of work activities, choice in staff, and a lifetime right of reentry and access to all Clubhouse services.

Each individual is welcomed, wanted, needed, and expected each day and is considered a critical part of a community engaged in important work. A core component of the program is the "work-ordered day," the structure around which daily activity is organized. The day-to-day operation of the Clubhouse is the responsibility of members and staff, who work side by side in a rehabilitative environment. Other core components include transitional, supported, and independent employment through which members can secure jobs at prevailing wages in the

wider community; access to community support, such as housing and medical services; assistance in accessing educational resources; "reach-out" to maintain contact with all active members; participation in program decision-making and governance; and evening, weekend, and holiday social programs.

St Joseph House staff who function as generalists maintain a caseload including managing employment placements, housing issues, and access to community supports. They also are responsible for the ongoing work of the Clubhouse and help organize and participate in social activities. Staff have diverse life experiences and backgrounds in a variety of disciplines, including psychology, counseling, social work, and education. Clubhouse members do not pay dues or membership fees. Their attendance is voluntary, and they can participate as little or as much as they choose. Because the membership of the St. Joseph's House is fluid there are three methods for describing service output. First, there are daily attendees whose numbers are limited by the number of available staff, as reflected in average daily visits. Second, there are active members who have attended services within the past 3 months. Generally, there are twice as many active members as attend on an average day. And last, there are permanent members who have been active within the past year, a number generally several times the active membership. St Joseph House is the only program in Houston accredited by the ICCD.

The current proposal has two ways in which it will expand psycho-social rehabilitation for the mental health community in Harris County. First, the current St. Joseph House will add 4 additional staff in order to expand current service capability from 60 daily attendees to 90. Second, a new location will be opened that will have a service capacity of 30 daily member visits. In order to address this issue we will choose to focus on **project option 1.12.2:** Expand the number of community based settings where behavioral health services may be delivered in underserved areas.

Goals and Relationship to Regional Goals:

Project Goals**:**

The goals of the program will be to help individuals who have a chronic mental illness, and many of whom are homeless, develop vocational skills, engage in employment related activities, develop linkages to assist with housing, and medical and dental care. The hope is to enable individuals with chronic mental illness to become productive members of the community.

Related to the following Regional Goals:

The proposed project directly meets broad goals identified by the regional needs assessment. First, it improves and builds upon an existing program, which has shown positive gains in providing best-practices for patient-centered care. Furthermore, by providing enhanced, evidence-based services to patients the program will meet the regional goal set out above. Moreover, the program supports the regional goal of developing a culture of patient-centered care whereby the patient/consumer plays a more active role as a stakeholder.

Expected 5-year Outcomes: The five year goal is to enhance service availability at the original location and open a second location of the ICCD model Clubhouse program tailored to serve at least a combined 209 permanent members per year with chronic mental illness. The milestones

we selected to measure our progress toward this goal are to reduce unnecessary inpatient hospitalizations, reduce criminal recidivism, and to increase employment among participants.

Rationale:
The "Clubhouse" model of rehabilitation is well-researched method of psychiatric rehabilitation, successfully implemented for more than sixty years (Fountain House, 1999, Bond et al. 1984, Bond et al. 1995). The model provides vocationally oriented rehabilitation opportunities for its members in a normalized social setting where members with serious mental illness may pursue recovery-oriented goals. These programs have proven effective in reducing the demoralization typically attendant to serious and persistent mental illness and have been found to reduce member's use of intensive services such as psychiatric hospitalization and jail bookings (Johnson & Hickey, 1999). Psychosocial rehabilitation and vocational rehabilitation using the ICCD Clubhouse Model, including work-oriented programs in-house and opportunities to work for money in the community. A major goal of this model is also to help consumers reach their highest level of independence.

The community mental health system in Harris County has a limited capacity for service that is insufficient to the needs of its residents. The Mental Health Needs Council of Harris County has estimated that 153,000 of the 552,000 Harris County adults with mental illness have a *severe* mental illness (Depression, Bipolar Disorder, and Schizophrenia). These individuals are among the 96,200 Harris County adults who have no public (Medicaid or Medicare) or private health insurance and therefore, are totally dependent on the public mental health service system for treatment. In 2007, approximately 27,000 adults received services from the public mental health system; 18,200 of these were uninsured (a number representing only 19% of estimated need). By deduction, one can conclude that approximately 78,000 adults with severe mental illness failed to access treatment from the public or private mental health systems. The rate of unemployment among MHMRA adult clients with serious mental illness is estimated at 81%.

St. Joseph House is currently the only Harris County provider of clubhouse model psychosocial rehabilitation services.

Baseline/Starting Point: Currently, MHMRA does not have a psychosocial rehabilitation program. However, the St. Joseph House currently has one location that serves 120 permanent members, and about 60 individuals who attend daily. A site for the second location of the St. Joseph's House program has not been identified yet.

Anticipated Challenges: Locating a site and establishing a new location is a challenge due to the needs of the program; however, modifications can be made to the facility as needed.

Unique Community Need Identification numbers: Specific community needs are also addressed through the proposed program:

- CN3-Inadequate access to Behavioral Health Care
- CN6- Inadequate access to treatment and services designed for special needs populations, including disabled, homeless, children and elderly
- CN9- High rates of preventable hospital readmissions

Relation between Project Choices and Community Needs: Expansion of outpatient behavioral health services will address the community needs above by providing greater access to behavioral health care, thereby offsetting the increased use of costly, intensive medical and psychiatric emergency services. Furthermore, a larger behavioral health workforce within MHMRA will provide more opportunities for collaboration between providers and for patient education. MHMRA clinicians already engage in a variety of community collaborations and education activities, despite their tremendous workload. With the addition of qualified behavioral health personnel, more services can be provided.

Relationship to other Projects: The proposed project is similar to several MHMRA DSRIP proposals in its goals, including the expansion of outpatient behavioral health services within adult outpatient clinics and the project intended to enhance the intensity of behavioral outpatient services. Extending outpatient behavioral health specialty service and increasing the intensity of these services will together ultimately provide more responsive, appropriate levels of care. Outcomes of such services provided are expected to have an impact on patient satisfaction, preventable hospital admissions, and re-admissions; and will likely reduce costs by replacing high-intensity, high-cost services with routine outpatient mental health care. In addition, a proposed project to improve continuity of care for discharged psychiatrically hospitalized patients will capitalize on the expansion of outpatient services.

Relationship to other Projects in the RHP: The behavioral health crisis in Region 3 is considerable and the proposed initiatives in our RHP plan will only imply a small impression into the overall community need for treatment, but is a good start. The outpatient focus of many RHP Plan initiatives will help numerous facilities focus to treating the patients in an ambulatory setting as well as continued navigation of services with a focus to keeping patients from the inpatient unit. This initiative is similar to many others in the sense of the category of behavioral health. The Region 3 Initiative Grid attached in the addendum will show the relationship to other programs.

Plan for Learning Collaborative: Consumer satisfaction with access to services, an outcome to be assessed with input from consumer groups, patients and family members will involve all in the quality improvement loop. Similarly, rates of public psychiatric hospitalization will be presented to public psychiatric hospital representatives with an invitation for them to provide input on the improvement process.

We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system.

Project Valuation: In the effort to value the proposed project accurately, assistance was sought from H. Shelton Brown, Ph.D. of the UT Houston School of Public Health and Thomas Bohman, Ph.D. of the UT Austin Center for Social Work Research. Their consultation was limited to only the valuation section of this document. 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 Analyses

A review of the scientific literature failed to produce QALY-based studies of cost utility of psychosocial clubhouse model rehabilitative services.

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. We did identify benefit-cost studies that were related.

DiMasso and colleagues (2001) performed an outcome study of the clubhouse model, contrasting vocational and hospital outcomes for engaged vs. poor attenders. They reported average reductions of 4.31 psychiatric hospitalizations during the 18 months following clubhouse program admission. This rate converts to an annual reduction of 2.87 hospital admissions per person. Given a local average length of stay of 10.25 days at a cost of $705/day, a savings of $20,739/person/year (2012, US dollars) can be calculated.

Bond (1984) estimated a savings of $7,282 in reduced psychiatric hospital care for clubhouse participants over the 9 months studied. Annualizing the rate ($7,282 x 1.33=$9,685) and converting to 2012 dollars yields an estimate of $21,474.68 savings per person per year for clubhouse participants.

Averaging the two estimates ($20,739 and $21,474.68) yields a single estimated value of $21,107 per person served.

100 (persons served)
× $21,107 (cost savings per person served)

= $2,110,700   QALY valuation

Additional Savings
Current research indicates additional savings in the form of improved vocational outcomes and reduced jail costs using this treatment model with this population.

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 $2,110,700 per 100 people served per year.**

Unique Identifier: 113180703.1. 9	**RHP PP Reference Number: 1.12.2**	**Project Components: NA**	**Expand the number of community based settings where behavioral health services may be delivered in underserved areas: Clubhouse Expansion**
Mental Health and Mental Retardation Authority of Harris County		**TPI: 113180703**	
Related Category 3 Measure(s): Patient Satisfaction	**OD-6**	**IT-6.1**	**Percent improvement over baseline of patient satisfaction scores**
Year 2	**Year 3**	**Year 4**	**Year 5**
(10/1/2012 – 9/30/2013)	**(10/1/2013 – 9/30/2014)**	**(10/1/2014 – 9/30/2015)**	**(10/1/2015 – 9/30/2016)**
Milestone 1: [P-2]. Identify licenses, equipment requirements and other components needed to implement and operate options selected. Metric 1: [P-2.5]. Develop a project plan and timeline detailing operational needs and equipment and components Data Source: Written Project Plan	**Milestone 3: [P-6]** Establish behavioral health services in new community-based settings in underserved areas Metric 1: [P-6.1] Number of new community-based settings where behavioral health services are delivered Data Source: Project documentation and MHMRA records Goals: Provide documentation of patients being served by new program and enhanced program	**Milestone 6: [I-11]:** Increased utilization of community behavioral healthcare Metric 1: [I-11.1] Percent utilization of community behavioral healthcare services. Data Source: MHMRA records Goal: Serve 80 permanent members more than baseline	**Milestone 9: I-11:** Increased utilization of community behavioral healthcare Metric 1:[I-11.1] Percent utilization of community behavioral healthcare services. Data Source: MHMRA records Goal: Serve 209 permanent members more than baseline
Estimated Incentive Payment:	**Estimated Incentive Payment:**	**Estimated Incentive Payment:**	**Estimated Incentive Payment:**
$720,802.12	**$545,523.36**	**$596,135.72**	**$573,387.89**

Unique Identifier: 113180703.1. 9	RHP PP Reference Number: 1.12.2	Project Components: NA	Expand the number of community based settings where behavioral health services may be delivered in underserved areas: Clubhouse Expansion
Mental Health and Mental Retardation Authority of Harris County		**TPI: 113180703**	
Related Category 3 Measure(s): Patient Satisfaction	**OD-6**	**IT-6.1**	**Percent improvement over baseline of patient satisfaction scores**
Year 2	**Year 3**	**Year 4**	**Year 5**
(10/1/2012 – 9/30/2013)	**(10/1/2013 – 9/30/2014)**	**(10/1/2014 – 9/30/2015)**	**(10/1/2015 – 9/30/2016)**
Milestone 2: [P-4]: Hire and train staff to operate and manage project Metric 1:[P-4.1]: Number of staff secured and trained Data Source: HR records Goal: hire 4 generalist staff members	**Milestone 4:[I-1]** Increased utilization of community behavioral healthcare Metric 1: [I-1.1]. Percent utilization of community behavioral healthcare services. Data Source: MHMRA records Goal: establish baseline and increase to 20 additional permanent members	**Milestone 7:** [I-X1]. Psychiatric Emergency Service (PES) Admissions and Inpatient Psych. Admissions Metric 1: [I-X1.1]. Percent of individuals who were admitted to inpatient facilities. Data Source: MHMRA and HCPC records Goal: A 5% decrease from baseline in PES/HCPC admissions	**Milestone 10:** [I-X1] Psychiatric Emergency Service (PES) Admissions and Inpatient Psych. Admissions Metric 1: [I-X.1] Percent of individuals who were admitted to inpatient facilities. Data Source: MHMRA and HCPC records Goal: A 10% decrease from baseline in PES/HCPC admissions
Estimated Incentive Payment:	**Estimated Incentive Payment:**	**Estimated Incentive Payment:**	**Estimated Incentive Payment:**
$720,802.12	**$545,523.36**	**$596,135.72**	**$573,387.90**

Unique Identifier: 113180703.1. 9	RHP PP Reference Number: 1.12.2	Project Components: NA	Expand the number of community based settings where behavioral health services may be delivered in underserved areas: Clubhouse Expansion
Mental Health and Mental Retardation Authority of Harris County		**TPI: 113180703**	
Related Category 3 Measure(s): Patient Satisfaction	**OD-6**	**IT-6.1**	**Percent improvement over baseline of patient satisfaction scores**
Year 2	**Year 3**	**Year 4**	**Year 5**
(10/1/2012 – 9/30/2013)	**(10/1/2013 – 9/30/2014)**	**(10/1/2014 – 9/30/2015)**	**(10/1/2015 – 9/30/2016)**
	Milestone 5: [I-X1]. Psychiatric Emergency Service (PES) Admissions and Inpatient Psych. Admissions Metric 1: [I-X1.1] Percent of individuals who were admitted to inpatient facilities. Data Source: Psychiatric Emergency Services (PES) records are part of the MHMRA electronic record. Harris County Psychiatric Center (HCPC) is the local public psychiatric inpatient unit which maintains separate records Goal: Establish baseline	**Milestone 8:** [I-X2]. Days in employment related activities Metric 1: [I-X2.1]. number of average days worked per member Data Source: MHMRA, St. Joseph's House Goal: establish baseline in employment as determined by average number of work days for permanent members	**Milestone 11:** [I-X2] Days in employment related activities Metric 1: [I-X2.1] number of average days worked per member Data Source: MHMRA, St. Joseph's House Goal: increase average number of work days for permanent members by 5%
	Estimated Incentive Payment:	**Estimated Incentive Payment:**	**Estimated Incentive Payment:**
	$545,523.36	**$596,135.72**	**$573,387.89**
Year 2 Estimated Milestone Bundle Amount:	**Year 3 Estimated Milestone Bundle Amount:**	**Year 4 Estimated Milestone Bundle Amount:**	**Year 5 Estimated Milestone Bundle Amount:**

Unique Identifier: 113180703.1. 9	**RHP PP Reference Number: 1.12.2**	**Project Components: NA**	**Expand the number of community based settings where behavioral health services may be delivered in underserved areas: Clubhouse Expansion**
Mental Health and Mental Retardation Authority of Harris County		**TPI: 113180703**	
Related Category 3 Measure(s): Patient Satisfaction	**OD-6**	**IT-6.1**	**Percent improvement over baseline of patient satisfaction scores**
Year 2	**Year 3**	**Year 4**	**Year 5**
(10/1/2012 – 9/30/2013)	**(10/1/2013 – 9/30/2014)**	**(10/1/2014 – 9/30/2015)**	**(10/1/2015 – 9/30/2016)**
$1,441,604	**$1,636,570**	**$1,788,407**	**$1,720,164**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $6,586,745			

References

Bond, G. (1984). An economic analysis of psychosocial rehabilitation. *Hospital and Community Psychiatry, 35,* 356-362.

Bond, G. (1995). Psychiatric rehabilitation. In A. E. Dell Orto & R. P. Marinelli (Eds.), *Encyclopedia of Disability and Rehabilitation*. New York: Macmillan.

Bond, G. Dincin, J., Setze, P. & Witheridge, T. (1984). The effectiveness of psychiatric rehabilitation: A summary of research at Thresholds. *Psychosocial Rehabilitation Journal, 7,* 6-22

Fountain House. (1999). The wellspring of the Clubhouse Model for social and vocational adjustment of persons with serious mental illness. *Psychiatric Services, 50,* 1472-1476.

Johnson, J. & Hickey, S. (1999) Arrests and incarcerations after psychosocial program involvement: Clubhouse vs. Jailhouse. *Psychiatric Rehabilitation Journal, 23*, 66-70.

DRAFT

Project Option 1.9 EXPAND SPECIALTY CARE CAPACITY: Lighthouse Mental Health Clinic

RHP Project ID: 113180703.1.10 / Pass 3
Provider / TPI: Mental Health and Mental Retardation Authority of Harris County / 113180703

Project Summary:
Provider: The Mental Health and Mental Retardation Authority (MHMRA) of Harris County is public agency serving as the safety net provider for adults with serious mental illnesses, for children and adolescents with serious emotional disorders, for the developmentally delayed and for individuals experiencing acute psychiatric distress. MHMRA provides inpatient, residential and outpatient treatments, including psycho-therapy, case management and medication management for individuals. MHMRA serves about 49,000 Harris County residents out of a culturally and ethnically diverse population of over 4.1 million. Of those individuals who received services in FY12, 60.0% were medically indigent and 32% had Medicaid. MHMRA plans to partner with The Lighthouse of Houston for this project. The Lighthouse, established in 1939, serves approximately 11,000 people each year and is a member agency of the United Way of Greater Houston. The primary goal of the Lighthouse is providing direct service to the individual.

Intervention(s): MHMRA proposes to establish behavioral healthcare clinic within the Lighthouse facility in order to provide mental health treatment capacity for persons with visual impairment to include identification of behavioral health needs, interventions, case management, patient and family education and coordination with primary care. The team (to include a director, 2 therapists, 1 intake counselor, a part-time nurse and psychiatrist) will develop services to address the specialized needs of persons with visual impairment with a mental health disorder to support wellness and independent functioning in the community.

Need for the project: Persons affected with blindness and visual impairment often experience difficulties in several life domains, including the development of behavioral health problems. The loss of independence associated with visual impairment can be a significant risk factor for depression and substance abuse disorders. Depression, a common and significant problem in and of itself, frequently also leads to negative functional outcomes in rehabilitation services for the visually impaired. Too often individuals with comorbid vision loss and depression do not seek services, and when they do, services are limited in scope, focusing exclusively on mental health issues to the exclusion of comorbid vision loss. Considering these consequences and the additional barriers faced by visually impaired persons in accessing mental health services, it seems advisable to integrate behavioral health services into the vision rehabilitation system.

Target population: The target population for this service will be individuals with visual impairment in need of behavioral health (mental health and substance abuse) services.

Category 1 or 2 expected patient benefits: Increase specialty care clinic volume from current state (no services) to 110 service recipient per year by DY5.

Category 3 outcomes: MHMRA expects to increase one domain of patient satisfaction (TBD) by 10% from baseline by DY5.

DRAFT

Project Option 1.9.2- Expand Specialty Care Capacity: Lighthouse

RHP Project Number: 113180703.1.10/Pass 3

Provider/TPI: Mental Health and Mental Retardation Authority of Harris County/113180703

Project Description:
The Mental Health and Mental Retardation Authority (MHMRA) of Harris County is a public agency serving as the safety net provider for adults with serious mental illnesses, for children and adolescents with serious emotional disorders, for the developmentally delayed and for individuals experiencing acute psychiatric distress. MHMRA provides inpatient, residential and outpatient treatments, including psycho-therapy, case management and medication management for individuals. MHMRA serves more than 49,000 Harris County residents out of a culturally and ethnically diverse population of over 4.1 million. Of those individuals who received any agency service in FY12, 36.5% were medically indigent and 51.9% had Medicaid. Of those who received IDD services in FY12, such as those being proposed in this project, 34.1% were medically indigent and 57.1% had Medicaid. With regard to income, 88% report family size and annual income placing them at or below 133% of 2012 Federal Poverty Level Guidelines. Only 5.2% of the agency's clientele report incomes above 100% of FPL. Harris County's ethnic diversity is reflected in the population served. Agency consumers self-describe the following ethnic backgrounds: African-Americans (34.5%), Anglos (27.1%), persons of Hispanic heritage (26.6%), Asian-Americans (2.8%) and those reporting other ethnicities (0.4%).

MHMRA plans to partner with The Lighthouse of Houston for this project. The Lighthouse, established in 1939, serves approximately 11,000 people each year and is a member agency of the United Way of Greater Houston. The primary goal of the Lighthouse is providing direct service to the individual. This includes not only providing direct service, but also a continual commitment to improving the quality and relevance of this service. All other organizational activities and functions are in support of this primary focus and have as their goal the development and dissemination of better service designs and interventions in order to enhance the optimal functioning of the individual.

Along with the Lighthouse, MHMRA proposes to expand behavioral healthcare capacity for persons with visual impairment to include identification of behavioral health needs, interventions, case management, patient and family education and coordination with primary care. The proposed site for this project is a recently purchased facility by the Lighthouse of Houston, adjacent to The Lighthouse of Houston and MHMRA on West Dallas in Houston. The proposed project will develop a specialized behavioral health team consisting of mental health, physical health, case management services, wraparound supports and adaptive technology. The team will develop services to address the specialized needs of persons with visual impairment with a mental health disorder to support wellness and independent functioning in the community. This project meets the Delivery System Incentive Reform Payment (DSRIP) Pool 1115(a) waiver component 1.9, Enhance service availability to appropriate levels of care— option 1.9.2 Improve access to specialty care.

Goals and Relationship to Regional Goals:

Project Goals:
The project will focus on the development of specialized mental health services for persons with visual impairment. Specialized services will include: (1) assessment of behavioral health needs in children and adults with visual impairment and (2) development and implementation of interventions for this population, including cognitive behavioral interventions, pharmacological interventions, case management support, patient and family education. These goals are consistent with the regional goals and community needs discussed below.

Regional Goals:
The project will increase access to specialty care in Harris County and will transform behavioral healthcare for the target population by providing timely, coordinated clinical care. When the behavioral health needs of people with impaired vision and mental illness are not treated until a crisis occurs interventions focus on episodic, emergent care without adequate coordination of aftercare. The project will provide coordinated care to prevent crises or resolve them with successful transition into stable maintenance. Furthermore, by increasing training capacity for new professionals, this project will develop a skilled workforce to multiply community options and improve access to treatment while improving satisfaction and behavioral health outcomes for the target population.

Challenges: One of the challenges will be hiring and training the appropriate level of staff to provide increased access and service to the targeted population. The proposed project will develop the workforce of clinicians who are competent to work with the target population and are comfortable doing so. MHMRA will continue to build upon existing partnerships with local universities, medical schools, public and private Medicaid providers and other agencies to develop clinicians who are skilled and willing to treat people with impaired vision, thereby growing an ever-expanding pool of competent community providers. The contractual agreements between MHMRA and medical schools and universities are already in place to provide internships and practicum opportunities to students and residents in child psychiatry, psychology, nursing, and social work. The Lighthouse of Houston also has well established partnerships with the medical community which will facilitate collaboration, development of specialized workforce and integration of care.

5-Year Expected Outcome for Provider and Patients: MHMRA expects to see an increase in utilization of specialty care services for as many as 300 patients over the DSRIP period.

Starting Point/Baseline: Currently, there are no specialized behavioral health services for persons with visual impairment as the one being proposed.

Rationale:
Persons affected with blindness and visual impairment often experience difficulties in several areas of functioning, including behavioral health. The loss of independence associated with visual impairment can be a significant risk factor for depression and substance abuse disorders. Depression is a common mental health problem among individuals who are visually impaired. A recent study found that 7% of the person applying for vision rehab services (over the age of 65) met the criteria for depression and an additional 27% had sub threshold depression. The prevalence of depression and other mental disorders may be even greater in young children and

middle age adults (40-45% has clinical significant depressive symptoms and 20% exhibit moderate to severe anxiety).

The consequences of mental health disorders for adults with visual impairment are far reaching. They have greater functional disability, morbidity and mortality. Too often individuals with comorbid vision loss and depression do not seek services, and when they do, services are limited and often do not address the comorbid vision loss. Depression is also likely to limit rehabilitation outcomes. Given these consequences and the additional barriers faced by visually impaired persons in accessing mental services, it seems imperative to integrate behavioral health services into the vision rehabilitation system.

In the greater Houston area, there are an estimated 74,538 persons who are blind or severely visually impaired. If we assume that 6% of them have a SPMI, that would imply that 4,472 persons with visual impairment also have a serious and persistent mental illness that interferes with their functioning. This does not include all of the others persons struggling with adjustment disorders, anxiety disorders and depression that, unless treated, will most likely exacerbate. Given the barriers to accessing care, it is assumed that most of these persons only seek help when in crisis and through the emergency room/hospital system. Persons with visual impairment also have higher rates of co-morbid medical conditions. For example, diabetes is prevalent in 15% of persons with visual impairment.

Project Components: Through the expansion of specialty care services project, we propose to meet all required project components listed below and believe that the selected milestones and metrics relate to the project components.

e) Increase service availability with extended hours
f) Increase number of specialty clinic locations
g) Implement transparent, standardized referrals across the system
h) Conduct quality improvement for project using methods such as rapid cycle improvement

Milestones and Metrics: The goals are consistent with the regional goals and community needs discussed above. Furthermore, the improvement metrics chosen for this project (I-23.1: Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services) will determine the progress MHMRA is making to meet our stated goals.

Unique community need identification number the project addresses: Expansion of the Lighthouse clinic will address the following community needs:

- CN3-Inadequate access to Behavioral Health
- CN6- Inadequate access to treatment and services designed for special needs populations, including disabled, homeless, children and elderly
- CN9- High rates of preventable hospital readmissions
- CN0- High rates of preventable hospital admissions
- CN18- Insufficient access to integrated care programs for behavioral health and physical health conditions

Related Category 3 Outcome Measure(s): IT 6.1 Percent improvement over baseline of patient satisfaction scores for one domain of patient satisfaction.

Reasons/rationale for selecting the outcome measure: Measurement of patient satisfaction is a key indicator of patient-centered care and has been targeted as a quality indicator by national organizations dedicated to improvement in patient outcomes, e.g. the National Council for Quality Assurance. Furthermore, if patients and their family are satisfied with services then we can assume they are being provided for adequately. On the other hand, if patients are dissatisfied having an avenue to express their concerns is important to empowering our clients.

Rationale for selecting the outcome measures: Harris County MHMRA proposes to expand an innovative outpatient option, the Lighthouse clinic, to provide behavioral medicine and behavioral support services to create a safety net for people with impaired vision and co-occurring mental illness who reside in Harris County. This program is a unique clinic with highly skilled clinicians and impaired vision specialists who work together to achieve positive outcomes for people with serious behavioral and/or mental health problems. These services allow for the best opportunity for patient satisfaction as they provide the appropriate level of care for this population.

Relationship to Other Projects: This proposed project has activities related to the MHMRA proposal 113180703.2.1 Collaborative Primary and Behavioral Health which also addresses both physical and mental health needs of patients. Several other MHMRA proposed projects are similar to this one in way of provided outpatient behavioral health.

Relationship to Other Performing Providers' Projects in the RHP: The behavioral health crisis in Region 3 is considerable and the proposed initiatives in our RHP plan will only imply a small impression into the overall community need for treatment, but is a good start. The outpatient focus of many RHP Plan initiatives will help numerous facilities focus to treating the patients in an ambulatory setting as well as continued navigation of services with a focus to keeping patients from the inpatient unit. This initiative is similar to many others in the sense of the category of behavioral health. The Region 3 Initiative Grid attached in the addendum will show the relationship to other programs.

Plan for Learning Collaborative: We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system.

Project Valuation: In the effort to value the proposed project accurately, assistance was sought from H. Shelton Brown, Ph.D. of the UT Houston School of Public Health and Thomas Bohman, Ph.D. of the UT Austin Center for Social Work Research. Their consultation was limited to only the valuation section of this document. 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:

Our literature review did not reveal QALY estimates specifically for the integration of mental health services and visual impairment. However, we believe there is a close parallel to the integration of mental health and medical care. A review of the scientific literature identified several QALY-based estimates of the cost utility of providing collaborative mental health care in medical settings. We believe there is a parallel in that co-location is not only convenient, it is possible that collaboration among those providing services for the visually impaired and mental health.

One study examined collaborative care intervention for multi-symptom patients including depression, diabetes, and coronary heart disease (Katon, Russo, Lin, Schmittdiel, Ciechanowski, Ludman & Von Korff, 2012). In this study the effect of the intervention was 0.335 QALYs gained.

A second study focusing exclusively on treatment of major depression in the primary practice setting reported an incremental QALY of 0.049 (Rost, Pyne, Dickinson & LoSasso, 2005). In addition, Pyne, Smith, Fortney, Zhang, Williams, & Rost (2003) reported the cost utility of collaborative care for major depression. Their estimates yielded a 0.123 QALY increment over treatment as usual for females and an estimate of a slight, non-significant loss for males (-0.073 QALYs).

An average increment across the three reports can be calculated as (0.335, 0.049, 0.123, and -0.073) yields 0.1085 QALYs gained.

Assuming the program would serve 100 persons in a year, the following formula shows the total valuation:

100	(persons served)
0.1085	(QALY gained)
× $50,000	(life year value)

$542,500	**Valuation**

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. We did identify benefit-cost studies that were related.
Rost and colleagues (2005) reported that their collaborative intervention for major depression produced a significant increment in days free of depression, resulting in 13.4 days between the first and second years of their study; whereas, Simon and colleagues (2012) reported a value of 47.7 additional depression-free days. Rost also reported health plan costs decreased $777.20 (2012 dollars) per treated person. Additional value can be calculated as:

100	(persons served)
x $777.2	(health plan cost savings)
= $77,720	**Cost Savings: Health Plan**

Similarly, Dewa et al. (2009) found that collaborative care saved $545 (2012 US Dollars) per patient in disability benefits. Additional value can be calculated as:

100	(persons served)
x $545	(disability benefit savings)
= $54,500	**Cost Savings: Disability**

Summary and Total Valuation

The total value per 100 people served per year can be calculated as:

$542,500	Incremental QALYs
$77,720	Health Plan Savings
+ $54,500	Disability Benefit Savings
= **$674,720**	**Total Valuation**

113180703.1.10	*1.9.2*	*A-D*	***EXPAND SPECIALTY CARE CAPACITY: LIGHTHOUSE***
Mental Health and Mental Retardation Authority of Harris County			113180703
Related Category 3 Outcome Measure(s):	*OD-6*	*IT-6.1*	*Percent Improvement over baseline of patient satisfaction scores*

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1: [P-21] Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects Metric 1:[P-21.2] Implement the "raise the floor" improvement initiatives established at the semiannual meeting. Data Source: written documentation Milestone 1 Estimated Incentive Payment: $190,894.62 **Milestone 2**: [P-19]. Participate in at least bi-weekly interactions with other	**Milestone 4:** [P-21] Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects Metric 1: [P-21.2] Implement the "raise the floor" improvement initiatives established at the semiannual meeting. Data Source: written documentation Milestone 4 Estimated Incentive Payment: $216,711.64 **Milestone 5**: [P-19] Participate in at least bi-weekly interactions (meetings,	**Milestone 7**: [I-23] Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1: [I-23.1] Documentation of increased number of visits. Data Source: Registry, EHR, claims or other Performing Provider source Goal: Increase patients served to 50 per year over baseline. Milestone 7 Estimated Incentive Payment: $710,452.91	**Milestone 8**: [I-23] Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1: [I-23.1] Documentation of increased number of visits. Data Source: Registry, EHR, claims or other Performing Provider source Goal: Increase patients served to 110 per year over baseline. Milestone 8 Estimated Incentive Payment: $683,342.88

113180703.1.10	1.9.2	A-D	EXPAND SPECIALTY CARE CAPACITY: LIGHTHOUSE	
Mental Health and Mental Retardation Authority of Harris County				113180703
Related Category 3 Outcome Measure(s):	*OD-6*	*IT-6.1*	*Percent Improvement over baseline of patient satisfaction scores*	

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
providers and the RHP to promote collaborative learning around shared or similar projects. Metric 1: [P-19.1] Number of bi-weekly RHP meetings MHMRA participated in Data Source: Documentation of weekly or bi-weekly interactions Milestone 2 Estimated Incentive Payment: $190,894.62 **Milestone 3**:[P-11]: Launch/expand a specialty care clinic Metric 1: [P- 11.1] Establish/expand Lighthouse specialty care clinics a. Number of patients served by specialty care clinic	conference calls, or webinars) with other providers and the RHP to promote collaborative learning around shared or similar projects Metric 1: [P-19.1] Number of bi-weekly RHP meetings MHMRA participated in Data Source: Written Documentation Milestone 5 Estimated Incentive Payment: $216,711.65 **Milestone 6**: [I-23]: Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1: [I-23.1] Documentation of increased number of visits. Data Source: Registry, EHR, claims or other Performing		

<table>
<tr><td>113180703.1.10</td><td>1.9.2</td><td>A-D</td><td colspan="2">EXPAND SPECIALTY CARE CAPACITY: LIGHTHOUSE</td></tr>
<tr><td colspan="4">Mental Health and Mental Retardation Authority of Harris County</td><td>113180703</td></tr>
<tr><td>Related Category 3 Outcome Measure(s):</td><td>OD-6</td><td>IT-6.1</td><td colspan="2">Percent Improvement over baseline of patient satisfaction scores</td></tr>
<tr><td>Year 2
(10/1/2012 – 9/30/2013)</td><td colspan="2">Year 3
(10/1/2013 – 9/30/2014)</td><td>Year 4
(10/1/2014 – 9/30/2015)</td><td>Year 5
(10/1/2015 – 9/30/2016)</td></tr>
<tr><td>Data Source: Documentation of new/expanded specialty care clinic

Milestone 3 Estimated Incentive Payment: $190,894.63</td><td colspan="2">Provider source
Goal: Serve 25 patients per year over baseline.

Milestone 6 Estimated Incentive Payment: $216,711.65</td><td></td><td></td></tr>
<tr><td>Year 2 Estimated Milestone Bundle Amount: $572,684</td><td colspan="2">Year 3 Estimated Milestone Bundle Amount: $650,135</td><td>Year 4 Estimated Milestone Bundle Amount: $710,453</td><td>Year 5 Estimated Milestone Bundle Amount: $683,343</td></tr>
<tr><td colspan="5">TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5): $2,616,615</td></tr>
</table>

OakBend Medical Center

Pass 1

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Project Option 1.3.1 : Implement and Utilize Disease Management Registry Functionality
Performing Provider: OakBend Medical Center (OBMC)/127303903
Unique Project ID: 127303903.1.1

- Provider: OakBend Medical Center is a stand-alone hospital authority that was established in October 1947 under the original name of Polly Ryon Memorial Hospital. OakBend Medical Center has grown to a hospital system, still governed by a hospital authority. It has expanded to two hospital locations, two diagnostic imaging centers, an outpatient surgical center, a free-standing Emergency Room and a Medical Group with 7 clinic locations. The Medical Group consists of Family Practice, OB/Gyn, Infectious Disease, Podiatry, Orthopedic, Cardiology and Interventional Cardiology. OakBend was able to provide more than $29,412,325 in charity care through September during FY 2012.

Volume Statistics - FY2012	Patient Payor Mix– YTD 9/12	Patient Demographics
Hospital admissions- 5,453 Births (babies delivered)- 1,080 Emergency visits- 23, 433	Self-Pay- 13.8% Medicaid and CHIP- 19.5% Medicare- 40.1% Other Funding- N/A Commercial Insurance- 26.6	Hispanic- 39.6% African American- 16.7 Caucasian- 34.6 Asian- 2.0 Other- 6.7 American Indian- 0.4

- Intervention(s): This project will develop a chronic disease registry to use county wide to ensure providers and clinical staff with access to determine clinical outcomes and to identify physician, psychological and emotional needs of the chronically ill patients that we care for each day.

- Need for the project: The purpose of this project, as well as the other Category one (1) and two (2) projects, is to identify and target the at risk chronic disease(s) population and to move towards decreasing their inappropriate utilization patterns. Once identified, we plan to educate and encourage them to self-manage their healthcare, thus improving their quality of life as well as their inappropriate utilization of healthcare services.

- Target population: All patients that seek their medical care through any of the OakBend Medical Center system entities, who will benefit from this and other projects. We plan to target patients with Medicaid, CHIP and Self-Pay, especially those with chronic disease(s).

- Category 1 or 2 expected patient benefits: Our DY3 goal is to expand the Registry functionality to 30% of the Performing Provider's sites with increases in enrollment in DY4 and DY5.

- Category 3 outcomes: IT 3.2 – Our goal is to reduce CHF 30 day readmissions by 2% of baseline in DY4 and 5% of baseline by DY5.

Title: Implement and Utilize Disease Management Registry Functionality

Unique RHP Project Identification Number: *127303903.1.1*

Performing Provider Name/TPI: OakBend Medical Center (OBMC) / 127303903

Project Description: 1.3 / 1.3.1

Providers in the OakBend Medical Group (OMG) and the Fort Bend Family Health Care Center (FBFHC) will receive monthly registry reports on their patients with CHF, COPD, Diabetes and ESRD. OBMC will develop and implement a registry in conjunction with FBFHC and specific home health providers. The Home Health (HH) providers will be selected based on quality outcome measures and hospital readmission indicators.

OBMC will develop curriculum and educational training in conjunction with FBFHC in the use of a disease management registry. In addition, OBMC will develop curriculum and educational training in conjunction with the specific HH companies that have disease management programs, as well as develop curriculum and educational training in conjunction with the OBMC nephrologists and dialysis centers to provide education to all pre-renal and current dialysis patients on a quarterly basis, at a minimum. OBMC will provide a meeting space for any educational offerings that are provided in collaboration with selected community-based HH agencies, nephrologists, dialysis centers or the FBFHC in conjunction with Community Health Workers (CHWs). The personal contact and encouragement of the CHW may assist in influencing and promoting the patients' willingness to become more involved in the management of their health care through the utilization of available resources.

Goal(s) and relationship to Regional goal(s):

Project goals:

OBMC will create, expand and/or integrate longitudinal databases and population registry of health care utilization and services for patients with common chronic diseases of Congestive Heart Failure (CHF), Chronic Obstructive Pulmonary Disease (COPD), Diabetes and End Stage Renal Disease (ESRD) to decrease the number of readmissions to the hospital.

This project meets the following Region 3 goals:

This project addresses the RHP's goal to "[d]evelop a regional approach to health care delivery that leverages and improves on existing programs and infrastructure, is responsive to patient needs throughout the entire region, and improves health care outcomes and patient satisfaction."

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Challenges and how addressed:

Working through time constraints allowed for each patient/physician interaction when caring for the chronic disease population; development and implementation of a disease-specific registry; developing a well-planned-out information support system with the ability for a robust data monitoring and outcomes management component; promoting and incentivizing the patient population to utilize available services; hiring and training of staff; managing non-compliant patients; space allocation for CHW; establishing a more focused coordination between the hospital and FBFHC with the CHW and other entities to achieve the shared goal of decreased readmissions. OBMC will address these challenges on a case-by-case basis, in large part by developing and providing education for patients in conjunction with the disease registry. The CHW will work in collaboration with each patient and their PCP / SCP to implement data entry and follow through of patients with disease specific diagnosis

5-year expected outcome for provider and patients:

Improved health outcomes for patients with common chronic diseases targeted by the disease management registry, including CHF, COPD, diabetes, and ESRD, as measured by this project's Category 1 improvement milestones and Category 3 improvement targets. We plan to track all patients registered in the data base to assist with forming a relationship with their PCP/SCP. We will also add and track new patients with any of the above chronic diseases as they are identified. We will monitor these patients for improved compliance thus improved chronic disease outcomes.

Starting Point/Baseline:

Baseline data:

OBMC does not currently have a disease management registry and has no patients enrolled.

Time period for baseline:

1/1/12 to 6/30/12

Rationale:

Reasons for selecting the project option:

One of the biggest issues facing appropriate management of chronic care conditions is the lack of coordination of care. By implementing a disease management registry OBMC can monitor the care utilization of patients with chronic diseases to determine whether they have had adequate follow-up and preventative care. CHWs can contact patients who are not receiving adequate care and work with partners like FBFHC to coordinate care delivery and ensure there is no duplication of services. Additionally, having this information will allow OBMC to track the

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long-term clinical success of tertiary care vendors HH and refer patients to those vendors who have demonstrated success in helping patients manage their chronic conditions. This will ultimately allow for better health outcomes and an increased quality of life for these patients.

Project components:

The core components of this project will be:

a) Enter patient data into unique chronic disease registry.

b) Use registry data to proactively contact, educate, and track patients by disease status, risk status, self-management status, community and family need.

c) Use registry reports to develop and implement targeted QI plan. 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

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

- One of OakBend's milestones in Year 4 is to implement a continuous quality improvement plan by establishing meetings with other RHP providers.

Unique community need identification number the project addresses:

CN.9: High rates of preventable hospital readmissions

CN-11: High rates of chronic disease and inadequate access to treatment programs and services for illnesses associated with chronic disease

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

The ability to track the clinical utilization of patients with certain diagnosis codes and specific chronic conditions will be a new and significant tool for OBMC to both coordinate the delivery of care with its clinical partners and monitor the long-term effectiveness of its treatments. The result will be a collaboration that improves the health outcomes for OBMC's patients and reduces the cost of care by delivering services in an efficient and coordinated

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manner. Furthermore, a better coordination of care will result in a better patient experience and more informed autonomous patient decisions.

Related Category 3 Outcome Measure(s):

IT-3.2 Congestive Heart Failure 30-Day Readmission Rate (Standalone Measure)

Reasons/rationale for selecting the outcome measure(s):

If the project is successful, then it will result in more effective management of chronic conditions, which in turn will result in the reduction of unnecessary readmissions. Congestive heart failure is an exemplar diagnosis for which effective disease management has been shown to reduce unnecessary hospital admissions. Therefore, the reduction in CHF admissions will be a reasonable metric by which to judge the effectiveness of this project.

Relationship to Other Projects:

How project supports, reinforces, and enables other projects:

This project will lay a foundation for, and reinforce the clinical effectiveness of OBMC's other DSRIP projects, including:

127303903.2.1: Redesign to Improve Patient Experience—Implement Consumer Assessment System

127303903.2.2: Establish Patient Care Navigation Program

127303903.1.3: Expand Specialty Care Capacity

127303903.1.2: Increase Training of Primary Care Workforce

Relationship to Other Performing Providers' Projects in the RHP:

The sheer volume of population as well as the complexity of patient conditions dictates the need of numerous disease registries in our region to properly identify and manage chronic conditions. The concept is utilized consistently throughout our region in order to help achieve milestones and outcomes specific to patient conditions. All disease registries presented have a similarity in concept but are unique in the sense of condition or patient population focus. The Region 3 initiative grid in the addendum reflects direct relations between all projects.

Plan for Learning Collaborative:

We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our

Region's healthcare system. Specifically relating to this project, we plan to use these learning collaboratives to discuss with other providers in the region methods of ensuring that overall regional CHF admission and readmission rates are decreased, rather than CHF patient populations merely being diverted from one provider to another.

Project Valuation:

Approach for valuing project:

OBMC values each project based on the specific needs of the community, the projected impact on the health outcomes of the community, the level of advancement to the healthcare delivery system, and the time, effort, and clinical resources necessary to implement each project.

In valuing this project, OBMC took into account the extent to which the implementation of a disease management registry would potentially meet the goals of the Waiver (support the development of a coordinated care delivery system, improve outcomes while containing costs, improve the healthcare infrastructure), the extent to which it will address the community needs, the population served, and the resources and cost necessary to implement the project.

Rationale/justification for valuation:

The implementation of a disease management registry will significantly improve health outcomes for patients with chronic diseases, improve patient experience, and ultimately result in the reduction of healthcare costs; therefore, OBMC took these factors into account when considering the appropriate incentive payment value for this project.

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PROJECT 127303903.1.1	1.3.1	1.3.1 A-D	IMPLEMENT AND UTILIZE DISEASE MANAGEMENT REGISTRY FUNCTIONALITY
OAKBEND MEDICAL CENTER			127303903
Related Category 3 Outcome Measure(s):	*127303903.3.1*	*IT-3.2*	*Congestive Heart Failure 30-Day Readmission Rate*

Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Milestone 1 P-1] 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). **Baseline/Goal:** OBMC does not currently have a disease management registry and has no patients enrolled **Metric1 P-1.1**: Documentation of patients to be entered into the registry. **Data Source**: Performing provider records/documentation. Milestone 1 Estimated Incentive Payment *(maximum amount):* **$440,580** **Milestone 2** P-2: Review current registry capability and assess future needs. **Metric 1 P-2.1:** Documentation of review of current registry capability	**Milestone 3** P-3: Develop cross-functional team to evaluate registry program. **Metric 1 P-3.1:** Documentation of personnel (clinical, IT, administrative) assigned to evaluate registry program. **Data Source:** Team roster and minutes from team meetings. Milestone 3 Estimated Incentive Payment: **$480,649** **Milestone 4** P-4: Implement/ expand a functional disease management registry. **Metric 1 P-4.1:** Registry functionality is available in 30% of the Performing Provider's sites and includes an expanded number of targeted diseases or clinical conditions.	**Milestone 5** I-15: Increase the percentage of patients enrolled in the registry. **Baseline/Goal: 2% improvement in enrollment in the registry over baseline of DY3.** **Metric 1 I-15.1:** Percentage of patients in the registry; metric may vary in terms of measuring absolute targets versus increasing the proportion of patients meeting a specific criteria (e.g., medical home patients, patients with a targeted chronic condition). **Data Source**: Registry or EHR Milestone 5 Estimated Incentive Payment: **$482,046** **Milestone 6** P-13: Review project data and respond to it every week with tests of new ideas, practices, tools, or solutions. This data will be	**Milestone 7** I-15 : Increase the percentage of patients enrolled in the registry. **Baseline/Goal: 5% improvement in enrollment in the registry over baseline of DY3.** **Metric 1 I-15.1:** Percentage of patients in the registry; metric may vary in terms of measuring absolute targets versus increasing the proportion of patients meeting a specific criteria (e.g., medical home patients, patients with a targeted chronic condition). **Data Source:** Registry or EHR Milestone 7 Estimated Incentive Payment: **$398,212** **Milestone 8** P-13: Review project

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PROJECT 127303903.1.1	*1.3.1*	*1.3.1 A-D*	*IMPLEMENT AND UTILIZE DISEASE MANAGEMENT REGISTRY FUNCTIONALITY*
OAKBEND MEDICAL CENTER			*127303903*
Related Category 3 Outcome Measure(s):	*127303903.3.1*	*IT-3.2*	*Congestive Heart Failure 30-Day Readmission Rate*

Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
and assessment of future registry needs. **Data Source:** EHR systems and/or other performing provider documentation. Milestone 2 Estimated Incentive Payment: **$440,580**	**Data Source:** Documentation of adoption, installation, upgrade, or interface, or similar documentation. Milestone 4 Estimated Incentive Payment: **$480,649**	collected with simple, interim measurement systems, and will be based on self-reported data and sampling that is sufficient for the purposes of improvement. **Metric 1**:P-13.1 Number of new ideas, practices, tools, or solutions tested. **Data Source**: Brief description of the idea, practice, tool, or solution tested each week, and summarized at quarterly intervals. Milestone 6 Estimated Incentive Payment: **$482,046**	data and respond to it every week with tests of new ideas, practices, tools, or solutions. This data will be collected with simple, interim measurement systems, and will be based on self-reported data and sampling that is sufficient for the purposes of improvement. **Metric 1**: P-13.1Number of new ideas, practices, tools, or solutions tested. **Data Source**: Brief description of the idea, practice, tool, or solution tested each week, and summarized at quarterly intervals. Milestone 8 Estimated Incentive Payment: **$398,212**

PROJECT 127303903.1.1	***1.3.1***		***1.3.1 A-D***	***IMPLEMENT AND UTILIZE DISEASE MANAGEMENT REGISTRY FUNCTIONALITY***	
OAKBEND MEDICAL CENTER					*127303903*
Related Category 3 Outcome Measure(s):	*127303903.3.1*		*IT-3.2*	*Congestive Heart Failure 30-Day Readmission Rate*	
Year 2 **(10/1/2012 – 9/30/2013)**		**Year 3** **(10/1/2013 – 9/30/2014)**		**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Year 2 Estimated Milestone Bundle Amount *(add incentive payments amounts from each milestone)*: **$881,161**		Year 3 Estimated Milestone Bundle Amount: **$961,299**		Year 4 Estimated Milestone Bundle Amount: **$964,094**	Year 5 Estimated Milestone Bundle Amount: **$796,425**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over DYs 2-5)*: **$3,602,979**					

Project Option: 1.2.2 Increase the number of primary care providers (PCP's)
Performing Provider: OakBend Medical Center (OBMC)/127303903
Unique Project ID: 127303903.1.2

- Provider: OakBend Medical Center is a stand alone hospital authority that was established in October 1947 under the original name of Polly Ryon Memorial Hospital. OakBend Medical Center has grown to a hospital system, still governed by a hospital authority. It has expanded to two hospital locations, two diagnostic imaging centers, an outpatient surgical center, a free-standing Emergency Room and a Medical Group with 7 clinic locations. The Medical Group consists of Family Practice, OB/Gyn, Infectious Disease, Podiatry, Orthopedic, Cardiology and Interventional Cardiology. OakBend was able to provide more than $29,412,325 in charity care through September during FY 2012.

Volume Statistics - FY2012	Patient Payor Mix– YTD 9/12	Patient Demographics
Hospital admissions- 5,453 Births (babies delivered)- 1,080 Emergency visits- 23, 433	Self-Pay- 13.8% Medicaid and CHIP- 19.5% Medicare- 40.1% Other Funding- N/A Commercial Insurance- 26.6	Hispanic- 39.6% African American- 16.7 Caucasian- 34.6 Asian- 2.0 Other- 6.7 American Indian- 0.4

- Intervention(s): The shortage of PCP's has contributed to increased wait times in hospitals, community clinics, and other care settings. This we feel discourages some individuals from seeking care due to the limited resources. This will increase access and capacity and help create an organized structure of PCP's, clinicians, and staff.

- Need for the project: The expansion of PCP's will promote and encourage patients to access appropriate level of care leading to better clinical outcomes for the community. The purpose of this project, and other Category one (1) and two (2) projects, is to increase availability of PCP's to improve quality of life as well as decrease inappropriate utilization of healthcare services.

- Target population: This project addresses the RHP's goal to increase access to primary and specialty care services, with a focus on underserved populations. To ensure patients receive the most appropriate care for their condition. We plan to target patients with Medicaid, CHIP and Self-Pay, especially those with chronic disease(s).

- Category 1 or 2 expected patient benefits: OBMC will expand the number of Primary Care Physicians (PCPs) on our current physician panel by two physicians in the Third (3rd) year and by a total of four (4) by year five (5).

- Category 3 outcomes: IT 3.2 – The increase in access to primary care physician services will decrease the number of admissions for diseases like CHF, that can be adequately managed on an outpatient basis.

Title: Increase Training of Primary Care Workforce

Unique RHP Project Identification Number: 127303903.1.2

Performing Provider Name/TPI: OakBend Medical Center (OBMC) / 127303903

Project Description: 1.2 / 1.2.2

Texas has a growing shortage of primary care doctors and nurses due to the needs of an aging population, a decline in the number of medical students choosing primary care, and thousands of aging baby boomers who are doctors and nurses looking towards retirement. The shortage of primary care workforce personnel in Texas is a critical problem that we have the opportunity to begin addressing under this Waiver. It is difficult to recruit and hire primary care physicians. The shortage of primary care providers has contributed to increased wait times in hospitals, community clinics, and other care settings. Expanding the primary care workforce will increase access and capacity and help create an organized structure of primary care providers, clinicians, and staff. Moreover, this expansion will strengthen an integrated health care system and play a key role in implementing disease management programs. A greater focus on primary care will be crucial to the success of an integrated health care system.

Goal(s) and relationship to Regional goal(s):

Project goals:

OBMC will expand the number of Primary Care Physicians (PCPs) on our current physician panel by two physicians in the second (2nd) year and by a total of four (4) by year five (5). We will also plan to increase the support staff to compliment the additional physicians. In addition, OBMC will provide training to these new physicians to integrate them into the community.

This project meets the following Region 3 goals:

This project addresses the RHP's goal to "[i]ncrease access to primary and specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their condition, regardless of where they live or their ability to pay."

Challenges and how addressed:

- Recruiting primary care physicians OBMC will address this challenge by emphasizing to potential providers the benefits of living and working in a vibrant and growing area such as Fort Bend County. The cost of living is lower than many places in the nations with low crime and no drastic seasonal changes. The shortage of PCP's has contributed to increased wait times in hospitals, community clinics, and other care settings. This we feel discourages

some individuals from seeking care due to the limited resources. This will increase access and capacity and help create an organized structure of PCP's, clinicians, and staff.

5-year expected outcome for provider and patients:

Increased access to primary health care services for patients in the community.

Starting Point/Baseline:

Baseline data:

OBMC currently has 15 primary care physicians in the community, but will need at least four more over the next five years in order to meet the demand for primary care services in the community.

Time period for baseline:

1/1/12 to 6/30/12

Rationale:

Reasons for selecting the project option:

Currently OBMC provides high-quality, affordable care to residents of Fort Bend County regardless of their ability to pay. However, access to primary care appointments is limited. As a result, many patients are cared for exclusively in the Emergency Department (ED). This setting is not designed to provide comprehensive assessment, disease-specific education, preventative care and coordination. Therefore OBMC chose to implement this project in order to address the need for primary care in the community.

Unique community need identification number the project addresses:

CN.1: Inadequate access to primary care

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

This will considerably improve OBMC's primary care capacity, as evidenced by a 25% increase in primary care encounters for OakBend Medical Group (OMG) and clinic sites compared to the current baseline. Additionally, this project will increase OBMC's ability to provide appropriate care in a timely manner and in the correct setting. This will enable OBMC to treat more patients in this type of setting, where they will receive education including disease-specific, as well as preventative care and screenings.

Related Category 3 Outcome Measure(s):

IT-2.1 Congestive Heart Failure Admission Rate (CHF)

Reasons/rationale for selecting the outcome measure(s):

The increase in access to primary care physician services will decrease the number of admissions for diseases that can be adequately managed like CHF.

Relationship to Other Projects:

How project supports, reinforces, and enables other projects:

This project will lay a foundation for, and reinforce the clinical effectiveness of, OBMC's other DSRIP projects, including:

127303903.1.3: Expand Specialty Care Capacity

127303903.1.1:Implement and Utilize Disease Management Registry Functionality

127303903.2.2: Establish Patient Care Navigation Program

Relationship to Other Performing Providers' Projects in the RHP:

Primary Care/Ambulatory Care clinics are a top priority to Region 3 due to the acuity of the regional patient mix, population concentration, and lack of primary care access points for our patient base. The regional approach of collaboration as well as existing patient referral pattern relationships allowed our team to properly identify the community needs based on the necessity of population, uninsured, and medically underserved patient bases. This program is consistent with our region and similar to numerous initiatives in our RHP plan sharing both concepts as well as outcome measures focused to percent improvement over baseline of patient satisfaction scores, reduction of inappropriate ED utilization, and third next available appointment status. The Region 3 Initiative Grid attached as a RHP Plan addendum reflects a grid of relationship for all initiatives.

Plan for Learning Collaborative:

We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system.

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Project Valuation:

Approach for valuing project:

OBMC values each project based on the specific needs of the community, the projected impact on the health outcomes of the community, the level of advancement to the healthcare delivery system, and the time, effort, and clinical resources necessary to implement each project.

In valuing this project, OBMC took into account the extent to which the expansion of primary care providers would potentially meet the goals of the Waiver (support the development of a coordinated care delivery system, improve outcomes while containing costs, improve the healthcare infrastructure), the extent to which it will address the community needs, the population served, and the resources and cost necessary to implement the project.

Rationale/justification for valuation:

The expansion of primary care providers will promote and encourage patients to access care which will lead to better clinical outcomes for the community. OBMC took these potential effects into account when considering the appropriate incentive payment value for this project.

<table>
<tr><td>127303903.1.2</td><td>1.2.2</td><td>1.2.2</td><td colspan="2">INCREASE TRAINING OF PRIMARY CARE WORKFORCE</td></tr>
<tr><td colspan="4">OAKBEND MEDICAL CENTER</td><td>127303903</td></tr>
<tr><td>Related Category 3 Outcome Measure(s):</td><td>127303903.3.2</td><td>IT-2.1</td><td colspan="2">Congestive Heart Failure Admission Rate (CHF)</td></tr>
<tr><th>Year 2

(10/1/2012 – 9/30/2013)</th><th colspan="2">Year 3

(10/1/2013 – 9/30/2014)</th><th>Year 4

(10/1/2014 – 9/30/2015)</th><th>Year 5

(10/1/2015 – 9/30/2016)</th></tr>
<tr><td>Milestone 1 P-1 Conduct a primary care gap analysis to determine workforce needs.

<u>Metric 1</u> <u>P-1.1</u>: Gap assessment of workforce shortages.

Submission of completed assessment.

Data Source: Assessment results.

Milestone 1 Estimated Incentive Payment (maximum amount): $570,163</td><td colspan="2">Milestone 2 I-12 Recruit/hire more trainees/graduates to primary care positions in Performing Provider facilities.

Baseline/Goal: Hire 1 new primary care MD or nurse practitioner over DY2 baseline.

<u>Metric 1</u> <u>I-12.1</u>: Percent change in number of graduates/trainees accepting positions in the Performing Provider's facilities over baseline.

Data Source: Documentation, such as HR documents compared to class lists.

Milestone 2 Estimated Incentive Payment: $622,017</td><td>Milestone 3 I-12 Recruit/hire more trainees/graduates to primary care positions in Performing Provider facilities.

Baseline/Goal: Hire 2 new primary care MDs or nurse practitioners over DY2 baseline.

<u>Metric 1</u> I-12.1 Percent change in number of graduates/trainees accepting positions in the Performing Provider's facilities over baseline.

Data Source: Documentation, such as HR documents compared to class lists.

Milestone 3 Estimated Incentive Payment: $623,825</td><td>Milestone 4 I-12 Recruit/hire more trainees/graduates to primary care positions in Performing Provider facilities.

Baseline/Goal: Hire 3 new primary care MDs or nurse practitioners over DY2 baseline.

<u>Metric 1</u> <u>I-12.1</u> Percent change in number of graduates/trainees accepting positions in the Performing Provider's facilities over baseline.

Data Source: Documentation, such as HR documents compared to class lists.

Milestone 4 Estimated Incentive Payment: $515,334</td></tr>
<tr><td>Year 2 Estimated Milestone Bundle Amount (add incentive payments amounts from each milestone): $570,163</td><td colspan="2">Year 3 Estimated Milestone Bundle Amount: $622,017</td><td>Year 4 Estimated Milestone Bundle Amount: $623,825</td><td>Year 5 Estimated Milestone Bundle Amount: $515,334</td></tr>
</table>

127303903.1.2	***1.2.2***	***1.2.2***	***INCREASE TRAINING OF PRIMARY CARE WORKFORCE***	
OAKBEND MEDICAL CENTER				*127303903*
Related Category 3 Outcome Measure(s):	*127303903.3.2*	*IT-2.1*	*Congestive Heart Failure Admission Rate (CHF)*	
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**		**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over DYs 2-5)***: $2,331,339**				

Project Option: 1.9.1 Expand Specialty Care Capacity
Performing Provider: OakBend Medical Center (OBMC) / 127303903
Unique Project ID: 127303903.1.3

- Provider: OakBend Medical Center is a stand-alone hospital authority that was established in October 1947 under the original name of Polly Ryon Memorial Hospital. OakBend Medical Center has grown to a hospital system, still governed by a hospital authority. It has expanded to two hospital locations, two diagnostic imaging centers, an outpatient surgical center, a free-standing Emergency Room and a Medical Group with 7 clinic locations. The Medical Group consists of Family Practice, OB/Gyn, Infectious Disease, Podiatry, Orthopedic, Cardiology and Intervential Cardiology. OakBend was able to provide more than $29,412,325 in charity care through September during FY 2012.

Volume Statistics - FY2012	Patient Payor Mix–YTD 9/12	Patient Demographics
Hospital admissions- 5,453 Births (babies delivered)- 1,080 Emergency visits- 23, 433	Self-Pay- 13.8% Medicaid and CHIP- 19.5% Medicare- 40.1% Other Funding- N/A Commercial Insurance- 26.6	Hispanic- 39.6% African American- 16.7 Caucasian- 34.6 Asian- 2.0 Other- 6.7 American Indian- 0.4

- Intervention(s): OBMC will expand the number of Specialty Care Physicians (SCPs) on our current physician panel by the addition of Obstetrics and Gynecology, Cardiology/Interventional Cardiology, Otolaryngology and Orthopedic specialty services.

- Need for the project: The increase in access to specialty physician services across a wide range of clinical specialties will result in a decrease in preventable readmissions because effective disease management and access to care reduce the incidence of acute conditions. The purpose of this project, and other Category one (1) and two (2) projects, is to increase availability of SCP's to improve quality of life as well as decrease inappropriate utilization of healthcare services.

- Target population: This project addresses the RHP's goal to increase access to primary and specialty care services, with a focus on underserved populations. To ensure patients receive the most appropriate care for their condition. We plan to target patients with Medicaid, CHIP and Self-Pay, especially those with chronic disease(s).

- Category 1 or 2 expected patient benefits: Our goal is to increase our current referral pattern in each disease-specific category by five (5%) percent in the third (3rd) year and by a total of fifteen (15%) percent by year five (5).

- Category 3 outcomes: IT 3.2 – Increase the number of specialty providers, clinic hours and/or procedure hours available for the most highly impacted medical specialties.

Title: Expand Specialty Care Capacity

Unique RHP Project Identification Number: 127303903.1.3

Performing Provider Name/TPI: OakBend Medical Center (OBMC) / 127303903

Project Description: 1.9 / 1.9.1

OBMC will expand the number of Specialty Care Physicians (SCPs) on our current physician panel by the addition of Obstetrics and Gynecology, Cardiology/Interventional Cardiology, Otolaryngology and Orthopedic specialty services. In order to assist in appropriate utilization of the additional physician specialists, OBMC will implement an electronic specialty referral process and train its providers on its use.

OBMC wishes to implement this project to increase the capacity to provide specialty care services and the availability of targeted specialty providers to better accommodate the high demand for specialty care services so that patients have increased access to specialty services. Federal funding (Medicare Direct Graduate Medical Education or DGME) for residency training is capped at 1996 levels for the direct support of graduate medical education. The cap only supports a third of the costs of 4,056 of the 4,598 actual positions in Texas, leaving the residency programs to cover the cost of two-thirds of the 4,056 positions and the full cost of 542 positions. Texas is currently over its Medicare cap by 13%. Residency programs require 3 to 8 years of training, depending on the specialty. Medicare funding only covers years 1 through 3. In 2011, Texas had more than 550 residency programs, offering a total of 6,788 positions. Only 22% (1,494) of these were first-year residency positions. According to the Coordinating Board, conservative estimates indicate that the cost to educate a resident physician for one year is $150,000. Hence the State and the Fort Bend Community specifically, has a need for specialists.

Goal(s) and relationship to Regional goal(s):

Project goals:

Our goal is to increase our current referral pattern in each disease-specific category by five (5%) percent in the second (2nd) year and by a total of fifteen (15%) percent by year five (5).

This project meets the following Region 3 goals:

This project addresses the RHP's goal to "[i]ncrease access to primary and specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their condition, regardless of where they live or their ability to pay."

Challenges and how addressed:

Recruitment of physician specialists; training staff on new referral procedures. OBMC will address the challenge of physician recruitment by emphasizing to potential specialist providers the benefits of living and working in a vibrant and growing area such as Fort Bend County. The cost of living is lower than many places in the nations with low crime and no drastic seasonal changes. The shortage of PCP's and SCP's has contributed to increased wait times in hospitals, community clinics, and other care settings. This we feel discourages some individuals from seeking care due to the limited resources. This will increase access and capacity and help create an organized structure of PCP's, SCP's, clinicians, and staff..

5-year expected outcome for provider and patients:

Increase access to specialty care, as measured by project milestones and metrics. We plan to accomplish this by use of a Community Health Worker and a Community Health Coordinator. These two positions will assist patients as they access the ECC (Emergency Care Center) either for outpatient treatment in an ECC setting or upon discharge from an observation or inpatient hospitalization. They will help these patients via coordination and establishment of referral patterns to PCP's and SCP's as indicated and medically appropriate.

Starting Point/Baseline:

Baseline data:

OBMC has begun the review of referral patterns to determine the clinical areas where specialists are needed.

Time period for baseline:

1/1/12 to 6/30/12

Rationale:

Reasons for selecting the project option:

This will increase OBMC's ability to provide appropriate care in a timely manner and in the correct setting. This will enable OBMC to treat more patients in this type of setting, where they will receive education including disease-specific, as well as preventative care and screenings. In addition, the project will considerably improve OBMC's communication between the primary care and other healthcare consultants, through improvement of our physician referral line and electronic specialty referral process.

Project components:

We will meet the core components of this project which include::

a) Organizational integration and prioritization of patient experience.
b) Identify high impact/most impacted specialty services and gaps in care and coordination.
c) Increase the number of residents/trainees choosing targeted shortage specialties.
d) Design workforce enhancement initiatives to support access to specialty providers in underserved markets and areas (recruitment and retention).
e) Conduct quality improvement for project using methods such as rapid cycle improvement. Activities may include, but are not limited to, identifying project impacts, identifying "lessons learned," opportunities to scale all or part of the project to a broader patient population, and identifying key challenges associated with expansion of the project, including special considerations for safety-net populations.

Milestones and Metrics:

The following milestones and metrics were chosen for the OakBend Expand Specialty Care Capacity Project based on the core components and the needs of the target population:
Process Milestones and Metrics: P-1 (P-1.1); P-2 (P-2.1); P-20 (P-20.1)

Improvement Milestones and Metrics: I-22 (I-22.1)

Unique community need identification number the project addresses:

CN.2: Inadequate access to specialty care

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

This project would represent a new initiative for OBMC to streamline the delivery of care by recruiting targeted physician specialists in the community rather than referring to specialists in neighboring areas. This provides increased access for patients in the community and allows for better and more efficient coordination of care.

Related Category 3 Outcome Measure(s):

IT-3.1 All Cause 30-Day Readmission Rate

Reasons/rationale for selecting the outcome measure(s):

The increase in access to specialty physician services across a wide range of clinical specialties will result in a decrease in preventable readmissions because effective disease management and access to care reduce the incidence of acute conditions.

Relationship to Other Projects:

How project supports, reinforces, and enables other projects:

This project will lay a foundation for, and reinforce the clinical effectiveness of, OBMC's other DSRIP projects, including:

1.10 Enhance Performance Improvement and Reporting Capacity

2.2 Expand Chronic Care Management Models

2.4 Redesign to Improve Patient Experience

2.5 Redesign for Cost Containment

127303903.1.1: Implement and Utilize Disease Management Functionality

127303903.1.2: Training of Primary Care Workforce

Relationship to Other Performing Providers' Projects in the RHP:

The increased access to primary care visits will naturally generate additional need of specialty care visits based on the condition and acuity of the patients served. Understanding that the patient base targeted through this initiative will generate significant specialty care visits due to chronic conditions and lack of previous treatments, this initiative and similar initiatives will focus to 30-day readmission rate reductions, improvement for patient satisfaction scores, and admission rates specific to chronic conditions. Numerous initiatives have been included in the RHP plan and the addendum of the Initiative Grid can directly tie all specialty care projects together by category.

Plan for Learning Collaborative:

We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system.

Project Valuation:

Approach for valuing project:

OBMC values each project based on the specific needs of the community, the projected impact on the health outcomes of the community, the level of advancement to the healthcare delivery system, and the time, effort, and clinical resources necessary to implement each project.

In valuing this project, OBMC took into account the extent to which the expansion of specialty care capacity would potentially meet the goals of the Waiver (support the development of a coordinated care delivery system, improve outcomes while containing costs, improve the healthcare infrastructure), the extent to which it will address the community needs, the population served, and the resources and cost necessary to implement the project.

Rationale/justification for valuation:

The expansion of specialty care capacity will promote and encourage patients to access care which will lead to better clinical outcomes for the community. OBMC took these potential effects into account when considering the appropriate incentive payment value for this project.

127303903.1.3	1.9.1	1.9.1 A-E	EXPAND SPECIALTY CARE CAPACITY
OAKBEND MEDICAL CENTER			127303903
Related Category 3 Outcome Measure(s):	127303903.3.3	IT-3.1	All Cause 30-Day Readmission Rate

Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Milestone 1 [P-1]: Conduct specialty care gap assessment based on community need. **Baseline/Goal: Complete gap assessment.** **Metric 1** P-1.1: Documentation of gap assessment. Demonstrate improvement over prior reporting period (baseline for DY2). **Data Source:** Needs assessment. Milestone 1 Estimated Incentive Payment *(maximum amount):* **$518,330**	**Milestone 2** [P-2]: Train care providers and staff on processes, guidelines and technology for referrals and consultations into selected medical specialties. **Baseline/Goal: Educate primary care providers on availability of specialists to whom referrals can be made.** **Metric 1** P-2.1 Training of staff and providers on referral guidelines, process and technology. **Data Source:** Log of specialty care personnel trained and curriculum for training. Milestone 2 Estimated Incentive Payment: **$282,735** **Milestone 3** [I-22]: Increase the number of specialist providers, clinic hours and/or procedure hours available for the high impact/most impacted medical specialties.	**Milestone 4** [I-22]: Increase the number of specialist providers, clinic hours and/or procedure hours available for the high impact/most impacted medical specialties. **Baseline/Goal: According to the gap assessment, increase number and continue to educate primary care providers on availability of additional specialists to whom referrals can be made. Increase specialty providers by 1 and/or clinic hours or procedure hours by 2 each month over DY2.** **Metric 1** I-22.1: Increase number of specialist providers, clinic hours and/or procedure hours in targeted specialties. **Data Source:** HR documents or other documentation demonstrating employed/ contracted specialists. Milestone 4 Estimated Incentive Payment: **$283,556**	**Milestone 6** [I-22]: Increase the number of specialist providers, clinic hours and/or procedure hours available for the high impact/most impacted medical specialties. **Baseline/Goal: Expand number and continue to educate primary care providers on availability of additional specialists to whom referrals can be made. Increase specialty providers by 2 and/or clinic hours or procedure hours by 4 each month over DY2.** **Metric 1** I-22.1: Increase number of specialist providers, clinic hours and/or procedure hours in targeted specialties. **Data Source:** HR documents or other documentation demonstrating employed/contracted specialists. Milestone 6 Estimated Incentive Payment: **$234,242**

127303903.1.3	1.9.1	1.9.1 A-E	EXPAND SPECIALTY CARE CAPACITY	
OAKBEND MEDICAL CENTER				127303903
Related Category 3 Outcome Measure(s):	127303903.3.3	IT-3.1	All Cause 30-Day Readmission Rate	

Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
	Baseline/Goal: 1 specialist MD or NP over baseline; or 1% increase in yearly procedure hours over baseline; or increase of 10 clinic hours per month over baseline. **Metric 1** I-22.1: Increase number of specialist providers, clinic hours and/or procedure hours in targeted specialties. **Data Source:** HR documents or other documentation demonstrating employed/contracted specialists. Milestone 3 Estimated Incentive Payment: **$282,735**	**Milestone 5** P-20: Review project data and respond to it every week with tests of new ideas, practices, tools, or solutions. This data will be collected with simple, interim measurement systems, and will be based on self-reported data and sampling that is sufficient for the purposes of improvement. **Baseline/Goal: 2 specialist MDs or NPs over baseline; or 2% increase in yearly procedure hours over baseline; or increase of 15 clinic hours per month over baseline.** **Metric 1** P-20.1 Number of new ideas, practices, tools, or solutions tested. **Data Source:** Brief description of the idea, practice, tool, or solution tested each week, and summarized at quarterly intervals. Milestone 5 Estimated Incentive Payment: **$283,556**	**Milestone 7** P-20: Review project data and respond to it every week with tests of new ideas, practices, tools, or solutions. This data will be collected with simple, interim measurement systems, and will be based on self-reported data and sampling that is sufficient for the purposes of improvement. **Baseline/Goal: 3 specialist MDs or NPs over baseline; or 3% increase in yearly procedure hours over baseline; or increase of 20 clinic hours per month over baseline.** **Metric1** P-20.1 Number of new ideas, practices, tools, or solutions tested. **Data Source**: Brief description of the idea, practice, tool, or solution tested each week, and summarized at quarterly intervals. Milestone 7 Estimated Incentive Payment: **$234,242**

127303903.1.3	1.9.1	1.9.1 A-E	EXPAND SPECIALTY CARE CAPACITY
OAKBEND MEDICAL CENTER			127303903
Related Category 3 Outcome Measure(s):	127303903.3.3	IT-3.1	All Cause 30-Day Readmission Rate
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Year 2 Estimated Milestone Bundle Amount *(add incentive payments amounts from each milestone)*: **$518,330**	Year 3 Estimated Milestone Bundle Amount: **$565,470**	Year 4 Estimated Milestone Bundle Amount: **$567,114**	Year 5 Estimated Milestone Bundle Amount: **$468,485**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over DYs 2-5)*: **$2,119,399**			

Rice Medical Center

Pass 1

Project Option 1.1.2: Expand existing primary care capacity

Unique RHP Project ID: 212060201.1.1
Performing Provider Name/TPI: Rice / 212060201

Project Summary:

Provider: Rice Medical Center is a 25-bed critical access hospital with Trauma IV designation in Eagle Lake, Texas serving a, 1100 square mile area and a population of approximately 20,000.

Intervention(s): Rice intends to expand the availability of family practice obstetric services in the East Bernard Rural Health Clinic ("RHC") and Rice Medical Center service areas by hiring a family practice obstetrician ("FP/OB") to work in the clinic. This project will entail identifying a larger space for the East Bernard RHC in which the FP/OB will practice and scheduling the FP/OB to provide after-hours services (noon-8pm shifts) during the week.

Need for the project: Wharton County, where the East Bernard Clinic is located, is populated by 10,964 women, 3,874 of which are between the ages of 15 and 44 years old (reproductive age). Approximately 30-40% of those women reside within the service area of the East Bernard clinic. The service area does not currently provide local FP/OB women's health coverage, requiring women in need of services to travel significant distances to access care.

Target population: The target population includes female patients who reside within the East Bernard Clinic's service area and currently have very limited access to OB services in the community (one part-time FP/OB and one family practice physician). The East Bernard Clinic treats approximately 8,000-10,000 patients per year and 18-22% of those patients are Medicaid eligible or uninsured. Approximately 50% of those patients are women, and are expected to benefit from the local availability of an FP/OB.

Category 1 or 2 expected patient benefits: The project seeks to provide local access to a family practice physician specializing in OB/Gyn services in DY3, and extended after-hours access to the FP/OB in DY4, allowing working women and school-age girls the opportunity to access the FP/OB in the evenings. Between DY4 and DY5, Rice seeks to increase the number of unique patients (women of reproductive age) treated by the FP/OB by 10%.

Category 3 outcomes: IT-6.1 – By DY4, Rice will improve East Bernard Clinic's patient satisfaction scores in the domain of timely access to care, appointments, and information by 5% over the baseline established in DY3 through the addition of the FP/OB to the East Bernard Clinic. By DY5, Rice seeks a 10% improvement in the same domain of patient satisfaction scores over baseline.

Project Option 1.1.2 - Expand existing primary care capacity

Unique RHP Project Identification number: 212060201.1.1
Performing Provider/TPI: Rice/212060201

Project Description:
Rice proposes to expand the availability of family practice obstetric services.

We intend to expand the availability of family practice obstetric services in the East Bernard RHC and Rice service areas by hiring a physician to provide these services. With increased access to women's family practice and OB services, the health outcomes for women and their infants will improve in the short- and long-term, as will the delivery system costs of providing care.

Specifically, Rice is going to build a new clinic in East Bernard to replace the existing RHC, as the current lease is up and Rice is no longer able to maintain the space. The East Bernard clinic is the only source of primary care in the East Bernard area. In conjunction with opening the new (and improved) East Bernard clinic, Rice intends to hire an FP/OB to provide services to women, and will pilot having the FP/OB to work after-hours (noon-8pm shifts) in order to allow working women and school-age girls to receive care.

Goals and Relationship to Regional Goals:
Expand the existing capacity of primary care in the East Bernard community to better accommodate the needs and increase the availability of care for this patient population allowing them to receive the right care at the right time in the right setting.

While the Region has many specific objectives and improvement targets based on stakeholder input and community needs assessments, the over-arching goals that have guided many of our decisions include the following:
Project Goals:

- Develop a regional approach to health care delivery that leverages and improves on existing programs and infrastructure, is responsive to patient needs throughout the entire region, and improves health care outcomes and patient satisfaction.
- Increase access to primary and specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their condition, regardless of where they live or their ability to pay.
- Transform health care delivery from a disease-focused model of episodic care to a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary or duplicative services, and builds on the accomplishments of our existing health care system, and
- Develop a culture of ongoing transformation and innovation that maximizes the use of technology and best-practices, facilitates regional collaboration and sharing, and engages patients, providers, and other stakeholders in the planning, implementation, and evaluation processes.

Challenges:

Rice expects the biggest challenge of this project to be recruiting the appropriate candidate willing and able to provide this type of care to an underserved community. Rice intends to approach this challenge with innovative solutions, including creating attractive benefits for a provider to relocate to this rural area.

5-Year Expected Outcome for Provider and Patients:
Rice expects women's overall health screening, treatment, and management to improve with the addition of the FP/OB primary care physician to the new East Bernard clinic. Patients will enjoy improved access to appointments and specialty care in the area of obstetrics. These improvements should yield longer-term benefits, including a reduction in low birth weights, earlier detection of breast, cervical, and other types of cancers affecting women, and reproductive education and control for women under the FP/OB's care.

Starting Point/Baseline:
The women of (northern) Wharton County do not currently have access to a full-time FP/OB in the (East Bernard) area, and have only access to a primary care physician providing those services in the RHC that the East Bernard Clinic will replace.

Rationale:
Wharton County is a federally designated Health Professional Shortage Area when it comes to primary care for low income residents. The low-income community members residing in East Bernard and the boundaries of the Rice Hospital District are underserved by physicians providing OB services as well, on top of which population growth trends and the recent 33% reduction in local OB providers support the need for an additional OB provider in the area.

Wharton County is populated by 10,964 women, 3,874 of which are between the ages of 15 and 44 years old. A percentage of those women reside within the service area of the East Bernard clinic. The service area currently is without FP/OB women's health coverage without significant travel.

Wharton County has a lower rate of mammography screening than the statewide average, which is one of many issues this project seeks to address. More than 8% of infants born in Wharton County suffer from low birth weight, which is another condition that can be positively affected by access to an FP/OB. Finally, Wharton County's teen birth rate is higher than the statewide rate, which an FP/OB can address through sex education and preventative measures for teens in the community. Increasing access to this type of primary care is imperative to preserving and improving women's health in the community.

Project Components:
This project will address the core requirements of this project option in the following ways:

a) Expand primary care clinic space:
    - The new East Bernard clinic will have expanded square footage, allowing the FP/OB his or her own space out of which to practice women's health care.

b) Expand primary care clinic hours:
    - The East Bernard clinic will operate after-hours for FP/OB services during the week, in order to provide care to working women and school-age children.

c) Expand primary care clinic staffing:
   - The East Bernard clinic will enjoy expanded staffing, in that the FP/OB will be a new addition, and equipped to handle specialty and primary care for women and girls in the community.

Milestones and Metrics:
The following milestones and metrics were chosen for the expansion of the existing primary care capacity project based on the core components and the needs of the target population:
Process Milestones and Metrics: P-1 (P-1.1); P-4 (P-4.1); P-5 (P-5.1)
Improvement Milestones and Metrics: I-12 (I-12.1, I-12.2)
Unique community needs identification numbers:
Ties to Region 3 unique community needs: CN.1, CN.3, CN.7, CN.8, CN.9, CN.12
Related Category 3 Outcome Measure(s):
OD-6 Patient Satisfaction, IT-6.1(1) - Patient satisfaction with getting timely care, appointments, and information

Reasons/rationale for selecting the outcome measures:
Rice chose this Category 3 Outcome domain because one of the main goals in recruiting the new FP/OB to the area is to improve patient satisfaction with their access to primary and specialty care. If patients feel they are able to receive timely care, appointments, and information, they are more likely to seek treatment and maintain best health practices under the supervision of their physician.

Relationship to other Projects:
This project relates to the following projects that Rice is submitting: Reduce Inappropriate Use of the ED and Chronic Disease Outreach. This project will tie in with giving patients improved access to primary care so they will be less inclined to use the ED for non-emergent treatment, and will allow additional patient touches that are always beneficial to patients at risk for or managing chronic diseases.

Relationship to Other Performing Providers' Projects in the RHP:
Primary Care/Ambulatory Care clinics are a top priority to Region 3 due to the acuity of the regional patient mix, population concentration, and lack of primary care access points for our patient base. The regional approach of collaboration as well as existing patient referral pattern relationships allowed our team to properly identify the community needs based on the necessity of population, uninsured, and medically underserved patient bases. This program is consistent with our region and similar to numerous initiatives in our RHP plan sharing both concepts as well as outcome measures focused to percent improvement over baseline of patient satisfaction scores, reduction of inappropriate ED utilization, and third next available appointment status. The Region 3 Initiative Grid attached as a RHP Plan addendum reflects a grid of relationship for all initiatives.

Plan for Learning Collaborative:

We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and

testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system.

Project Valuation:

The valuation of each Rice project takes into account the degree to which the project accomplishes the triple-aim of the Waiver, community needs, the population served by the project (both number of people and complexity of patient needs), and investment required to implement the project. This project was valued Rice's most valuable because it most clearly accomplishes the goals of the Waiver by increasing access to primary and specialty care through additional staffing, hours, and space) and a reduction in expensive use of the ED and preventable hospital admissions for treatment.

This provider will be available to all women of reproductive age in the Region and can provide education, screening, diagnosis, and treatment for reproductive issues. The project will take significant investment in recruiting, training, and paying the new provider, as well as providing additional perks or benefits to incentivize a provider to relocate to a rural area like Colorado County and work after-hours during the week.

212060201.1.1	*1.1.2*	*1.1.2 A-C*	*EXPAND EXISTING PRIMARY CARE CAPACITY*
Rice			212060201
Related Category 3 Outcome Measure(s):	*212060201.3.1*	*IT-6.1*	*Percent improvement over baseline of patient satisfaction scores*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-1]: Establish additional/expand existing/relocate primary care clinics. Metric 1[P-1.1]: Rice will relocate the existing RHC and expand capacity by hiring an additional physician Baseline/Goal: Currently limited space with no FP/OB physician Data source**:** Plans and documentation evidencing the relocation of the East Bernard clinic to a larger space accommodating the additional physician Milestone 1 Estimated Incentive Payment: $67,486	**Milestone 2** [P-5]: Train/hire additional care providers and staff. Metric 1 [P-5.1]: Documentation of increased number of providers and staff and/or clinic sites. Baseline/Goal**:** Currently no FP/OB provider, Rice will recruit and hire an FP/OB to provide services in the East Bernard clinic. Data Source**:** Physician contract and/or HR documentation Milestone 2 Estimated Incentive Payment: $73,624	**Milestone 3** [P-4]: Expand the hours of a primary care clinic, including evening and/or weekend hours. Metric 1 [P-4.1]: Increased number of hours at primary care clinic over baselines. Baseline/Goal**:** Rice will require the FP/OB to provide after-hours services (noon-8pm shift in all likelihood) during the week, which are currently not offered Data Source: Clinic documentation Milestone 3 Estimated Incentive Payment: $73,838	**Milestone 4** [I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 [I-12.1]: Documentation of increased number of visits Baseline/Goal**:** Rice will increase the volume of visits by the FP/OB by 10% over DY4 Data Source: EHR/Registry Metric 2 [I-12.2] Documentation of increased number of unique patients (i.e. women seeing the FP/OB). Demonstrate improvement over prior reporting period Baseline/Goal**:** Rice will increase the number of unique patients seen by the FP/OB by 10% Data Source**:** EHR/Registry Milestone 4 Estimated Incentive Payment $60,996
Year 2 Estimated Milestone Bundle Amount: $67,486	Year 3 Estimated Milestone Bundle Amount: $73,624	Year 4 Estimated Milestone Bundle Amount: $73,838	Year 5 Estimated Milestone Bundle Amount: $60,996
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:** $275,944			

Rice Medical Center

Pass 3

Project Option 1.7.1: Implement telemedicine program to provide or expand specialist referral services in an area identified as needed to the region- Implement Telehealth & Telemedicine in Colorado County
Unique RHP Project Identification Number: 212060201.1.2
Performing Provider Name/TPI: Rice TPI/212060201

- Provider: Rice Medical Center is a critical access hospital located in Eagle Lake, Colorado County, TX. The county population served by Rice is approximately 21,000. Rice also serves East Bernard in Wharton County, home to approximately 2,000 residents.
- Intervention(s): Rice intends to develop the use of telemedicine in its Colorado County facilities and in schools to increase and improve access to specialty care services for community stakeholders. Rice intends to use this program in 4 distinct ways: (1) to increase local patients' access to specialty consultations without having to travel to Houston; (2) to obtain tele-psychiatric consults to aid in the timely transfer of psychiatric patients presenting in Rice's ED to the appropriate care settings; (3) to attract businesses to Colorado County by using the telemedicine project to engage in the practice of occupational medicine; and (4) to aid school nurses in treating children by linking them electronically with primary care providers in the community.
- Need for the project: The availability of telemedicine services allows community members access to specialties they may not otherwise access. Many residents of the County cannot afford to travel for healthcare, do not have access to transportation, or cannot afford to take time off from work or school. According to the Region's County Health Rankings, Colorado County has a higher rate of premature death, poor physical health days, low birth weight, and adult obesity than the statewide average. Each of these statistics can be tied to conditions requiring specialty care that may not be available in Colorado County, supporting Rice's initiative to increase access to needed care and decrease the burden on patients by implementing a telemedicine program.
- Target population: The target population of this project is patients in Colorado County who have needs for specialty care but currently have difficulty accessing it. Rice treats approximately 8,000-10,000 patients per year, 28-32% of which are Medicaid or uninsured, all of whom can benefit from the telemedicine program (depending on the specialist participants Rice is able to recruit).
- Category 1 or 2 expected patient benefits: Rice expects an increase in Colorado County residents' access to and use of specialty care because distance will no longer be a limiting factor. Additionally, Rice expects the transfer time for psychiatric patients presenting in the ED to be significantly reduced and Rice's occupational medicine capabilities to increase. Rice will implement telehealth and telemedicine capabilities in DY3, and will improve the volume of patient access by 15% between DY3 and DY5.
- Category 3 outcomes: IT 6.1 Rice chose the patient satisfaction outcome measure because it ties in directly with the goal of this project, which is to allow patients and their PCPs to have access to specialists for consultations and referrals.

Project Option 1.7.1: Implement telemedicine program to provide or expand specialist referral services in an area identified as needed to the region- Implement Telehealth & Telemedicine in Colorado County

Unique RHP Project ID: 212060201.1.2 / Pass 3
Performing Provider Name/TPI: Rice / 212060201

Project Description:

Rice intends to develop the use of telemedicine in its Colorado County facilities and in schools to increase and improve access to specialty care services for community stakeholders. Rice intends to use this program in 4 distinct ways: (1) to increase local patients' access to specialty consultations without having to travel to Houston; (2) to obtain tele-psychiatric consults to aid in the timely transfer of psychiatric patients presenting in Rice's ED to the appropriate care settings; (3) to attract businesses to Colorado County by using the telemedicine project to engage in the practice of occupational medicine; and (4) to aid school nurses in treating children by linking them electronically with primary care providers in the community. While patients in Colorado County have identified needs for specialty care, there is not enough demand to support recruitment of specialists. In the absence of the telemedicine services, patients must either wait until their conditions become chronic necessitating hospitalizations or spend long hours commuting to Houston for such care.

Goals and Relationship to Regional Goals:

While the Region has many specific objectives and improvement targets based on stakeholder input and community needs assessments, the over-arching goals that have guided many of our decisions include the following:

- Develop a regional approach to health care delivery that leverages and improves on existing programs and infrastructure, is responsive to patient needs throughout the entire region, and improves health care outcomes and patient satisfaction.
- Increase access to primary and specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their condition, regardless of where they live or their ability to pay.
- Transform health care delivery from a disease-focused model of episodic care to a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary or duplicative services, and builds on the accomplishments of our existing health care system, and
- Develop a culture of ongoing transformation and innovation that maximizes the use of technology and best-practices, facilitates regional collaboration and sharing, and engages patients, providers, and other stakeholders in the planning, implementation, and evaluation processes.

Challenges:

Expected challenges include: (1) educating providers and patients to embrace technological advantages of telemedicine; (2) training providers to use the technology; (3) establishing a

network of specialists willing to work with Rice's providers (including psychiatrists); and, (4) implementing the necessary technology to make the program possible in the clinics. The project will address these challenges by using DYs 2-3 to plan and deploy the infrastructure for the program, and then proceeding in DY 4-5 to make the best use of the new telemedicine services.

5 year expected outcome:

Rice expects an increase in Colorado County residents' access to and use of specialty care because distance will no longer be a limiting factor. Specifically, Rice expects to set a baseline of telemedicine visits in DY3 when it establishes the program, and then to increase the number of visits by a total of 20% by the end of DY5.

Additionally, Rice expects the transfer time for psychiatric patients presenting in the ED to be significantly reduced and Rice's occupational medicine capabilities to increase.

Starting Point/Baseline:

Patients in the Colorado County community do not currently have access to telemedicine services, and have to travel to Houston to access many specialty services, which involves at least an hour of travel each way for patients and/or their families.

Rationale:

Telemedicine is currently unavailable in the Rice Hospital District service area. The availability of telemedicine services allows community members access to specialties they may not otherwise access. Many residents of the County cannot afford to travel for healthcare, do not have access to transportation, or cannot afford to take time off from work or school.

According to the Region's County Health Rankings, Colorado County has a higher rate of premature death, poor physical health days, low birth weight, and adult obesity than the statewide average. Each of these statistics can be tied to conditions requiring specialty care that may not be available in Colorado County, supporting Rice's initiative to increase access to needed care and decrease the burden on patients by DY5 through implementing a telemedicine program.

Project Components:

This project will address the following core requirements in the following ways:

- Rice will enable Colorado County residents through the hospital and its clinics to access consultations with medical and surgical specialists, as well as other practitioners when needed. This will entail creating a network of providers and establishing a system for consultations and referrals out of the system. Specialties and/or conditions targeted by this program are likely to include Family Practice, Psychiatry, Cardiology, Neurology, Pediatrics, and/or Obstetrics.

- Rice will engage in quality improvement with regard to its telemedicine project by measuring the project's efficacy and impact on the Colorado County community in

DY4, assessing where improvements can be made going forward. Quality improvements over the life of the project may include: targeting new and/or different specialties, reaching out to the patient community to expand the use of the services, or expanding the use of telemedicine beyond Colorado County.

Ties to unique Region community needs:

CN.1- Inadequate access to primary care

CN.2- Inadequate access to specialty care

CN.3- Inadequate access to behavioral health care

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

This is an entirely new initiative for Rice Medical Center and the surrounding community.

Related Category 3 Outcome Measure(s):

OD-6 Patient Satisfaction, P1 – Project planning, P2 – Establish baseline rates

IT 6.1(3), Percent improvement over baseline of patient satisfaction in patient's rating of doctor access to specialist

Reasons/Rational for selecting the outcome measure:

This outcome measure ties in directly with the goal of this project, which is to allow patients and their primary care physicians to have access to specialists for consultations and referrals.

Relationship to other Projects:

This project relates to the following projects that Rice is submitting: Increasing access to health care, primary and specialty, This project will tie in with giving patients improved access to primary health care and a variety of special health care services so they will be less inclined to use the ED for non-emergent treatment and will allow patient access to beneficial services, especially those patients without access to healthcare for any variety of reasons and those patients at risk for managing chronic diseases.

Relationship to Other Performing Providers' Projects in the RHP:

An innovative approach to increasing access to primary care and specialty care has been created by the miracles of the internet and computer systems. Telemedicine is leading edge for those communities who cannot easily access behavioral health or specialty care due to remote locations, lack of physicians, or urgency of encounter needs. Numerous telemedicine projects have been proposed, as seen in the Region 3 Initiative grid in the addendum, and all focus to outcomes such as appropriate emergency department utilization, 30-day readmission rates, and patient satisfaction scores.

Plan for Learning Collaborative:

We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system.

Project Valuation:

The valuation of each Rice project takes into account the degree to which the project accomplishes the triple-aim of the Waiver, community needs, the population served by the project (both number of people and complexity of patient needs), and investment required to implement the project. The value of this project derives from the investment necessary to implement it (equipment, provider training, outreach to specialists in Texas), its expected impact on the community (increased access to specialists with reduced effort, more efficient transfer of psychiatric patients out of the ED, and increased occupational medicine capabilities), and its expected impact on the institutional cost of providing care (earlier intervention by appropriate practitioner should lead to better outcomes and lower costs). Psychiatric patients often languish in EDs or other inappropriate care settings, so this project will impact a traditionally underserved population of patients. Rural patients requiring specialist consults in order to receive treatment also face barriers in accessing care, which this project seeks to bridge. Assuming that Rice is successful in recruiting a comprehensive group of specialists to participate in the telemedicine program, this project will touch a broad base on Rice's patient community and completely redesign the care delivery system in Colorado and neighboring counties. For these reasons, this project is very valuable to Rice.

212060201.1.2	1.7.1	1.7.1(A-B)	IMPLEMENT TELEHEALTH	
		Rice		212060201
Related Category 3 Outcome Measure(s):	212060201.3.5	IT-6.1(3)	Percent improvement over baseline of patient satisfaction in patient's rating of doctor access to specialist	

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1 [P-1]: Conduct needs assessment to identify needed specialties that can be provided via telemedicine. Metric 1 [P-1.1]: Needs assessment to identify the types of personnel needed to implement the program and hiring of the respective personnel. Goal: Rice will use its access to patient records and community data to assess which specialty services are most needed in the community, and work on creating a network of those specialists. Rice will additionally seek psychiatrists to participate in the telemedicine program in the hospital's ED. Data source: Documentation of the assessment Milestone 1 Estimated Incentive Payment: $469,403	**Milestone 2** [P-4]: Implement or expand telehealth program for targeted health services, based upon regional and local community need. Metric 1 [P-4.1]: Documentation of the program materials, including implementation plan, vendor agreements/contracts, staff training, and HR documents. Goal: Rice will implement a telemedicine program in its hospital that uses a network of specialty providers for conditions/services identified in the specialty needs assessment as lacking in the community. Data Source: Program materials Milestone 2 Estimated Incentive Payment: $220,895.50 **Milestone 3** [P-4]: Implement or expand telehealth program for targeted health services, based upon regional and local community need. Metric 1 [P-4.1]: Documentation of the program materials, including implementation plan, vendor agreements/contracts, staff training, and HR documents. Goal: Rice will create a telehealth	**Milestone 4** [P-X]: Assess efficacy of processes in place and recommend process improvements to implement, if necessary. Metric 1 [P-X.1]: Review data about the rate and volume of consults by specialty to determine if changes need to be made (i.e. wider network of specialists, targeting different specialties, etc.) Data source: Report of findings and recommendations Milestone 4 Estimated Incentive Payment: $207,089.50 **Milestone 5** [I-12]: Increase number of telemedicine visits for each specialty identified as high need. Metric 1 [I-12.1]: Number of telemedicine visits Goal: Increased number of telemedicine visits over the DY3 baseline by 5%. Rice will increase the number of telemedicine visits for its patients needing consultations in the identified specialty areas. Numerator: Numbers of visits in which Rice patients are seen using telemedicine services for each type of medical or surgical subspecialty	**Milestone 6** [I-12]: Increase number of telemedicine visits for each specialty identified as high need. Metric 1 [I-12.1]: Number of telemedicine visits Goal: Increased number of telemedicine visits over the DY3 baseline by 15%. Rice will increase the number of telemedicine visits for its patients needing consultations in the identified specialty areas. Numerator: Numbers of visits in which Rice patients are seen using telemedicine services for each type of medical or surgical subspecialty during the demonstration year. Denominator: number of patients referred to medical specialties. Data Source: Rice EHR Milestone 6 Estimated Incentive Payment: $314,776

212060201.1.2	1.7.1	1.7.1(A-B)	IMPLEMENT TELEHEALTH
Rice			*212060201*
Related Category 3 Outcome Measure(s):	***212060201.3.5***	*IT-6.1(3)*	*Percent improvement over baseline of patient satisfaction in patient's rating of doctor access to specialist*

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
	program to implement in local public schools in Colorado County, which will assist school nurses in treating children without the children needing to leave the school setting. Data Source: Documentation of plan and implementation in the schools. Milestone 3 Estimated Incentive Payment: $220,895.50	during the demonstration year. Denominator: number of patients referred to medical specialties. Data Source: Rice EHR Milestone 5 Estimated Incentive Payment: $207,089.50	
Year 2 Estimated Milestone Bundle Amount: $469,403	Year 3 Estimated Milestone Bundle Amount: $441,791	Year 4 Estimated Milestone Bundle Amount: $414,179	Year 5 Estimated Milestone Bundle Amount: $314,776
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)**:*** $1,640,149			

Project Option 1.1.1: Establish more primary care clinics- Expand primary care clinics
Unique RHP Project Identification Number: 212060201.1.3
Performing Provider Name/TPI: Rice TPI/212060201

- Provider: Rice Medical Center is a critical access hospital located in Eagle Lake, Colorado County, TX. The county population served by Rice is approximately 21,000. Rice also serves the town of East Bernard in Wharton County with a population of approximately 2,000.
- Intervention(s): Rice will establish a primary care clinic in Wallis, Texas. This clinic will be operated by a mid-level provider supervised by a physician. Rice believes that this clinic will allow patients in the Wallis area to receive care appropriate to the medical conditions they experience.
- Need for the project: The residents of Wallis have no local primary care services. Wallis is located in Austin County (neighbor to Colorado County, where Rice Medical Center is located), and its ratio of patients to primary care physicians is over 4 times that of the statewide average (4505:1 and 1050:1, respectively). The population of Austin County, including Wallis, suffers from a higher rate of poor physical and mental health days and preventable hospitals stays than the statewide average. There is logically a connection between the paucity of primary care providers in Austin County and the high incidence of poor health in the community. Rice believes that opening a local clinic will go far towards improving the health of the Wallis community.
- Target population: The target population of this project is the residents of Wallis, Texas and other patients within a ten-mile radius who have no local primary care services. In Austin County, where Wallis is located, 1 in 4 residents are uninsured. The clinic will be especially tailored to treat patients with no third party source of payment and with inadequate funding to self-pay for their primary care services.
- Category 1 or 2 expected patient benefits: Rice expects this project to result in improved patient health outcomes due to easier access to primary care that is geographically proximate to the patients who need this care. Specifically, Rice expects the clinic to be open to treat patients in DY3, and to increase the volume of patients treated by 5% over DY3 (when the clinic is opened), and another 5% increase in DY5 over the volume of patients treated in DY4.
- Category 3 outcomes: IT 6.1 – Rice chose the patient satisfaction outcome measure because it ties in directly with the goal of this project, which is to increase the overall health of residents of the Wallis community by making primary care services available in their community. Specifically, Rice seeks to improve Wallis patients' satisfaction with their access to care, appointments, and information during the Waiver by a percentage that will be determined in DY3.

Project Option 1.1.1: Establish more primary care clinics- Expand primary care clinics

Unique Project ID: 212060201.1.3 / Pass 3
Performing Provider Name/TPI: Rice Medical Center / 212060201

Project Description:
Rice Medical Center proposes to expand primary care access in the greater Colorado County area by establishing a clinic in Wallis, Texas.

In an effort to improve access to primary care in the greater Colorado County area, Rice will establish a primary care clinic in Wallis, Texas. This clinic will be operated by a mid-level provider supervised by a physician. Rice believes that this clinic will allow patients in the Wallis area to receive care appropriate to the medical conditions they experience.

Goals and Relationship to Regional Goals:

The goal of this project is to improve access to specialty care in the greater Colorado County area, and in particular the Wallis area.

Project Goals:

- Increase the availability of primary care services for patient populations in the Wallis area.

This project meets the following regional goals:

- Develop a regional approach to health care delivery that leverages and improves on existing programs and infrastructure, is responsive to patient needs throughout the entire region, and improves health care outcomes and patient satisfaction.
- Increase access to primary and specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their condition, regardless of where they live or their ability to pay.

This project will improve patient outcomes and patient satisfaction by allowing patients to receive better and more effective primary care than that which is currently available to them.

Furthermore, this project will increase primary care services for the underserved population of the Wallis, Texas area.

Challenges:

Expected challenges include: (1) recruiting staff for the clinic; and (2) negotiating space for the clinic location.

5-Year Expected Outcome for Provider and Patients:

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Rice expects this project to result in improved patient health outcomes due to easier access to primary care that is geographically proximate to the patients who need this care. Rice expects patient satisfaction to increase as a result of increased access to primary care and the attendant better outcomes.

Starting Point/Baseline:

The residents of Wallis, Texas do not have any access to local primary care services and must travel outside of their local community in order to obtain such services.

Rationale:

The residents of Wallis have no local primary care services. The clinic will serve this population and receive a patient flow from within a ten-mile radius. Wallis is located in Austin County (neighbor to Colorado County, where Rice Medical Center is located), and its ratio of patients to primary care physicians is over 4 times that of the statewide average (4505:1 and 1050:1, respectively). The population of Austin County, including Wallis, suffers from a higher rate of poor physical and mental health days and preventable hospitals stays than the statewide average. There is logically a connection between the paucity of primary care providers in Austin County and the high incidence of poor health in the community. Rice believes that opening a local clinic will go far towards improving the health of the Wallis community.

Project Components:

This project will address the core requirements of this project option in the following ways:

- Rice will establish a new primary care clinic in Wallis, Texas.

Unique community need identification numbers the project addresses:

- CN-1: Inadequate access to primary care
  - Consequences include: patients' inability to locate a medical home; delayed diagnoses and treatment which leads to more serious health care conditions and higher costs; inappropriate utilization of emergency room facilities and higher costs; lack of care coordination and patient education. Community needs include: increased access through more clinics/providers/facilities; expansion of clinic hours and appointment times; improved transportation options for patients who have problems getting to a provider; expansion of provider training and recruitment programs; improved care coordination and patient education to ensure patients receive the right care at the right time.
- CN-8: High rates of inappropriate emergency department utilization

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

This project is a significant new initiative because it will result in the provision of primary care services that are currently unavailable in the Wallis community.

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Related Category 3 Outcome Measures:

OD-6: Patient Satisfaction; IT 6.1(5): Percent improvement over baseline of patient satisfaction—patient's overall health status; 212060201.3.6

Reasons/rationale for selecting the outcome measures:

This outcome measure ties in directly with the goal of this project, which is to increase the overall health of residents of the Wallis community by making primary care services available in their community.

Relationship to other Projects: This project relates to the following projects that Rice is submitting in RHP Region 3: Increase Access to Specialty Care, Chronic disease management.

Relationship to Other Performing Providers' Projects and Plan for Learning Collaborative: We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for RHP Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system.

Primary Care/Ambulatory Care clinics are a top priority to Region 3 due to the acuity of the regional patient mix, population concentration, and lack of primary care access points for our patient base. The regional approach of collaboration as well as existing patient referral pattern relationships allowed our team to properly identify the community needs based on the necessity of population, uninsured, and medically underserved patient bases. This program is consistent with our region and similar to numerous initiatives in our RHP plan sharing both concepts as well as outcome measures focused to percent improvement over baseline of patient satisfaction scores, reduction of inappropriate ED utilization, and third next available appointment status. The Region 3 Initiative Grid attached as a RHP Plan addendum reflects a grid of relationship for all initiatives.

Project Valuation: The valuation of each Rice project takes into account the degree to which the project accomplishes the triple-aim of the Waiver, community needs, the population served by the project (both number of people and complexity of patient needs), and investment required to implement the project. The value of this project derives from the investment necessary to implement the new clinic, its expected impact on the community (in particular, increased and easier access to essential primary care for Wallis residents), and its expected impact on the institutional cost of providing care (earlier intervention through primary care services should lead to better outcomes and lower costs). It is generally understood in the medical community that regular access to and use of primary care services improves patient overall health outcomes, disease management, and quality of life. Rural patients are especially likely to have difficulty accessing primary care in their communities, thus this project meets a critical community need in the Wallis community.

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<table>
<tr><td>212060201.1.3</td><td>1.1.1</td><td>N/A</td><td colspan="2">EXPAND ACCESS TO PRIMARY CARE</td></tr>
<tr><td colspan="4">Rice Medical Center</td><td>212060201</td></tr>
<tr><td>Related Category 3 Outcome Measure(s):</td><td>212060201.3.6</td><td>IT-6.1</td><td colspan="2">Percent Improvement over Baseline of Patient Satisfaction Scores</td></tr>
</table>

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1 [P-X]: Submit a plan, in order to do appropriate planning for the implementation of major infrastructure development. <u>Metric 1</u> [P-X.1]: Create a plan for establishing the Wallis Clinic, which includes identifying space, necessary equipment, staff, and a strategy for community outreach. Data source: documentation of the plan Milestone 1 Estimated Incentive Payment: $657,164	**Milestone 2** [P-1]: Establish additional/expand existing/relocate primary care clinics <u>Metric 1</u> [P-1.1]: Number of additional clinics or expanded hours or space. Baseline/Goal: One additional clinic. Data Source: New primary care schedule or other Performing Provider document or other plans as designated by Performing Provider. Milestone 2 Estimated Incentive Payment: $$618,507	**Milestone 3** [I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. <u>Metric 1</u> [I-12.1]: Documentation of increased number of visits. Demonstrate improvement over prior reporting period. Baseline/Goal: 5% increase in patient visits over DY3 baseline. Data Source: Registry; EHR; claims; other Performing Provider source. Milestone 3 Estimated Incentive Payment: $579,851	**Milestone 4** [I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. <u>Metric 1</u> [I-12.1]: Documentation of increased number of visits. Demonstrate improvement over prior reporting period. Baseline/Goal: 5% increase in patient visits over DY4. Data Source: Registry; EHR; claims; other Performing Provider source. Milestone 4 Estimated Incentive Payment: $440,687
Year 2 Estimated Milestone Bundle Amount: $657,164	Year 3 Estimated Milestone Bundle Amount: $$618,507	Year 4 Estimated Milestone Bundle Amount: $579,851	Year 5 Estimated Milestone Bundle Amount: $440,687
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $2,296,209			

Project Option 1.6.1 – Expand urgent care services- Enhance urgent medical advice.
Unique RHP Project Identification Number: 212060201.1.4
Performing Provider Name/TPI: Rice TPI/212060201

- Provider: Rice Medical Center is a critical access hospital located in Eagle Lake, Colorado County, TX. The county population served by Rice is approximately 21,000. Rice also serves the town of East Bernard in Wharton County with a population of approximately 2,000.
- Intervention(s): In an effort to enhance the urgent medical advice resources available to patient populations in Colorado County, Rice Medical Center will establish a new urgent care clinic. This new clinic will be an outpatient clinic and will be physically located in Rice's hospital facility. Non-emergent patients who present at Rice's Emergency Department will be directed to this new urgent care clinic and given the option of seeking urgent care at the clinic instead of emergent care at the Emergency Department, making it easier for patients to make a real and informed choice to utilize the most appropriate level of care for their particular medical conditions and reducing the costs of non-emergent care.
- Need for the project: Rice has experienced an overutilization of its Emergency Department, due to patients not seeking the appropriate level of care. The urgent care clinic to be implemented by this project will provide a convenient alternative for these patients, redirecting them from Rice's Emergency Department and reducing the costs associated with treating them, while also improving the quality of their care.
- Target population: The target population of this project is non-emergent patients who are currently using Rice's Emergency Department even though it is not the appropriate level of care given their particular conditions. Approximately 40-50% of patients presenting at Rice's ED are non-emergent cases, and approximately 28-32% of the patients treated at Rice are Medicaid-eligible or uninsured patients.
- Category 1 or 2 expected patient benefits: The goal of this project is to enhance urgent medical advice in Colorado County. Specifically, in DYs 2-3 Rice will establish a baseline of ED encounters and train nurses in protocols for redirecting patients; in DYs 4-5 Rice will increase the volume of patients electing to receive treatment in the new clinic by 20% over DY3s volume, which benefits patients who will receive the right care in the right setting.
- Category 3 outcomes: IT 9.2 - Rice chose this outcome measure because it ties in directly with the goal of this project, which is to provide patients with the opportunity to choose the most appropriate level of care for their urgent conditions, rather than seeking treatment for non-emergent conditions at Rice's Emergency Department.

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Project Option 1.6.1 – Expand urgent care services- Enhance urgent medical advice.

Unique Project ID: 212060201.1.4 / Pass 3
Performing Provider Name/TPI: Rice Medical Center / 212060201

Project Description:
Rice Medical Center proposes to enhance urgent medical advice in Colorado County by establishing an outpatient urgent care clinic in its hospital facility.

In an effort to enhance the urgent medical advice resources available to patient populations in Colorado County, Rice Medical Center will establish a new urgent care clinic. This new clinic will be an outpatient clinic and will be physically located in Rice's hospital facility. Non-emergent patients who present at Rice's Emergency Department will be directed to this new urgent care clinic and given the option of seeking urgent care at the clinic instead of emergent care at the Emergency Department, making it more possible for patients to make a real and informed choice to utilize the most appropriate level of care for their particular medical conditions and reducing the costs of non-emergent care. More than 40% of the patients who utilize Emergency Department services at Rice's hospital facility are Medicaid or uninsured.

Goals and Relationship to Regional Goals:

The goal of this project is to enhance urgent medical advice in Colorado County.

Project Goals:

- Establish an urgent care center in the Rice hospital facility.
- Direct non-emergent patients presenting at the Emergency Department to the urgent care center when appropriate, allowing such patients to voluntarily choose the most appropriate level of care.

This project meets the following regional goals:

- Develop a regional approach to health care delivery that leverages and improves on existing programs and infrastructure, is responsive to patient needs throughout the entire region, and improves health care outcomes and patient satisfaction.
- Increase access to primary and specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their condition, regardless of where they live or their ability to pay.

This project will leverage existing infrastructure in that the new urgent care services will be provided in Rice's existing hospital facility; it will also improve patient outcomes and patient satisfaction.

Furthermore, this project will increase urgent care services for an underserved population, regardless of where they live, allowing residents of Colorado County to receive the care most appropriate to their particular medical conditions.

Challenges:

Expected challenges include: (1) staffing the urgent care clinic; (2) informing patients of the availability of urgent care services at the urgent care clinic.

5-Year Expected Outcome for Provider and Patients:

Rice expects this project to result in improved patient health outcomes due to easier access to the most appropriate level of care for each patient's condition. Rice also expects a reduction in improper Emergency Department utilization.

Starting Point/Baseline:

There is currently no urgent care clinic in Rice's hospital facility. Urgent patients have few alternatives other than presenting at Rice's Emergency Department and seeking emergent care. Rice records approximately 225 Emergency Department visits per month, of which only 40% are truly emergent.

Rationale:

When patients receive the level of care most appropriate to their particular conditions, better patient outcomes will result. Additionally, Rice has experienced an overutilization of its Emergency Department, due to patients not seeking the appropriate level of care. The urgent care clinic to be implemented by this project will provide a convenient alternative for these patients, redirecting them from Rice's Emergency Department and reducing the costs associated with treating them, while also improving the quality of their care.

Project Components:

This project will address the core requirements of this project option in the following ways:

- Rice will establish an outpatient urgent care clinic in its hospital facility.
- Once this clinic is established, Rice will refine the operations of the clinic by conducting quality improvement for the project using methods such as rapid cycle improvement.

Unique community need identification numbers the project addresses:

- CN-1: Insufficient access to primary and specialty health care providers and facilities (increase number of providers, expansion of clinic hours, service locations). Consequences include: patients' inability to locate a medical home; delayed diagnoses and treatment which leads to more serious health care conditions and higher costs; inappropriate utilization of emergency room facilities and higher costs; lack of care coordination and patient education. Community needs include: increased access through more clinics/providers/facilities; expansion of clinic hours and appointment times; improved transportation options for patients who have problems getting to a provider;

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expansion of provider training and recruitment programs; improved care coordination and patient education to ensure patients receive the right care at the right time.

- CN-8: High rates of inappropriate emergency department utilization

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

This project is a significant new initiative because it will result in the provision of urgent care services that are currently unavailable in Colorado County.

Related Category 3 Outcome Measures:

OD-9: Right Care, Right Setting; IT-9.2: ED appropriate utilization; 212060201.3.7

Reasons/rationale for selecting the outcome measures:

This outcome measure ties in directly with the goal of this project, which is to provide patients with the opportunity to choose the most appropriate level of care for their urgent conditions, rather than seeking treatment for non-emergent conditions at Rice's Emergency Department.

Relationship to other Projects: This project relates to the following projects that Rice is submitting in RHP Region 3: Chronic disease management; Expand Primary Care Access (East Bernard and Wallis clinics).

Relationship to Other Performing Providers' Projects and Plan for Learning Collaborative: We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for RHP Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system.

A primary focus of the waiver as well as our region is ensuring appropriate emergency department utilization for our patient base. The lack of primary care, specialty care, and behavioral health treatment currently creates congestion in the emergency departments thus increasing cost and comprehensive treatment of patients with chronic conditions. The ED initiatives focus to outcomes of readmission rates, appropriate ED utilization, and patient satisfaction and all initiative relationships can be found on the Region 3 initiative grid in the addendum.

Project Valuation: The valuation of each Rice project takes into account the degree to which the project accomplishes the triple-aim of the Waiver, community needs, the population served by the project (both number of people and complexity of patient needs), and investment required to implement the project. The value of this project derives from the investment necessary to implement the hospital-based urgent care clinic, its expected impact on the community (in particular, increased and easier access to urgent care for Colorado County residents), and its expected impact on the institutional cost of providing care (i.e., a reduction of inappropriate Emergency Department utilization by directing patients to more appropriate and less costly sites

of care). This project represents an innovative solution to problems faced in the community – ideally, patients will access primary care outside of the hospital setting, but until bad habits are changed, patients can access urgent care services onsite at the hospital instead of being admitted to the ED. This project will have a broad impact on the community, including on the 1 in 5 patients Rice treats who are completely uninsured, and for that reason it is a valuable project.

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212060201.1.4	*1.6.1*	*N/A*	*ENHANCE URGENT MEDICAL ADVICE*	
Rice Medical Center				*212060201*
Related Category 3 Outcome Measure(s):	***212060201.3.7***	*IT-9.2*	***ED Appropriate Utilization***	

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-X]: Establish baseline for metrics P-3.1 and I-17.1. Metric 1 [P-X1.1]: Establish a baseline of the number of patients presenting at the Rice Medical Center ED who are deemed non-emergent. Also collect data about how many of those patients are uninsured/indigent, and how many of those patients have access to affordable urgent and/or primary care in the community. Milestone 1 Estimated Incentive Payment: $610,224	**Milestone 2** [P-3]: Train nurses on clinical protocols. Metric 1 [P-3.1]: Number of nurses trained to treat patients in Rice's new urgent care clinic. Baseline/Goal: Train/hire at least 2 nurses capable of staffing the urgent care clinic. Data Source: Documentation of new/expanded specialty care clinic staffing. Milestone 2 Estimated Incentive Payment: $574,328	**Milestone 3** [I-17]: Implement interventions to improve access to care of patients receiving urgent medical advice. Metric 1 [I-17.1]: Documentation of increased number of unique patients served by innovative program. Baseline/Goal: 10% increase in patients electing to use the urgent care over DY2 baseline of non-emergent patients presenting to the ED. Data Source: Registry; EHR; claims; other Performing Provider source. Milestone 3 Estimated Incentive Payment: $538,433	**Milestone 4** [I-17]: Implement interventions to improve access to care of patients receiving urgent medical advice. Metric 1 [I-17.1]: Documentation of increased number of unique patients served by innovative program. Baseline/Goal: 20% increase in patients electing to use the urgent care over DY2 baseline of non-emergent patients presenting in the ED. Data Source: Registry; EHR; claims; other Performing Provider source. Milestone 4 Estimated Incentive Payment: $409,209
Year 2 Estimated Milestone Bundle Amount: $610,224	Year 3 Estimated Milestone Bundle Amount: $574,328	Year 4 Estimated Milestone Bundle Amount: $538,433	Year 5 Estimated Milestone Bundle Amount: $409,209
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $2,132,194			

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Project Option 1.9.2: Improve access to specialty care- Improve access to specialty care in Colorado County
Unique RHP Project Identification Number: 212060201.1.5
Performing Provider Name/TPI: Rice TPI/212060201

- Provider: Rice Medical Center is a critical access hospital located in Eagle Lake, Colorado County, TX. The county population served by Rice is approximately 21,000. Rice also serves the town of East Bernard in Wharton County with a population of approximately 2,000.
- Intervention(s): In an effort to improve access to specialty care in Colorado County, Rice will recruit an otolaryngologist (ENT physician) to provide patient testing, treatment, and, when necessary, referrals to appropriate facilities within RHP Region 3. Rice intends for this ENT physician to provide an additional 4 hours per week of clinic hours. Rice will also improve access to specialty care in Colorado County by recruiting a qualified orthopedic provider to provide patient testing, treatment, and, when necessary, referrals to appropriate facilities within RHP Region 3. Rice also intends for this orthopedic provider to provide an additional 4 hours per week of clinic hours.
- Need for the project: ENT and orthopedic specialty healthcare services are currently unavailable in the Rice Hospital District service area. The rural nature of this area makes it very difficult for patients to obtain the specialty care they need, often requiring them to travel hundreds of miles to see specialist providers. According to the Region's County Health Rankings, Colorado County has a higher rate of premature death, poor physical health days, and adult obesity than the statewide average. Each of these statistics can be tied to conditions requiring specialty care that the new specialists may be able to treat more effectively than a PCP.
- Target population: The target population of this project is patients in Colorado County who have needs for ENT and orthopedic specialty healthcare services but currently do not have access. Specifically, these specialists will be willing and able to provide services to the 30% of Colorado County residents who are uninsured and may seek care in at Rice Medical Center for ENT or orthopedic conditions (which treats 8-10,000 patients per year).
- Category 1 or 2 expected patient benefits: Rice expects this project to result in improved patient health outcomes due to easier access to these specialists for the purposes of diagnosis, treatment and referrals. Specifically, Rice will recruit the specialists and launch the specialty clinic in DYs 2-3, and will improve the patient volume treated by the specialists by 5% over DY3 in DY4, and by another 5% in DY5 over DY4.
- Category 3 outcomes: IT 6.1 - Rice chose the patient satisfaction outcome measure because it ties in directly with the goal of this project, which is to allow patients and their primary care physicians to have access to specialists for consultations and referrals.

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Project Option 1.9.2: Improve access to specialty care - Improve access to specialty care in Colorado County

Unique Project ID: 212060201.1.5 / Pass 3
Performing Provider Name/TPI: Rice Medical Center / 212060201

Project Description:
Rice Medical Center proposes to improve access to specialty care in Colorado County

In an effort to improve access to specialty care in Colorado County, Rice will recruit an otolaryngologist (ENT physician) to provide services at least once a week in its specialty clinic. This clinic is located next to the hospital, making it particularly accessible to the Colorado County community and the patient population which the project is intended to serve. This ENT physician will provide patient testing, treatment, and, when necessary, referrals to appropriate facilities within RHP Region 3. Rice intends for this ENT physician to provide an additional 4 hours per week of clinic hours at Rice's clinic.

Rice will also improve access to specialty care in Colorado County by recruiting a qualified orthopedic provider to provide services at least once a week in its specialty clinic located next to the hospital. This orthopedic provider will provide patient testing, treatment, and, when necessary, referrals to appropriate facilities within RHP Region 3. Rice intends for this orthopedic provider to provide an additional 4 hours per week of clinic hours at Rice's clinic.

Goals and Relationship to Regional Goals:

The goal of this project is to improve access to specialty care in Colorado County, for those services most needed by Rice's patient population. Providing local access to specialty care at Rice's clinic will decrease delayed referrals to Houston hospitals for costly and potentially preventable services.

Project Goals:

- Increase the volume of patient testing, treatment, and referrals in the community by recruiting an ENT physician.
- Increase the volume of patient testing, treatment, and referrals in the community by recruiting an orthopedic provider.

This project meets the following regional goals:

- Develop a regional approach to health care delivery that leverages and improves on existing programs and infrastructure, is responsive to patient needs throughout the entire region, and improves health care outcomes and patient satisfaction.
- Increase access to primary and specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their condition, regardless of where they live or their ability to pay.

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This project will leverage existing infrastructure in that the new specialty care services will be provided in an existing clinic located in Rice's existing hospital facility; it will also improve patient outcomes and patient satisfaction.

Furthermore, this project will increase specialty care services for an underserved population, regardless of where they live.

Challenges:

Expected challenges include: (1) locating and recruiting the appropriate candidates willing and able to provide specialty care to an underserved community; and (2) patient education about the increased availability of services.

5-Year Expected Outcome for Provider and Patients:

Rice expects this project to result in improved patient health outcomes due to easier access to these specialists for the purposes of diagnosis, treatment and referrals. Rice also expects a reduction in the cost of obtaining this care for patients; one particular area in which these costs will be reduced is travel costs, as orthopedic and ENT patients will no longer need to travel to larger healthcare markets in order to obtain their needed care.

Starting Point/Baseline:

Patients in the Colorado County community currently have limited access to orthopedic specialists or ENT specialists in their community. The easiest way for these patients to obtain the care they need is to travel to Houston, but many are unable to do so.

Rationale:

ENT and orthopedic specialty healthcare services are currently unavailable in the Rice Hospital District service area. The rural nature of this area (and of Colorado County in general) makes it very difficult for patients to obtain the specialty care they need, often requiring them to travel hundreds of miles to see specialist providers. According to the Region's County Health Rankings, Colorado County has a higher rate of premature death, poor physical health days, low birth weight, and adult obesity than the statewide average. Each of these statistics can be tied to conditions requiring specialty care that may not be available in Colorado County, supporting Rice's initiative to increase access to needed care and decrease the burden on patients through expanding specialty services at its in-hospital specialty clinic.

Project Components:

This project will address the core requirements of this project option in the following ways:

- Rice will increase specialty service availability by extending clinic hours for orthopedic and ENT specialty services. Rice intends that each provider will provide these additional services for an additional 4 hours per week at the hospital's specialty clinic.

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- Rice will increase the number of specialty clinic locations in Colorado County providing ENT and orthopedic services by recruiting these providers. Currently there are no clinics in Colorado County providing ENT or orthopedic specialty services.

- Rice will increase specialty service availability by implementing standardized specialty referrals throughout its system; these particular referrals will be made by the ENT and orthopedic specialty providers who will provide services under this project.

- Rice will continue to develop this project by conducting quality improvement for the project using methods such as rapid cycle improvement.

Unique community need identification numbers the project addresses:

- CN-1: Insufficient access to primary care
- CN-2: Insufficient access to specialty health care
    - Consequences include: patients' inability to locate a medical home; delayed diagnoses and treatment which leads to more serious health care conditions and higher costs; inappropriate utilization of emergency room facilities and higher costs; lack of care coordination and patient education. Community needs include: increased access through more clinics/providers/facilities; expansion of clinic hours and appointment times; improved transportation options for patients who have problems getting to a provider; expansion of provider training and recruitment programs; improved care coordination and patient education to ensure patients receive the right care at the right time.

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

This project is a significant new initiative because it will result in the provision of specialty services that are currently unavailable in Colorado County.

Related Category 3 Outcome Measures:

OD-6: Patient Satisfaction; IT 6.1(3): Percent improvement over baseline of patient satisfaction—patient's rating of doctor access to specialist; 212060201.3.#

Reasons/rationale for selecting the outcome measures:

This outcome measure ties in directly with the goal of this project, which is to allow patients and their primary care physicians to have access to specialists for consultations and referrals.

Relationship to other Projects: This project relates to the following projects that Rice is submitting in RHP Region 3: Increase access to primary care (East Bernard and Wallis).

Relationship to Other Performing Providers' Projects and Plan for Learning Collaborative: We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for RHP Region 3, Harris Health System. Our participation in this

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collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system.

The increased access to primary care visits will naturally generate additional need of specialty care visits based on the condition and acuity of the patients served. Understanding that the patient base targeted through this initiative will generate significant specialty care visits due to chronic conditions and lack of previous treatments, this initiative and similar initiatives will focus to 30-day readmission rate reductions, improvement for patient satisfaction scores, and admission rates specific to chronic conditions. Numerous initiatives have been included in the RHP plan and the addendum of the Initiative Grid can directly tie all specialty care projects together by category.

Project Valuation: The valuation of each Rice project takes into account the degree to which the project accomplishes the triple-aim of the Waiver, community needs, the population served by the project (both number of people and complexity of patient needs), and investment required to implement the project. The value of this project derives from the investment necessary to implement it (recruiting and retaining qualified physicians willing to work in a rural county, training and integrating the new physicians), its expected impact on the community (in particular, increased and easier access to specialists for Colorado County residents), and its expected impact on the institutional cost of providing care (earlier intervention by an appropriate specialist should lead to better outcomes and lower costs for patients with relevant ailments). Regional transformation of the healthcare delivery system must include increasing the access to the full continuum of care for rural residents, and especially for those residents who have financial or mobility difficulties. This project will address this goal of the Waiver head-on.

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212060201.1.5	***1.9.2***	***1.9.2.(A-D)***	***Improve Access to Specialty Care in Colorado County***	
Rice Medical Center				*212060201*
Related Category 3 Outcome Measure(s):	*212060201.3.#*	*IT-6.1*	*Percent Improvement over Baseline of Patient Satisfaction Scores*	

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-X]: Establish baseline for metrics P-11.1, I-23.3 Metric 1 [P-X1.1]: Establish baseline for future years. Milestone 1 Estimated Incentive Payment: $751,045	**Milestone 2** [P-11]: Launch/expand a specialty care clinic Metric 1 [P-11.1]: Establish/expand specialty care clinics. Baseline/Goal: 8 additional hours of clinic services per week. Data Source: Documentation of new/expanded specialty care clinic. Milestone 2 Estimated Incentive Payment: $706,866	**Milestone 3** [I-23]: Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 [I-23.1]: Documentation of increased number of visits. Demonstrate improvement over prior reporting period. Baseline/Goal: 5% increase over DY2 baseline. Data Source: Registry; EHR; claims; other Performing Provider source. Milestone 3 Estimated Incentive Payment: $662,686	**Milestone 4** [I-23]: Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 [I-23.31: Documentation of increased number of visits. Demonstrate improvement over prior reporting period. Baseline/Goal: 5% increase over DY4. Data Source: Registry; EHR; claims; other Performing Provider source. Milestone 4 Estimated Incentive Payment: $503,642
Year 2 Estimated Milestone Bundle Amount: $751,045	Year 3 Estimated Milestone Bundle Amount: $706,866	Year 4 Estimated Milestone Bundle Amount: $662,686	Year 5 Estimated Milestone Bundle Amount: $503,642
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $2,624,239			

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Project Option 1.1.2: Expand existing primary care capacity- Expand the East Bernard Clinic
Unique RHP Project Identification Number: 212060201.1.6
Performing Provider Name/TPI: Rice TPI/212060201

- Provider: Rice Medical Center is a critical access hospital located in Eagle Lake, Colorado County, TX. The county population served by Rice is approximately 21,000. Rice also serves the town of East Bernard in Wharton County with a population of approximately 2,000.
- Intervention(s): Rice intends to relocate and improve the existing Rural Health Clinic ("RHC") in East Bernard in order to expand access to primary care services in this community and a surrounding radius of at least 10 miles outside the city limits. Additionally, the new clinic will have updated equipment and will be a more welcoming environment for patients than the existing clinic space, which is quite old and outdated. Rice will provide more clinic hours through the expanded East Bernard Clinic than the current RHC provides so that working residents and the school-age children of East Bernard and the surrounding community have access to this primary care source. Rice will also expand the East Bernard Clinic staffing from its current level by at least one provider (physician or mid-level) by the end of the Waiver (DY5).
- Need for the project: Like the rest of Wharton County, East Bernard suffers from a higher rate of poor physical and mental health days and preventable hospital stays than the Statewide average; access to primary care may reduce these local trends, through improving the health of the community.
- Target population: The target population of this project is children, adults and seniors in need of primary care services. In particular, the members of this population who do not receive regular services but instead wait until the situation is acute and requires hospitalization. The project will specifically target the 28% of Wharton County residents who are uninsured and the 27% of children who live in poverty. Currently, the East Bernard Clinic treats 8,000-10,000 patients per year, 18-22% of which are Medicaid or uninsured.
- Category 1 or 2 expected patient benefits: The goal of this project is to establish a primary care clinic that will increase the availability of preventative care, including child, adult, geriatric and women's health services. Rice expects that this expansion will result in increased patient volume for the East Bernard Clinic by at least 15% over the life of the Waiver.
- Category 3 outcomes: IT 6.1 - Rice chose the patient satisfaction outcome because one of the goals of expanding the East Bernard Clinic is to improve patients' access to primary care services. Thus, it is important that patients perceive that they can access appointments and information; if they do not, then Rice will need to adjust its outreach to the community to assure that residents are aware of the services available to them and/or make internal changes to increase access.

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Project Option 1.1.2: Expand existing primary care capacity- Expand the East Bernard Clinic

Unique RHP Project ID: 212060201.1.6 / Pass 3
Performing Provider Name/TPI: Rice / 212060201

Project Description:

The East Bernard community lacks adequate primary care services and, as a result, its population relies on hospital services rather than preventive care. Complicating the situation is the fact that residents do not receive regular services so they wait until the situation is acute and requires hospitalization. As such, Rice intends to relocate and improve the existing Rural Health Clinic ("RHC") in East Bernard in order to expand access to primary care services in this community and a surrounding radius of at least 10 miles outside the city limits.

Goals and Relationship to Regional Goals:

While the Region has many specific objectives and improvement targets based on stakeholder input and community needs assessments, the over-arching goals that have guided many of our decisions include the following:

- Develop a regional approach to health care delivery that leverages and improves on existing programs and infrastructure, is responsive to patient needs throughout the entire region, and improves health care outcomes and patient satisfaction.
- Increase access to primary and specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their condition, regardless of where they live or their ability to pay.
- Transform health care delivery from a disease-focused model of episodic care to a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary or duplicative services, and builds on the accomplishments of our existing health care system, and
- Develop a culture of ongoing transformation and innovation that maximizes the use of technology and best-practices, facilitates regional collaboration and sharing, and engages patients, providers, and other stakeholders in the planning, implementation, and evaluation processes.

Challenges:

Expected challenges include: (1) recruiting staff for the clinic, (2) coordinating the hours of the clinic so that patients use the clinic in lieu of emergency departments for low acuity services, and (3) locating, designing, equipping, and opening the new space.

5-Year Expected Outcome:

The goal of this project is to establish a primary care clinic that will increase the availability of preventative care, including child, adult, geriatric and women's health services. Rice expects that

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this expansion will result in increased patient volume for the East Bernard Clinic by at least 15% over the life of the Waiver.

Starting Point/Baseline:

Currently, the East Bernard RHC has 1.5 practitioners on staff, is open 35 hours per week, and has 2247 square feet of space. The clinic sees an average of 125-150 patients per week.

Rationale:

Like the rest of Wharton County, East Bernard suffers from a higher rate of poor physical and mental health days and preventable hospital stays than the Statewide average; access to primary care may reduce these local trends, through improving the health of the community. Additionally, 28% of Wharton County residents are uninsured and 27% of children live in poverty, thus it is crucial to improving patient health outcomes and the cost of providing care that these residents have access to primary care in the community without having to visit the hospital ED.

Project Components:

Rice will meet the core requirements of this project in the following manner:

1. Rice is expanding the primary care clinic space in East Bernard. The new clinic facility will have more square footage than the existing clinic, which only occupies 2247 square feet. The new clinic will occupy 5810 square feet. Additionally, the new clinic will have updated equipment and will be a more welcoming environment for patients than the existing clinic space, which is quite old and outdated.

2. Rice will provide more clinic hours through the expanded East Bernard Clinic than the current RHC provides (which is approximately 35 hours per week). Specifically, the clinic will provide service availability at least 9 more hours per week than it currently provides. Additionally, the clinic's hours will be structured to allow for some availability after hours and/or on weekends, so that working residents and the school-age children of East Bernard and the surrounding community have access to this primary care source.

3. Rice will expand the East Bernard Clinic staffing from its current level by at least one provider (physician or mid-level) by the end of the Waiver (DY5).

Ties to unique Region community needs:

CN.1- Inadequate access to primary care

CN.3- Inadequate access to behavioral health care

CN.10- High rates of preventable hospital admissions

CN.12- High rates of tobacco use and excessive alcohol use

CN.13- High teen birth rates

CN.14- High rates of poor birth outcomes and low birth-weight babies

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

The East Bernard clinic is currently in operation, but the relocation to a larger space with increased capacity is a new initiative for Rice.

Related Category 3 Outcome Measure(s):

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

Reasons/Rationale for selecting the outcome measure:

Rice chose this Outcome because one of the goals of expanding the East Bernard Clinic is to improve patients' access to primary care services. Thus, it is important that patients perceive that they can access appointments and information; if they do not, then Rice will need to adjust its outreach to the community to assure that residents are aware of the services available to them and/or make internal changes to increase access.

Relationship to other Projects: This project is related to the Reducing Inappropriate Use of the ED project. These initiatives are intended to work alongside each other to create better patient outcomes and reduced costs of providing healthcare.

Relationship to Other Performing Providers' Projects in the RHP:

Primary Care/Ambulatory Care clinics are a top priority to Region 3 due to the acuity of the regional patient mix, population concentration, and lack of primary care access points for our patient base. The regional approach of collaboration as well as existing patient referral pattern relationships allowed our team to properly identify the community needs based on the necessity of population, uninsured, and medically underserved patient bases. This program is consistent with our region and similar to numerous initiatives in our RHP plan sharing both concepts as well as outcome measures focused to percent improvement over baseline of patient satisfaction scores, reduction of inappropriate ED utilization, and third next available appointment status. The Region 3 Initiative Grid attached as a RHP Plan addendum reflects a grid of relationship for all initiatives.

Plan for Learning Collaborative: We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have

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similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system.

Project Valuation: The valuation of each Rice project takes into account the degree to which the project accomplishes the triple-aims of the Waiver, community needs, the population served by the project (both number of people and complexity of patient needs), and investment required to implement the project. Access to primary care is essential to improving the short- and long-term health outcomes for East Bernard's residents, and for reducing the cost of health care delivery in the County. Primary and preventative care can lead to reduced rates of chronic disease, better management of chronic conditions, and improved patient education about best-practices for maintaining a healthy lifestyle, which is invaluable to for the overall health of the community. Patients in rural areas like Wharton County already have difficulty accessing primary care (due to a shortage of providers), and the high uninsured rate in the community exacerbates this problem significantly. Patients without access to primary care are more likely to use the ED for primary care needs, which is a behavior this project seeks to address. Thus, this project is high value for Rice. The project will require significant investment in recruiting, identifying, obtaining, and equipping the increased space, and working with providers to increase the hours of availability and the volume of patients treated per week.

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212060201.1.6	***1.1.2***	***1.1.2 (A-C)***	***EXPAND THE EAST BERNARD CLINIC***
Rice			*212060201*
Related Category 3 Outcome Measure(s):	***212060201.3.9***	*IT-6.1*	*Percent improvement over baseline of patient satisfaction scores: (1) patients are getting timely care, appointments, and information*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1 [P-1]: Establish additional/expand existing/relocate primary care clinics. Metric 1 [P-1.1]: Number of additional clinics or expanded hours or space Goal: Rice will relocate the existing RHC in East Bernard to a larger, newer space in order to serve additional patients and improve the patient experience. Amount of expanded space – estimated to be an additional 3500 square feet. Data source: Documentation of detailed expansion plans Milestone 1 Estimated Incentive Payment: $657,164	**Milestone 2** [P-5]: Train/hire additional primary care providers and staff. Metric 1 [P-5.1]: Documentation of increased number of providers and staff and/or clinic sites. Goal: Documentation of increased number of providers. - Rice will hire/contract with at least one additional physician and/or mid-level to provide services at the East Bernard Clinic. Data source: Provider contract or schedule evidencing employment at the clinic Milestone 2 Estimated Incentive Payment: $309,254 **Milestone 3** [P-4]: Expand the hours of a primary care clinic, including evening or weekend hours. Metric 1 [P-4.1]: Increased number of hours at primary care clinic over baseline Goal: Increased number of hours at primary clinic over baseline- Rice will increase the service hours at the East Bernard Clinic from DY3 by 9 hours per week, which include at least 3 hours after work or on weekends. Data source: Clinic records of open service hours.	Milestone 4 [I-12] Increase primary care clinic volume of visits and evidence of improved access for patient seeking services. Metric 1 [I-12.1]: Documentation of increased number of visits. Goal: Rice will increase the East Bernard Clinic's volume of patients by 10% over its DY3 volume. Numerator: volume of patients seen at the East Bernard Clinic in DY5 Denominator: same measurement for DY3 Data source: Electronic Health Records/Registry maintained by the clinic Milestone 4 Estimated Incentive Payment: $579,851	Milestone 5 [I-12] Increase primary care clinic volume of visits and evidence of improved access for patient seeking services. Metric 1 [I-12.1]: Documentation of increased number of visits. Goal: Rice will increase the East Bernard Clinic's volume of patients by 15% over its DY3 volume. Numerator: volume of patients seen at the East Bernard Clinic in DY5 Denominator: same measurement for DY3 Data source: Electronic Health Records/Registry maintained by the clinic Milestone 5 Estimated Incentive Payment: $440,686

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212060201.1.6	*1.1.2*	*1.1.2 (A-C)*	*EXPAND THE EAST BERNARD CLINIC*	
		Rice		*212060201*
Related Category 3 Outcome Measure(s):	***212060201.3.9***	*IT-6.1*	*Percent improvement over baseline of patient satisfaction scores: (1) patients are getting timely care, appointments, and information*	

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	Year 5 (10/1/2015 – 9/30/2016)
	Milestone 3 Estimated Incentive Payment: $309,254		
Year 2 Estimated Milestone Bundle Amount: $657,164	Year 3 Estimated Milestone Bundle Amount: $618,508	Year 4 Estimated Milestone Bundle Amount: $579,851	Year 5 Estimated Milestone Bundle Amount: $440,686
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)****:*** $2,296,209			

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Spindletop Center

Pass 2

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Project Option 1.7.7: Implement other project to expand/establish telehealth services--client health information access portal- Client Health Information Access Portal

Unique RHP Project ID: 096166602.1.1 / Pass 2
RHP Performing Provider / TPI: Spindletop Center / 096166602

Project Summary:

Provider: Spindletop Center is a public entity community center that provides services for approximately 2900 adult, child, and adolescent behavioral health clients, 1070 substance abuse clients, 980 adult and child individuals with intellectual and developmental disabilities, and 800 children in the early childhood intervention program. With locations in Beaumont, Orange, Port Arthur, Lumberton, and Silsbee, Spindletop serves a population of more than 400,000 in Jefferson, Orange, Hardin, and Chambers counties.

Intervention: Spindletop will develop a web-based portal where secure client-focused health information can be accessed by users with only basic computer skills. Select clients will be provided Wi-Fi enabled tablets to for the implementation of the new client information portal.

Need for project: To improve client access to healthcare, healthcare providers are providing systems for electronic distribution of client health information via email or websites, but clients of intensive Medicaid services often have little or no access to the electronic devices that help them find and use healthcare information being provided via the internet. As more services and health information are available online, this project would help our clients take charge of their own health and use resources that may have been out of reach to them.

Target: This project program is targeted primarily to the behavioral health population that Spindletop serves. 54% of these adults and 88% of the child and adolescent clients are on Medicaid, with most of the remainder being indigent. Therefore, almost all of the individuals who participate in this program will be either indigent or enrolled in Medicaid.

Expected benefits: The expected outcome of this program by the end of demonstration year 5 is to increase client access to health care information through the development of the client portal and distributing internet-ready devices to 50% of all outpatient consumers and necessary staff.

- For demonstration year 2, the process milestone is to hire a project manager, purchase initial hardware/software, and contract with professional vendors to install software and deploy hardware. In DY3, the improvement milestone will be to continue development of the portal, test equipment, create training materials, and develop portal content. In DY 4-5, the improvement milestones will be to deploy tablets to and train 50% of Spindletop's behavioral health outpatient consumers by the end of year 5.

Category 3 outcomes:

- The Category 3 outcome measure is IT-6.2, percent improvement over baseline of patient satisfaction scores, patients getting timely health information. The survey will be designed to produce comparable data on the patient's perspective on care that will allow objective and meaningful assessment of the program in meeting the needs of the clients.

Project Option 1.7.7: Implement other project to expand/establish telehealth services--client health information access portal- Client Health Information Access Portal

<u>Unique RHP Project ID:</u> 096166602.1.1 / Pass 2
<u>RHP Performing Provider / TPI:</u> Spindletop Center / 096166602

<u>Description:</u>

<u>Goal:</u> The goal of this project is to support client health care, health-related education, public health and health administration by using the internet for clients to obtain specialized health information and on-line discussion groups to provide peer-to-peer support.

<u>Description:</u> Spindletop will develop a web-based portal where client-focused health information can be securely housed and easily accessed by users with only basic computer skills. Further, select clients will be provided Wi-Fi enabled tablets to facilitate the successful adoption and improvement of the new client information portal, thus eliminating the need to purchase expensive equipment on their own and ensure better access to care. The client web portal will be designed to provide immediate access to client-centered information, services, discussion groups, and alerts. Over time the portal will improve as recommendations by the user groups are adopted and the site content grows. Specifically the client portal will offer and improve access to the following:

1. Electronic Access to Client-Centered Information
    a. Healthcare summary (Continuity of Care document) updated regularly
    b. Summary of services and treatment plans
    c. Secured site to update client profile/ healthcare information for providers
    d. Peer-created discussion forums
2. Access to Information and Electronic Communication Tools
    a. Request official medical record
    b. Clients Rights Handbook
    c. Links to additional service providers and resource sites
    d. 800 numbers for information or complaints
    e. Links to Center message boards Like Twitter and Facebook
3. Alerts and Notifications
    a. Link to request email notices
        i. Appointment reminders
        ii. Emergency contact
    b. Spindletop holiday schedule or emergency closings
    c. New services and current events
    d. Satisfaction surveys

Relation to regional goals: This project relates to the Region 2 goal of improving the health of our region by expanding and coordinating access to patient-centered primary care and behavioral health care services that includes health promotion and disease prevention.

Challenges: Developing the client access portal will require the expertise of numerous outside vendors and will take up to one year to purchase and install equipment and configure the

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software. By using industry standard software like MS-SharePoint and contracting with qualified partners and consultants, we will ensure that the platform is developed expeditiously and securely.

Training service providers and clients to use an internet-ready device (tablet pc) to access the client portal will require hands-on instruction in a structured classroom environment. To meet this challenge, one full-time project manager will be hired to provide comprehensive training to staff and clients, act as the liaison between the center's clinical and IT staff, develop and maintain the client portal, and be the site's webmaster.

5-Year Expected Outcomes: The expected outcome of this program by the end of demonstration year 5 is to increase client access to health care information through the development of the client portal and distributing internet-ready devices (tablet pc) to 50% of all outpatient consumers as well as necessary staff.

Starting Point/Baseline:

Spindletop currently has an external website with information that remains fairly static. We also have a Facebook and Twitter presence, but we do little to publicize this for client use. Although we have experience with SharePoint, this is limited to employee secure information and is not client-directed or accessible. Some staff use tablet pc's but are able to share what they know on a limited basis. Client email addresses are collected when available, but we do not currently push information out via this mechanism.

Rationale:

In an effort to improve client access to healthcare, numerous recent initiatives have been mandated that encourage the use of technology. Healthcare providers have begun to provide systems for electronic distribution of client health information via email or websites; however, one key factor limiting the success of these programs is the assumption that all clients have ready access to a web enabled device or computer. Clients of intensive Medicaid services are often those who have little or no access to the devices (laptops, tablets, or smartphones) that are able to help them find and use healthcare information being provided via the internet. As more and more services and health information are available online, this project would help our clients take charge of their own health and use resources that may have been out of reach to them.

Access to client information in the current healthcare system is fragmented, requires the acquisition of health information to be completed in person, and often limits timely self-directed interventions. Through the use of a client-centered web portal, information can be shared in a secure and timely manner, thus improving care and reducing costs. Moreover, the training and equipment we provide through this project will be utilized to access other providers and resources both online and in the community which creates additional opportunities for improved outcomes and a better integrated healthcare delivery system.

Project Components:

- Hiring a project manager to coordinate the project, train staff and clients, and be the webmaster

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- Developing the project plan
- Contracting with outside consultants for website development and hardware installation
- Purchasing equipment for staff and clients
- Training staff and clients on the use of the new tablets to access the client portal, to setup and use email accounts, and on basic use of the internet.
- For ongoing quality improvement, Spindletop will conduct client satisfaction surveys routinely and publish the results utilizing an industry standard electronic survey tool. Comments will be reviewed and used to improve the quality of site content and client satisfaction.

Milestones:

For demonstration year 2, the process milestone is to hire the project manager, purchase initial hardware and software, and contract with various professional vendors to install and deploy hardware and software for the client access portal.

In demonstration year 3, the improvement milestones will be to continue development of the portal and purchase additional equipment. Once the site is operational, the project manager will organize a pilot group of staff and clients to help test all equipment, create training materials, and develop portal content.

In demonstration year 4, the improvement milestones will be to deploy tablets to and train 25% of Spindletop's behavioral health outpatient consumers on the client portal as well as necessary staff. In demonstration year 5, the improvement milestones will be to deploy tablets to and train 50% of our behavioral health outpatient consumers on the client portal.

Unique community needs the project addresses:

The Client Access Portal project proposed in this plan relates to community needs CN.1, CN.16, and CN.17.

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

This client health information access portal would be a new service for Spindletop. No U.S. Department of Health and Human Services funding is received for this program.

<u>Related Category 3 Outcome Measure:</u>

Spindletop has selected improvement outcome measure IT-6.2, Other: percent improvement over baseline of patient satisfaction scores, patients getting timely health information. One of the purposes of this project is for clients to have access to their healthcare information and learn skills that allow them to become more self-sufficient and have more control over their physical and behavioral health. The survey will be designed to produce comparable data on the patient's perspective on care that will allow objective and meaningful assessment of the program in

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meeting the needs of the clients. Public reporting of survey results will serve to enhance accountability in health care by increasing the transparency of the quality of care provided in return for the public investment.

Relationship to Other Projects:

This project relates to Spindletop's projects to integrate primary care with behavioral health #096166602.2.1 as physical health information would be available to clients on the web portal; to enhance behavioral health training #096166602.2.3 as providers are trained on using the client portal to support health care; and to utilize peer-to-peer support services #096166602.2.7 as group discussions related to health care are developed.

Relationship to Other Performing Providers' Projects: An innovative approach to increasing access to primary care and specialty care has been created by the miracles of the internet and computer systems. Telemedicine is leading edge for those communities who cannot easily access behavioral health or specialty care due to remote locations, lack of physicians, or urgency of encounter needs. Numerous telemedicine projects have been proposed, as seen in the Region 3 Initiative grid in the addendum, and all focus to outcomes such as appropriate emergency department utilization, 30-day readmission rates, and patient satisfaction scores.

Project Valuation:

Spindletop considered several factors in valuing this project including reductions in costs associated with hospitalizations for behavioral and developmental disorders and emergency room visits. Another valuation factor used for this project is the monetary value for a collaborative primary/behavioral health intervention as measured by quality adjusted life-years multiplied by a life year value. This valuation methodology uses health economic studies to assign a life year value associated with the health intervention. Since behavioral health clients have a high incidence of severe illnesses that shorten their life spans by 25 years compared to the general public, any programs that improve their mental and physical health should increase both the length and quality of their lives.

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096166602.1.1	***1.7.7***	***N/A***	***Client Health Information Access Portal***
Spindletop Center			*096166602*
Related Category 3 Outcome Measure(s):	*096166602.3.2*	*IT-6.2*	*Other: Percent improvement over baseline of patient satisfaction scores- Patients getting timely healthcare information*
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-X]: Hire project manager; contract with consultants; purchase initial equipment Metric 1 [P-X.1]: Goal: Hire project manager, contract with consultants, purchase initial equipment Data Source: Payroll records, consultant agreements, purchase records Milestone 1 Estimated Incentive Payment *:* $41,422	**Milestone 2** [P-X2]: Develop client portal; purchase additional equipment; issue tablets to and train test group Metric 1 [P-X2.1]: Baseline/Goal: Develop client portal; purchase additional equipment; issue tablets to and train test group Data Source: Program documentation, purchase records Milestone 2 Estimated Incentive Payment: $46,488	**Milestone 3** [I-X]: Issue tablets to and train clients on portal Metric 1 [I-X.1]: Baseline/Goal: 25% of MH outpatient clients Data Source: Training documentation, purchase records Milestone 3 Estimated Incentive Payment: $50,306	**Milestone 4** [I-X]: Issue tablets to and train clients on portal Metric 1 [I-X.1]: Baseline/Goal: 50% of MH outpatient clients Data Source: Training documentation, purchase records Milestone 4 Estimated Incentive Payment: $48,433
Year 2 Estimated Milestone Bundle Amount: $41,422	Year 3 Estimated Milestone Bundle Amount: $46,488	Year 4 Estimated Milestone Bundle Amount: $50,306	Year 5 Estimated Milestone Bundle Amount: $48,433
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:** $186,649			

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Project Option 1.12.2 - Expand the number of community based settings where behavioral health services may be delivered in underserved areas: Enhance service availability of appropriate levels of behavioral health care (applied behavior analysis and speech-language pathology for children diagnosed with autism spectrum disorders)

Unique RHP Project Identification Number: 081522701.1.1
Performing Provider Name/TPI: Texana Center / 081522701

Project Summary:
Enhance service availability of appropriate levels of behavioral health care (applied behavior analysis and speech-language pathology for children diagnosed with autism spectrum disorders) to expand the number of community based settings where behavioral health services may be delivered in underserved areas.
Provider Description:
Texana Center is the Local Authority for Behavioral Healthcare and Intellectual Developmental Disabilities Services for 6 counties within the RHP 3 area: Austin, Colorado, Fort Bend, Matagorda, Waller and Wharton. Texana Center serves approximately 9,800 people annually (an estimated 7,000 in BH services and 3,000 in IDD services), employs 742, and has an annual operating budget of $39,211,988.
Intervention(s):
This project will develop and implement evidence-based interventions of applied behavior analysis (ABA) and speech-language pathology (SLP) in an additional location for children with a diagnosis of autism spectrum disorder. Interventions include assessment, treatment development, and intervention overseen by Board Certified Behavior Analyst and Speech Language Pathologists, as well as training care givers using Applied Behavior Analysis.
Need for the Project:
There are increasing numbers of children diagnosed with ASD as evidenced by the latest statistics from the Center for Disease Control indicating 1:88 children have an ASD diagnosis. The Texana Children's Center for Autism only has 1 setting, currently serving 42 children diagnosed with ASD. Waiting lists in the area range from 30 to 200 per clinic and waits can be up to 2 years or until the child ages out of eligibility.
Target population:
Children with ASD diagnosis or related condition from the age of diagnosis through the age of 10.
Category 1 expected patient benefits:
Our goal is to increase utilization of community behavioral healthcare (i.e., ABA and SLP services for ASD). Capacity in DY1 was 42 at current site, in DY2 goal is to add 1 additional site and serve 7 children, DY3 17 children, DY4 up to 20 children, and DY5 up to 22 children at the second site. Children will exhaust the 24 month treatment cap and additional children will be admitted to the program, thus resulting in a projected 39 children served by the 1115 waiver through DY5.
Category 3 Outcomes:
The project seeks to increase the quality of life for individuals served specifically these treatments are designed to increase functional skills, language/communication, social interactions, pre-academic achievement, as well as decrease problem behaviors as measured by an evidence-based and validated assessment tool for children diagnosed with ASD.

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Project Option 1.12.2 - Expand the number of community based settings where behavioral health services may be delivered in underserved areas: Enhance service availability of appropriate levels of behavioral health care (applied behavior analysis and speech-language pathology for children diagnosed with autism spectrum disorders)

Unique RHP Project Identification Number: 081522701.1.1
Performing Provider Name/TPI: Texana Center / 081522701

Project Description:
This category 1 project, 1.12.2, will provide specialized behavioral health care services to the complex behavioral health population of children with diagnoses of autism spectrum disorders and related conditions.

Texana Children's Center for Autism will add a second location to provide access to Applied Behavior Analysis (ABA) and Speech Language Pathology (SLP) interventions to serve 22 additional children at a time (from a current level of approximately 40 children at a time). This will result in a minimum of 39 additional children to receive this type of service through year 5. These children require 1:1 intensive services for 25-40 hours per week for at least 2 years. Treatment is most effective if initiated before the age of 4 but it is effective for all ages. The proposed age group includes age of diagnosis through age 10. Treatment will be provided in a clinic/day treatment, community, or home setting. Treatment will be limited to up to 24 months per child so that more children can benefit from the program.

The population of children with an autism diagnosis often has key health challenges and multiple issues such as lack of daily living skills, cognitive challenges, and limited support in the community. The State's mental health system provides some minimal services, but can only serve a fraction of the population. The existing behavioral healthcare environment does not provide the necessary range of specialized therapies needed to address the complex needs of a child with autism. Positive healthcare outcomes are contingent on the ability of the patients to obtain services as soon as possible after diagnosis. However, many Texas children are unable to access these much needed services.

There are increasing numbers of individuals diagnosed with Autism Spectrum Disorders (ASD). The latest statistics from the Center for Disease Control (CDC) indicate that 1 in 88 children have a diagnosis of autism. Repeated studies by special tasks forces and others such as the US Surgeon General and the National Autism Standards Project have consistently found that Applied Behavior Analysis (ABA) intervention is the most effective intervention for children with ASD. In fact, research indicates that approximately 50% of children that receive 1:1 intensive ABA before the age of 4 for 25-40 hours a week for at least 2 years will no longer meet the diagnostic criteria for an ASD diagnosis (Howard, et al. 2005). Recent research, including the National Standards Project, emphasizes the importance of empirically based Speech Language Pathology (SLP) intervention in addition to the primary mode of intervention of ABA. With a success rate of 47 percent for early intensive behavioral intervention (Lovaas, 1987), one study found that cost savings following intensive ABA are estimated to be from $2,439,710 to $2,816,535 with inflation to age 55 per child served (Jacobson, Mulik, & Green, 1998).

This project proposes to enhance availability of specialized therapies, ABA and SLP treatment, for children with ASD consistent with best practices (Howard et al. 2005, National Autism Center's National Standard's Report 2009). The innovative care model proposed

includes interventions to increase language and communication, social skills, play skills, group participation skills, self-help skills, pre-academics skills, natural environment training, feeding intervention, community skills, pre-vocational skills, school-readiness skills, and parent training. Treatment will be developed and supervised by Board Certified Behavior Analysts (BCBA) and licensed Speech and Language Pathologists. Treatment will be provided in a clinic/day treatment, community, or home setting. Eligible persons are individuals with ASD from the age of diagnosis through the age of 10.

This project is consistent with several of the regional goals. First, it contributes to development of a regional approach to health care delivery that leverages and improves on existing programs and infrastructure, is responsive to patient needs throughout the region, and improves health care outcomes. Second, the project is consistent with the goal of developing a culture of ongoing transformation and innovation that maximizes the use of technology and best-practices, facilitates regional collaboration and sharing, and engages patients, providers, and other stakeholders in the planning, implementation, and evaluation processes. Lastly, it increases access to specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their condition, with more available locations regardless of their ability to pay.

Starting Point/Baseline:

The Texana Children's Center for Autism currently only has 1 setting. In this setting, Texana currently serves 42 children diagnosed with Autism Spectrum Disorders or related conditions. Twenty of these children are able to access treatment via private funds or private insurance. The remaining twenty-two children are able to access services through an existing grant from the Department of Assistive and Rehabilitative Services, DARS. The Children's Center for Autism anticipates serving approximately 50 total children by the end of this fiscal year (September 2012-August 31, 2012). These children receive between 15 and 32 hours of intensive ABA per week. Despite this, waiting lists in the area range from 30 to 200 per clinic and waits can be up to 2 years or until the child ages out of eligibility.

The current project will allow us to expand to a second location serving up to 22 additional full time (32.5 hours per week) children *at a time by year 5*. With admission and discharges in year 5, approximately 32 children will be served in just that one year in the new setting. Children will be limited to up to 24 months in the program in order to increase the absolute number of children served. Therefore at least 39 children will be served at the new community-based setting. With the proposed project Texana plans to expand to a second location in year 2. Texana plans to serve 7 additional clients in year 2; beginning within 90 days of being given approval. Texana projects the ramp up to include seeing 7-10 children year 2 with one BCBA hired and increase to 17-20 children year 3 with a second BCBA hired. A BCBA caseload is typically 10-11 clients, so Texana will add to the caseloads in years 4 and 5. There will be only 1 new site across the 5 years. See table below.

	Year 1	Year 2	Year 3	Year 4	Year 5
Number of NEW community-based settings where children are served	0	1	NA	NA	NA
Total Cumulative Number of Children Served at NEW community-based site	0	7	17	27	39

Child census at NEW community-based sites	0	7	17	20	22
Children Admitted to NEW community-based site	0	7	10	10	12
Projected total Children's Center Census (2 sites)	42	49	59	62	64
Children Discharged from NEW community-based site	0	0	0	7	10

Rationale:

Texana Center selected this project for the following reasons:

- This project is data driven. As previously mentioned, there is an increasing number of individuals diagnosed with Autism Spectrum Disorders (ASD). Current statistics from the CDC indicate that 1 in 88 children have a diagnosis of ASD. In fiscal year 2012, through Strategic Planning, Texana Center recognized the need to shift some resources from adult services to children services. Eighty-five percent of the individuals waiting for eligibility determination are under 21, and are seeking behavior supports and/or respite as a primary service. The 25 school districts in our local area reported that in the 2011-2012 school year, 4,332 students with IDD were served and 2,374 of these children had a diagnosis of ASD. As the number of children diagnosed with ASD increases, the need for treatment also increases. ABA and SLP are the treatments with the most evidence supporting their effectiveness (National Autism Center's National Standards Report, 2009). In 1999, the Surgeon General named ABA, the treatment of choice for children diagnosed with Autism. Lovaas (1987) documented 9/19 or 47% children who received early intensive (40 hr per week) ABA before the age of 4 for at least 2 years had cognitive and language scores in the normal range by age of 6-7 years. Numerous additional studies have supported this finding (e.g. Howard, et. al., 2005).
- This project addresses the needs of the community for expanded behavioral healthcare. RHP CN 2 - Insufficient access to behavioral health care services, resulting in lack of care or delay of care, delivery of inappropriate and insufficient care, unnecessary and preventable complications, and increased demand on criminal justice system. Children with ASD diagnoses in our area frequently never access services due to lack of funding or are placed on a waiting list for 1-3 years or until they age out of eligibility. This is highly detrimental to the trajectory of their future outcomes.
- This project is cost effective. In 1998, Jacobson et al found that cost savings following intensive ABA are estimated to be from $2,439,710 to $2,816,535 with inflation to *age 55 per child* served (Jacobson, Mulik, & Green, 1998). Additionally, in 2007, Chasson et al results indicate that the state of Texas will save $208,500 *per child across eighteen years of education* with early intensive ABA.
- Texana center has the experience to implement this project. Since 2004, Texana has been operating an intensive ABA program for children diagnosed with Autism, the Children's Center for Autism. Texana has the administrative support and clinical expertise as well as the existing infrastructure to ensure a smooth and successful expansion.

Related Category 3 Outcome Measure(s):

The Category 3 Quality Improvement Outcome Measure, Quality of Life, relates to the Category 1.12.2 project of increased utilization of community behavioral healthcare services of ABA and SLP for individuals with ASD. These treatments are specifically designed to improve symptoms and function, two essential components of quality of life. Early intensive ABA treatment results in increased language and communication skills, improved social skills, achievement in pre-academic and academic areas, and decreased problem behaviors (Howard et al. 2005). Early intensive ABA as described above can be costly, exceeding $50,000 per year. This project will improve access to needed behavioral health services for low income families.

Baseline data will be collected during years 2 and 3 using a variety of the below and related assessment tools. One or a combination of 2 or 3 of these tools will be utilized to demonstrate progress during years 3-5 based on baseline data collected during years 2 and 3.

- Demonstrated improvement in quality of life scores on evidence-based, validated standardized assessment tools for the target population. Previous instruments used in the Children's Center for Autism include the Pervasive Developmental Disorders Behavior Inventory (PDDBI) and Psychoeducational Profile-3 (PEP-3). Other recommended instruments include the Developmental Profile-Third Edition (DP-3), Peabody Picture Vocabulary Test-Fourth Edition (PPVT-4), Expressive Vocabulary Test-Second Edition (EVT-2), Bayley Scales of Infant Development-Revised (BSID-R), Wechsler Primary Preschool Scales of Intelligence-Revised (WPPSI-R), Differential Abilities Scale (DAS), Developmental Assessment of Young Children (DAYC), Vineland Adaptive Behavior Scales (VABS), Reynell Developmental Language Scales, and the Merrill-Palmer Scale of Mental Tests (Howard, et al. 2005).
- Demonstrated improvement in quality of life on the Assessment of Basic Language and Learning Skills (ABLLS-R), Verbal Behavior Milestones Assessment and Placement Program (VB-MAPP), and/or the Assessment of Functional Living Skills (AFLS). Progress can be measured by examining changes in the student's scores from one administration to the next (e.g., Goin-Kochel, Myers, Hendricks, Carr, &Wiley, 2007;Sullivan & Perry, 2006). The ABLLS-R and similar tools were selected because they are now commonly used by educators, school personnel, and psychologists to assess and monitor skills of children with autism who are receiving behavior therapy (e.g., Bradley-Johnson, Johnson, & Vladescu, 2008; Goin-Kochel et al., 2007; Schwartz, Boulware, McBride, & Sandall, 2001) and, according to Aman et al. (2004), the ABLLS-R has been selected as an outcome measure by the National Institute of Mental Health Research Units in Pediatric Psychopharmacology and Psychological Intervention Autism Network.

Relationship to other Projects:

The development and improvement of services for patients with behavioral health disorders, such as ASD, is a focus of multiple projects throughout the RHP, including those in Category I for expanding access and Category II for developing innovative solutions to priority issues. This project supports expanding specialty care capacity, developing behavioral health crisis stabilization as alternatives to hospitalization, providing an intervention for targeted behavioral health population to prevent unnecessary use of services in a specified setting, and recruiting, training, and supporting consumers of mental health services to provide peer support services.

Relationship to Other Performing Providers' Projects in the RHP:
The behavioral health crisis in Region 3 is considerable and the proposed initiatives in our RHP plan will only imply a small impression into the overall community need for treatment, but is a good start. The outpatient focus of many RHP Plan initiatives will help numerous facilities focus to treating the patients in an ambulatory setting as well as continued navigation of services with a focus to keeping patients from an inpatient unit. This initiative is similar to many others in the sense that it impacts the category of behavioral health. The Region 3 Initiative Grid attached in the addendum will show the relationship to other programs. Intellectual and developmental disabilities (IDD) are a large focus of our community including our local mental health authorities in the region. There are additional initiatives in the RHP plan with a focus on IDD and are represented in the addendum (Region 3 Initiative Grid). The IDD initiatives primarily support outcome measures of patient satisfaction scores, and admission/re-admission rates.
Local Authorities for intellectual and developmental disabilities (IDD) services throughout the state are proposing the implementation of projects to improve access to services for individuals with IDD for their respective RHP areas. The Department of Aging and Disabilities Services (DADS) has encouraged local authorities to propose projects to address the needs of the IDD population including ASD. Specifically, Harris County MHMRA is proposing 2 projects that included ABA services, STARS and in-home services. The Andrews Center MHMRA is also proposing ABA services for children with autism.
Plan for Learning Collaborative:
Through this project, Texana Center and MHMRA of Harris County will expand the existing collaboration to include monthly telephone conferences to share best practices, new ideas and solutions for the autism intervention project. The established provider meetings will provide an effective forum for gathering input of stakeholders in the project processes. Through this expanded learning collaborative, Texana and participating Local Authorities will share challenges and testing of new ideas and solutions. Additionally, Texana plans to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System as appropriate. Texana's participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system. This exchange will facilitate effective processes, efficient use of resources, and consistent data benchmarking across similar projects statewide.
Outcome Project Valuation:
This project addresses a priority need for the population of individuals with ASD to receive intensive ABA and SLP services in the community. One of the goals of this project is to avert outcomes such as potentially avoidable inpatient admissions and readmissions in settings including general acute and psychiatric hospitals, state supported living centers, and self-contained special education classrooms; to promote wellness and adherence to treatment; to promote independence in the community; and to improve quality of life. The vision will be realized throughout the child's lifetime, however, the reduction in the need for self-contained special education classrooms and in some cases the elimination of the need for special education for children served in this project would be realized during the 4 year DSRIP project.
By providing ABA services to children with autism, it allows for cost avoidance. The current project proposes to serve at least 39 children in years 2-5. Based on the figures derived from the 2007 Chasson study, the state of Texas could save $8,131,500 across 18 years of education by providing ABA treatment to these 39 children. Furthermore, based on the figures derived from

the 1998 Jacobson study, the state of Texas could save $95,148,690 through age 55 for these 39 children by providing early intensive ABA treatment.

Total Five Year Valuation: $9,105,687.

Resources:

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081522701.1.1	*1.12.2*	*N/A*	*Enhance service availability of appropriate levels of behavioral health care (applied behavior analysis and speech-language pathology for children diagnosed with autism spectrum disorders)*
Texana Center			*081522701*
Related Category 3 Outcome Measure(s):	*081522701.3.1*	*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-3]: Develop administrative protocols and clinical guidelines for projects selected (i.e. protocols for additional community based setting) Metric 1[P-3.1]: Manual of operations for the project detailing administrative protocols and clinical guidelines Baseline- existing protocols for the current setting Goal-to modify/customize these protocols and create any necessary subsequent protocols for the additional settings Data Source: Administrative protocols; clinical guidelines Milestone 1Estimated Incentive Payment *(maximum amount):* $882,194.33 **Milestone2**[P-6]: Establish behavioral health services in new community-based settings in underserved areas Metric 2[P-6.1]: Number of new community based settings where behavioral health services are delivered (i.e. applied behavior analysis and speech and language	**Milestone 4**[P-8]: Participate in at least bi-weekly interactions (meeting, conference calls, or webinars) with other providers, and the RHP to promote collaborative learning around shared or similar projects. Participation includes: 1) sharing challenges and any solutions; 2) sharing results and quantitative improvement that the provider is testing; and 3) identifying a new improvement and publically commit to testing it in the week to come. Metric 1 [P-8.1]: Number of bi-weekly meetings, conference calls, or webinars organized by the RHP that the provider participated in. Data Source: Documentation of weekly or bi-weekly phone meetings, conference calls, or webinars including agendas for phone calls, slides from webinars, and/or meeting notes. Metric 2 [P-8.2]: Share challenges and solutions successfully implemented during this bi-weekly interaction. Data Source: Catalogue of challenges, solutions, tests, and	**Milestone 6**[P-8]: Participate in at least bi-weekly interactions (meeting, conference calls, or webinars) with other providers, and the RHP to promote collaborative learning around shared or similar projects. Participation includes: 1) sharing challenges and any solutions; 2) sharing results and quantitative improvement that the provider is testing; and 3) identifying a new improvement and publically commit to testing it in the week to come. Metric 1 [P-8.1]: Number of bi-weekly meetings, conference calls, or webinars organized by the RHP that the provider participated in. Data Source: Documentation of weekly or bi-weekly phone meetings, conference calls, or webinars including agendas for phone calls, slides from webinars, and/or meeting notes. Metric 2 [P-8.2]: Share challenges and solutions successfully implemented during this bi-weekly interaction. Data Source: Catalogue of challenges, solutions, tests, and	**Milestone 8**[P-8]: Participate in at least bi-weekly interactions (meeting, conference calls, or webinars) with other providers, and the RHP to promote collaborative learning around shared or similar projects. Participation includes: 1) sharing challenges and any solutions; 2) sharing results and quantitative improvement that the provider is testing; and 3) identifying a new improvement and publically commit to testing it in the week to come. Metric 1 [P-8.1]: Number of bi-weekly meetings, conference calls, or webinars organized by the RHP that the provider participated in. Data Source: Documentation of weekly or bi-weekly phone meetings, conference calls, or webinars including agendas for phone calls, slides from webinars, and/or meeting notes. Metric 2 [P-8.2]: Share challenges and solutions successfully implemented during this bi-weekly interaction. Data Source: Catalogue of challenges, solutions, tests, and

081522701.1.1	***1.12.2***	***N/A***	*Enhance service availability of appropriate levels of behavioral health care (applied behavior analysis and speech-language pathology for children diagnosed with autism spectrum disorders)*
Texana Center			*081522701*
Related Category 3 Outcome Measure(s):	*081522701.3.1*	*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)**
pathology) Baseline/Goal: 1 setting Goal: add 1 additional setting to total 2 settings Data source: Project Documentation Milestone 2 Estimated Incentive Payment *(maximum amount):* $882,194.33 **Milestone 3** [I-11]: Increased utilization of community behavioral healthcare (i.e., ABA and SLP services for autism). Metric 1 [I-11.1]: Percent utilization of new community behavioral healthcare services. Baseline: 0 children at new setting Goal: 7 children served will be funded by the expansion Data Source: Claims data and encounter data Milestone 3 Estimated Incentive Payment: $882,194.33	progress shared by the participating provider during each bi-weekly interaction, with at least quarterly summary. Milestone 3 Estimated Incentive Payment: $1,036,998 **Milestone 5** [I-11]: Increased utilization of community behavioral healthcare (i.e., ABA and SLP services for autism). Metric 1 [I-11.1]: Percent utilization of new community behavioral healthcare services. Baseline: 7 children Goal: 17 children served will be funded by the expansion Data Source: Claims data and encounter data Milestone 5 Estimated Incentive Payment: $1,036,998	progress shared by the participating provider during each bi-weekly interaction, with at least quarterly summary. Milestone 6 Estimated Incentive Payment: $1,097,900 **Milestone 7** [I-11]: Increased utilization of community behavioral healthcare (i.e., ABA and SLP services for autism). Metric 1 [I-11.1]: Percent utilization of new community behavioral healthcare services. Baseline: 17 children Goal: 27 children served will be funded by the expansion Data Source: Claims data and encounter data Milestone 7 Estimated Incentive Payment: $1,097,900	progress shared by the participating provider during each bi-weekly interaction, with at least quarterly summary. Milestone 6 Estimated Incentive Payment: $1,094,654 **Milestone 9** [I-11]: Increased utilization of community behavioral healthcare (i.e., ABA and SLP services for autism). Metric 1 [I-11.1]: Percent utilization of new community behavioral healthcare services. Baseline: 27 children Goal: 39 children served will be funded by the expansion Data Source: Claims data and encounter data Milestone 7 Estimated Incentive Payment: $1,094,654
Year 2 Estimated Milestone Bundle Amount*:* $ 2,646,583	Year 3 Estimated Milestone Bundle Amount: $ 2,073,996	Year 4 Estimated Milestone Bundle Amount: $2,195,800	Year 5 Estimated Milestone Bundle Amount: $2,189,308

081522701.1.1	***1.12.2***	***N/A***	*Enhance service availability of appropriate levels of behavioral health care (applied behavior analysis and speech-language pathology for children diagnosed with autism spectrum disorders)*
Texana Center			*081522701*
Related Category 3 Outcome Measure(s):	*081522701.3.1*	*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)**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:**$ 9,105,687			

Project Option 1.13.1 - Develop and implement crisis stabilization services to address the identified gaps in the current community crisis system: Behavioral Healthcare Crisis Center for six-county area

Unique RHP Project Identification Number: 081522701.1.2
Performing Provider Name/TPI: Texana Center / 081522701

Project Summary:

Provider:
Texana Center is the Local Authority for Behavioral Healthcare and Intellectual and Developmental Disability Services for six counties within RHP 3: Austin, Colorado, Fort Bend, Matagorda, Waller, and Wharton. Texana Center serves approximately 9,800 individuals annually (an estimated 7,000 in BH services and 3,000 in IDD services), employs 742, and has an annual operating budget of $39,211,988.

Intervention(s):
This project will develop an 8 bed 48-hour extended observation unit and a 14 bed crisis residential unit where individuals in crisis may go to be assessed and stabilized by providing crisis intervention services. This center will provide a clinically appropriate setting and less costly alternative to hospital inpatient stays, emergency room visits, and jail.

Need for the project:
Currently, there is not a behavioral healthcare crisis center or behavioral healthcare emergency services center located in the six county service area. A crisis center is a less costly and more clinically appropriate alternative to hospital emergency rooms, state hospital inpatient beds, and jails. At the present time, there are no other alternatives in the community.

Target Population:
The target population includes all Medicaid and indigent patients in crisis and in need of assessment and stabilization services.

Category 1 or 2 expected patient benefits:
Our DY4 goal is to improve upon DY3 by 3% and for DY5 an additional improvement of 3% over DY4. Over the course of DY3-DY5, this center will see a minimum of 1,872 patients.

Category 3 outcomes:
OD-2 – Potentially Preventable Admissions: IT-2.4 Behavioral Health/Substance Abuse (BH/SA) Admission Rate - Our goal is to decrease the number of state hospital admissions by assessing and stabilizing patients in the crisis center as opposed to transporting them to Austin State Hospital, our designated state hospital for indigent/Medicaid patients.

Project Option 1.13.1 - Develop and implement crisis stabilization services to address the identified gaps in the current community crisis system: Behavioral Healthcare Crisis Center for six-county area

Unique RHP Project Identification Number: 081522701.1.2
Performing Provider Name/TPI: Texana Center / 081522701

Project Description:
Texana Center, the local mental health authority, proposes to start a behavioral healthcare crisis center to serve a six-county area (Fort Bend, Matagorda, Wharton, Colorado, Austin, and Waller Counties).

The center will include an 8 bed 48-hour extended observation unit and a 14 bed crisis residential unit where individuals in crisis may go to be assessed and stabilized. The project number is 1.13.1 – Develop and implement crisis stabilization services to address the identified gaps in the current community crisis system.

When an individual lacks the appropriate behavioral health crisis resolution mechanisms, first responders are often limited in their options to resolve the situation. Sometimes the choice comes down to the ER, jail or inpatient hospital bed. Crisis stabilization services can be developed that create alternatives to these less desirable settings. While hospitalization provides a high degree of safety for the person in crisis, it is very expensive and is often more than what is needed to address the crisis. Community based crisis alternatives can effectively reduce expensive and undesirable outcomes, such as preventable inpatient stays. For example, state psychiatric hospital recidivism trended downward coincident with implementation of crisis outpatient services in some Texas communities. The percent of persons readmitted to a Texas state psychiatric hospital within 30 days decreased from 8.0% in SFY2008 (before implementation of alternatives) to 6.9% in SFY2011[92].

Currently, there is not a behavioral healthcare crisis center or behavioral healthcare emergency services center located in the six county service area. A crisis center is a less costly and more clinically appropriate alternative to hospital emergency rooms, inpatient beds, and jails. At the present time, there are no other alternatives in the community. With the exception of geriatric-psychiatric units in local general hospitals, there are also no inpatient psychiatric beds in the service area. Patients requiring hospitalization are transported to Austin State Hospital in Austin, Texas (170 miles away) or if the patient has a payer source, to a private psychiatric hospital in Houston. This sometimes occurs because of the lack of other stabilization options in the service area primarily, observation, residential and/or respite beds.

In the largest county served by the performing provider, Fort Bend County, approximately 20% of the Fort Bend County jail population has a serious mental illness. Due to the lack of alternatives for community evaluation and treatment, these individuals are often booked into the jail so they will be held in a safe environment where they will receive the limited pharmacological management services provided by the jail. Local emergency rooms also must house individuals for extended periods of time (up to 96 hours) as there are no other local options available and many times no inpatient beds available in the state hospital system.

By having a place to safely house individuals experiencing a behavioral healthcare crisis, we can avoid more costly options of extended stays in hospital emergency rooms and jails. In addition, receiving the most clinically appropriate intervention in the least restrictive setting ensures the maximum potential for successful long term treatment and recovery.

Extended observation units are designed to provide emergency stabilization to individuals experiencing a behavioral healthcare crisis in a secure and protected environment with immediate access to emergent or urgent medical evaluation and treatment. Individuals are provided appropriate and coordinated transfer to a higher level of care if and when needed. Many times, a higher level of care can be avoided due to the immediate intervention offered in the observation unit.

Crisis residential services provide short-term, community-based residential, crisis treatment to persons who may pose some risk of harm to self or others and who may have fairly severe functional impairment. Crisis residential facilities provide a safe environment with staff on site at all times. However, these facilities are designed to allow individuals to come and go and therefore do not accept individuals who are court ordered committed for treatment. Recommended maximum length of stay is 14 days and the average length of stay is between 3 and 7 days.

Goals and Relationship to Regional Goals:

While the Region has many specific objectives and improvement targets based on stakeholder input and community needs assessments, the over-arching goals that have guided many of our decisions include the following which is consistent with this project's goals:

- Develop a regional approach to health care delivery that leverages and improves on existing programs and infrastructure, is responsive to patient needs throughout the entire region, and improves health care outcomes and patient satisfaction.
- Increase access to primary and specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their condition, regardless of where they live or their ability to pay.
- Develop a culture of ongoing transformation and innovation that maximizes the use of technology and best-practices, facilitates regional collaboration and sharing, and engages patients, providers, and other stakeholders in the planning, implementation, and evaluation processes.

Texana Center, the performing provider currently does not have space in existing facilities to create this crisis center. However, an existing building for sale has been located. Texana Center proposes to purchase and renovate the building by using existing funds and fund-raising for the purchase price and cost of renovations. This project would be modeled after an existing 2011 American Psychiatric Association Gold Achievement Award[93] winning facility located in Lufkin, Texas and operated by the Burke Center. The identified facility is also close to the Texana Center at Rosenberg Behavioral Healthcare Clinic which will provide back-up staffing support and cost efficiencies by sharing staff (i.e. psychiatrists.) In addition, this location provides easy access for all six counties as it is located two blocks from Interstate Hwy. 59. Stakeholders have voiced an easily accessible location for this proposed facility as a primary concern. The location proposed alleviates the stakeholder's concerns. Texana Center plans to

[93] **Psychiatric Services** November 2011, Volume 62, No. 11; ps.pyschiatryonline.org

purchase the building and begin renovations as soon as the plan is approved and be ready to open doors at the beginning of DY3.

5-Year Expected Outcome for Provider and Patients:

The 5-year expected outcome of this project is to provide alternatives to hospitalization, emergency rooms, and incarceration and therefore reduce the events in these settings. Every patient seen the crisis center is a potentially preventable admission to one of the current available settings. Not only will this reduce costs in inappropriate settings, it will improve the outcome and potential for recovery for the patient.

Starting Point/Baseline:

There are currently no patients serviced by the crisis center as it does not exist as an option in the community. Texana Center anticipates serving approximately 50 individuals per month or 600 per year in the first year the crisis center is open.

Rationale:

The population of the six counties included in this project is more than 800,000 and extends over 6,000 square miles. The significant growth rate in both Fort Bend and Waller counties increases the population by 25,000 to 30,000 annually. Having virtually no inpatient beds or crisis center for a region this size means there is no place for these individuals to go. These patients often end up for extended periods in local hospital emergency rooms and/or the jail as a last resort. The closest psychiatric inpatient facilities are located in Harris County, fairly close to parts of Fort Bend and Waller Counties but increasingly distant from other rural counties. These facilities are often at capacity as well as the state hospital system. The psychiatric hospitals in Harris County also do not have beds for uninsured, indigent patients. For these patients, the wait in the emergency room is even longer.

The most recent Needs Assessment of Fort Bend County conducted by the Lyndon Baines Johnson School of Public Affairs in the summer of 2011 states that the lack of services for the mentally ill has resulted in "mental health becoming a law enforcement issue."[94]

Texana Center has worked very closely over the last five years with the Sheriff's Office Detention and Patrol, Fort Bend NAMI, Mental Health America – Fort Bend, Adult Probation, and numerous other organizations to identify the gaps in service and work on solutions. One of the primary gaps identified by this group is a "place" to take individuals other than the hospital emergency rooms and jails. In addition, throughout the collaborative RHP process, stakeholders have ranked a crisis center as the priority for this service area.

The unique community need this project addresses is CN2 – Insufficient access to behavioral healthcare services, resulting in lack of care or delay of care, delivery of inappropriate and insufficient care, unnecessary and preventable complications, and increased demand on the criminal justice system.

Project Components:

Although a great deal of work has already been done around the core components of this project, Texana Center will use DY2 to finalize these core components. These components are as follows:

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[94] http://www.rgkcenter.org/sites/default/files/file/research/FB%20Report_for_posting.pdf

- Convene community stakeholders who can support the development of crisis stabilization services to conduct a gap analysis of the current community crisis system and develop a specific action plan that identifies specific crisis stabilization services to address identified gaps (Since stakeholders have been meeting for the last 4 – 5 years, this component has already been fulfilled.)
- Analyze the current system of crisis stabilization services available in the community including capacity of each service, current utilization patterns, eligibility criteria and discharge criteria for each service
- Assess the behavioral health needs of patients currently receiving crisis services in the jails, EDs, or psychiatric hospitals. Determine the types and volume of services needed to resolve crises stabilization alternatives that will meet the behavioral health needs of the patients
- Explore potential crisis alternative service models and determine acceptable and feasible models for implementation
- Texana Center will use DY3-DY5 to conduct quality improvements for the project as described in the following core component.
- Review the intervention(s) impact on access to and quality of behavioral health crisis stabilization services and identify "lessons learned," opportunities to scale all or part of the intervention(s) to a broader patient population, and identify key challenges associated with expansion of the intervention(s), including special considerations for safety-net populations

Milestones & Metrics:
For this project, Texana Center has selected the following process milestones and metrics. These were chosen to ensure core components, some of which have already been fulfilled, are completed and documented appropriately.

- P-2 – Conduct mapping and gap analysis of current crisis system.
  - Metric: Produce a written analysis of community needs for crisis services.
- P-3 – Develop implementation plans for needed crisis services.
  - Metric: Produce data-driven written action plan for development of specific crisis stabilization alternatives that are needed in each community based on gap analysis and assessment of needs.
- P-4 - Hire and train staff to implement identified crisis stabilization services.
  - Metric: Number of staff hired and trained.
- P-5 – Develop administration of operational protocols and clinical guidelines for crisis services.
  - Metric: Completion of policies and procedures.
- P-9 – Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around similar or shared projects.
  - Metric: Participate in semi-annual face-to-face meetings or seminars organized by the RHP.

Since this is a start-up project and these services are not available, all of these milestones/ metrics are necessary for a successful project.

In addition, the following improvement milestone and metrics were chosen.

- I-12 – Utilization of appropriate crisis alternatives.

- Metric: 3% increase in utilization of appropriate crisis services over baseline DY3.

This milestone was chosen to ensure the crisis center is being used appropriately in lieu of hospital emergency rooms and jails.

Related Category 3 Outcome Measure(s):

Currently, the Category 3 Outcome Measure to be chosen falls within OD-2-Potentially Preventable Admissions and/or OD-3 Potentially Preventable Re-Admissions – 30 day Readmission Rates (PPRs). Texana Center needs to identify data sources (hospitals) and processes to obtain the data in order to make a data-driven decision for a specific outcome measure. By focusing on these outcome measures, low income populations with no funding source for these services will have a place to go in the local community which will allow them to remain close to natural supports which will help prevent admissions and readmissions into psychiatric hospitals.

Relationship to Other Projects:

This project is very closely tied with the creation of a law enforcement Crisis Intervention Team proposed by Fort Bend County. Once a law enforcement team is trained to recognize mental illness and appropriate law enforcement interventions to use for this population, they must have a place to take these individuals other than the jail and emergency rooms for complete evaluation and assessment.

Relationship to Other Performing Providers' Projects in the RHP:

Numerous community needs assessments reflect an extreme need for behavioral health services to include outpatient treatment centers, crisis stabilization units, inpatient beds, and much more. The lack of funding as well as complexity of the regions patient base has limited the amount of behavioral health treatments available to our region and continues to drive cost in emergent and inpatient situations. The Crisis Stabilization Unit has a direct correlation to all behavioral health programs recommended in the RHP plan and will be a focus of two of the largest Local Mental Health Authorities of our region. Both CSU's share the outcome measures of mental health admissions & readmissions, and improvement of patient satisfaction scores. The Region 3 Initiative Grid attached in the addendum reflects the direct relationships of this initiative.

081522701.1.2	*1.13.1*	*1.13.1.A-E*	*BEHAVIORAL HEALTHCARE CRISIS CENTER*
Texana Center			*081522701*
Related Category 3 Outcome Measure(s):	*081522701.3.2*	*TBD*	*TBD*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-2]: Conduct mapping and gap analysis of current crisis system. Metric 1 [P-2.1]: Produce a written analysis of community needs for crisis services. Data Source: Written plan Milestone 1 Estimated Incentive Payment *:* $885,471 **Milestone 2** [P-3]: Develop implementation plans for needed crisis services. Metric 1 [P-3.1]: Produce data-driven written action plan for development of specific crisis stabilization alternatives that are needed in each community based on gap analysis and assessment of needs. Data Source: Written plan Milestone 2 Estimated Incentive Payment *:* $885,471	**Milestone 3** [P-4]: Hire and train staff to implement identified crisis stabilization services. Metric 1 [P-4.1]: Number of staff hired and trained. Data Source: a. Staff rosters and training records; Training curricula Milestone 3 Estimated Incentive Payment: $1,672,429 **Milestone 4** [P-5]: Develop administration of operational protocols and clinical guidelines for crisis services Metric 1 [P-5.1]: Completion of policies and procedures. Data Source: Internal policies and procedures documents and operations manual. Milestone 4 Estimated Incentive Payment: $1,672,429	**Milestone 5** [P-9]: Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. Metric 1 [P-9.1]: Participate in semi-annual face-to-face meetings or seminars organize by the RHP. Data Source: Documentation of semiannual face-to-face meetings including meeting agendas, slides from presentations, and/or meeting notes. Milestone 5 Estimated Incentive Payment: $1,760,681 **Milestone 6** [I-12]: Utilization of appropriate crisis alternatives Metric 1 [I-12.1]: 3% increase in utilization of appropriate crisis alternatives. Goal: Avg. of 52 per month Data Source: Claims, encounter, and clinical record data Milestone 6 Estimated Incentive	**Milestone 7** [P-9]: Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. Metric 1 [P-9.1]: Participate in semi-annual face-to-face meetings or seminars organize by the RHP. Data Source: Documentation of semiannual face-to-face meetings including meeting agendas, slides from presentations, and/or meeting notes. Milestone 7 Estimated Incentive Payment: $1,669,468 **Milestone 8** [I-12]: Utilization of appropriate crisis alternatives Metric 1 [I-12.1]: 3% increase in utilization of appropriate crisis alternatives. Goal: Avg. of 54 per month Data Source: Claims, encounter, and clinical record data Milestone 8 Estimated Incentive

081522701.1.2	***1.13.1***	***1.13.1.A-E***	***BEHAVIORAL HEALTHCARE CRISIS CENTER***
Texana Center			*081522701*
Related Category 3 Outcome Measure(s):	*081522701.3.2*	*TBD*	*TBD*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
		Payment: $1,760,681	Payment: $1,669,468
Year 2 Estimated Milestone Bundle Amount: $1,770,942	Year 3 Estimated Milestone Bundle Amount: $3,344,858	Year 4 Estimated Milestone Bundle Amount: $3,521,362	Year 5 Estimated Milestone Bundle Amount: $3,338,935
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $11,976,097			

Texana Center

Pass 2

Category 1: Infrastructure Development
Project Option 1.9.2: Expand Specialty Care Capacity: Improve access to specialty care.
RHP Project Identification Number: 081522701.1.3
Performing Provider Name: Texana Center
Texas Provider Identifier: 081522701

Project Description: Establish or expand initiatives to increase the availability of targeted specialty care providers for infants and toddlers 0-3 years old who exhibit mild developmental delays or have a recognized risk factor that puts them at risk of developmental delay.

Provider: Texana Center is the Local Authority for Behavioral Healthcare and Intellectual Developmental Disabilities Services for 6 counties within the RHP 3 area: Austin, Colorado, Fort Bend, Matagorda, Waller and Wharton. Texana Center serves approximately 9,800 people annually (an estimated 7,000 in BH services and 3,000 in IDD services), employs 742, and has an annual operating budget of $39,211,988.

Intervention: This project will implement a system of early identification and delivery of therapeutic services that blends the best aspects of private therapy and a natural environment based model and includes social work and/or monitoring by a child development specialist to support parental involvement and supplement the number of clinical hours recommended.

Need for the project: Currently there is no unified program for children under the age of three years available to provide comprehensive services to children with developmental delays that do not qualify for Early Childhood Intervention services or children with established risk factors for developing delays.

Target population: This project will serve children and families in Austin, Colorado, Fort Bend, Matagorda, Waller and Wharton Counties and coordinate with the Region III Educational Service Center ECI and Project GROW ECI programs.

Category 1 expected patient benefits: This project will enroll a minimum of 24 children for services in DY 2. The number of service slots will be increased to a minimum of 48, 56 and 60 children in DY 3,4,and 5. As children exit services due to achieving developmental proficiency or aging out and being referred to other services, vacancies will be filled. It is expected that the total number of children served will be twice the number of enrollment slots in a given reporting period. Children receiving therapeutic interventions through this project will have an increased likelihood of age appropriate skill development and a decreased likelihood of needing continued therapy or IDEA Part B special education services at age 3.

Category 3 outcomes: IT-2.13: Our goal is to provide interventions and supports to children 0-3 years with mild developmental delays or established risk factors reducing or eliminating the need for continued specialized therapy or IDEA Part B special education services at age 3, with benefits extending throughout the elementary school years.

Project Option 1.9.2: Improve access to specialty care- Therapeutic Intervention for Infants and Toddlers at Risk

Unique RHP Project ID: 081522701.1.3 / Pass 2
Performing Provider Name / TPI: Texana Center / 081522701

Project Description:
This category 1 project, 1.9.2 will increase the capacity to provide specialty care services (occupational, physical, behavior, and speech therapy) and the availability of targeted specialty providers to better accommodate the high demand for specialty care services so that patients have increased access to care.

The time between birth and 36 months of age is a critical developmental period[95] when the neural circuits of a child's brain are most flexible and subject to change[96]. Intervention provided to children during this critical period is likely to be more effective and less costly[97] and can decrease the need for special education and related services when a child enters school[98]. *Voices for America's Children* states that children, who start school behind, particularly on more than one dimension of school readiness, have difficulty catching up[99]. Children who fall behind in oral language in the years before formal schooling are less likely to be successful beginning readers and their achievement lag is likely to persist[100]. While not every child who experiences mild developmental delays or is at risk for delays will need special education services at school age, those who receive therapeutic supports at an early age have an increased likelihood of being "school ready." The per-pupil expenditures for special-education students can be estimated to be near double the per-pupil expenditures for general-education students[101].

This project will implement a system of early identification and delivery of therapeutic services that blends the best aspects of private therapy and a natural environment based model and includes social work and/or monitoring by a child development specialist to support parental involvement. Modeled on Department of Assistive and Rehabilitative Services Early Childhood Intervention (ECI) program[102], recognized by Medicaid as cost efficient, the proposed project would establish procedures for accepting referrals from local ECI programs for children with developmental delays of 15%-24% based on standardized testing or risk factors not qualifying for ECI services, as well as accepting referrals from community resources or families and assessing the need for intervention and support. Children identified by the proposed project as meeting eligibility for ECI services would be referred to the appropriate local ECI program.

[95] Source: www.oif.org/site/DocServer/**EarlyIntervention**
[96] Source: nectac website: www.nectac.org
[97] Source: nectac website: www.nectac.org
[98] Source: www.oif.org/site/DocServer/**EarlyIntervention**
[99] Rothstein, R. (2004). *Class and schools: Using social, economic, and educational reform to close the black-white achievement gap.*
[100] National Institute for Early Education Research (2006). *Early literacy: Policy and practice in the preschool years*.
[101] Scull, Janie & Amber m. Winkler (2011). *Shifting trends in special education.*
[102] Source: Department of Assistive and Rehabilitative Services Early Childhood Intervention website: www.dars.state.tx.us/ecis

Therapy services will be provided in a center-based setting to maximize both personnel and fiscal resources. Families without transportation, will be eligible for home-based therapy services. Home visits will be made by social workers and/or child development specialists to monitor progress and functionality in the natural environment as well as to support parents as their child's first and most important teacher[103].

Goals and Relationship to Regional Goals:

- To develop a unified system of therapeutic services and supports for infants and toddlers, 0-3 years old, who have established risk factors for developmental delay or who already demonstrate a mild delay of 15%-24% on a standardized test.
- To provide necessary services and supports to very young children and increase the chance of age appropriate development and decrease potential eligibility for IDEA Part B services at age 3 years.
- To increase access to services and supports to families who are uninsured, underinsured, who live in rural areas with limited available resources or who desire a family centered service model rather than a medical model of services.

The above project goals meet the Regional Goal to "increase access to primary and specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their condition regardless of where they live or their ability to pay."

Challenges and how to address:

The proposed project faces challenges in more than one area. All anticipated challenges present with viable solutions.

- Availability of licensed therapists in rural areas: as the proposed project will serve a 6 county area, staff serving more populated/urban areas will travel to rural areas if a shortage of available, licensed therapeutic staff is identified.
- Maximizing staff and funding resources for greatest efficiency: the proposed project will offer a blend of center-based services and home-based services. While center-based services make most efficient use of staff time and program economic resources, home-based services increase access for families without transportation and promotes family involvement.
- Public awareness of available services: initially, the proposed project will draw referrals from the local Early Childhood Intervention programs to serve those children determined ineligible for ECI services but still showing delays or having risk factors. A joint plan for public awareness will be developed and implemented with the two ECI programs serving the 6 county catchment area.
- Documentation and record keeping in a large geographic area: Texana will support electronic note submittal and all reimbursement activities for the proposed project. All staff will have assigned laptop computers and any signature or portable copiers necessary for efficient business use.

5-Year Expected Outcome for Provider and Patients:

The expected outcome for the proposed project is to become a sister program to the two ECI programs serving the 6 county area. Families of children with established developmental risk factors or developmental delay would be assured of available, economically accessible services

[103] Voices for America's Children(2010). *Early learning left out: building an early learning childhood system to secure America's future*, 3rd edition.

to meet identified needs through the waiver program if a child is ineligible for ECI services. All infants and toddlers faced with challenges to typical development would be given the best possible opportunity to be age appropriate and school ready on aging out of the proposed project.

Starting Point/Baseline:

Currently there is no unified program for children under the age of three years available to provide comprehensive services to children with developmental delays that do not qualify for Early Childhood Intervention services or children with established risk factors for developing delays.

This project will serve children and families in Austin, Colorado, Fort Bend, Matagorda, Waller and Wharton Counties and coordinate with the Region III Educational Service Center ECI and Project GROW ECI programs. The estimated population of children 0-3 in the six counties served is 21,450[104]. It is estimated that at least 3% of this population potentially qualifies for ECI services, but local programs qualified 8% fewer children referred during the current fiscal year than were qualified in FY 2011 due to the narrowing of eligibility.

This project will enroll a minimum of 24 children for services in DY 2. The number of service slots will be increased to 48, 56 and 60 children in DY 3,4,and 5. As children exit services due to achieving developmental proficiency or aging out and being referred to other services, vacancies will be filled. It is expected that the total number of children served will be twice the number of enrollment slots in a given reporting period.

Rationale:

Texana Center selected this project for the following reasons:

- This project addresses the needs of the community for expanded access to specialty services (RHP CN.2). At the direction of the Texas Legislature, eligibility for Early Childhood Intervention (ECI) services was narrowed starting in FY 2012 with a goal of reducing the number of children served by 8.4%[105]. With this narrowing of eligibility, ECI identifies a significant number of children who display developmental delays, but less than the 25+% delay that qualifies them for ECI services. The Early Childhood Intervention program hosted by Texana Center has seen a decrease in total number of children enrolled for services of 9% in FY 2012. The total children referred for services that were determined eligible and were enrolled decreased by 8%. In addition, children identified as being at-risk for developmental delay due to prematurity or prenatal drug exposure are not eligible for ECI services without first developing a qualifying delay[106]. Families of these children have only two options: do nothing until their child is school age, or seek private therapy. Families who are uninsured or under-insured often find the private therapy option financially prohibitive.
- This project is cost effective. Modeled on the proven and successful parental involvement philosophy of Early Childhood Intervention, the cost of delivering therapy services during a

[104] US Census 2010

[105] Source: Department of Assistive and Rehabilitative Services Early Childhood Intervention website: www.dars.state.tx.us/ecis

[106] Texas Administrative Code §108.805

child's enrollment in the proposed project will be ½ of traditional recommendations from private providers. Savings continue to be realized after exiting the proposed project as each child receiving therapeutic interventions and supports as infants or toddlers has an increased likelihood of entering regular education at age 5 rather than special education at age 3, This saves the local school districts $17,816 per child over that two year period. Each additional year a child is in regular education services rather than special education services realizes an additional savings of approximately $8,000 a year per child. This equals to a potential savings of $48,000 per child during the elementary school years (K-5th grade) for a combined savings (2 years pre-K plus K-5th grade) of $65,816 per child.

- Texana Center has the experience to implement this project. Texana Center has a history of successfully operating an Early Childhood Intervention (ECI) program. Texana has the administrative support and clinical expertise as well as the existing infrastructure to ensure an easy and successful expansion of services to include infants and toddlers with milder delays or risk factors.

Project Components:

a) Increase service availability with extended hours: as this is a new program, there are not yet any established hours to extend. However, it is planned to establish a flexible schedule to accommodate family's unique needs.
b) Increase number of specialty clinic locations: each location of operation will increase or establish (if none is available in a given area) access to specialty services in each of the 6 county catchment areas.
c) Implement transparent, standardized referrals across the system: the project will use a single referral system that includes notification of outcome when accepting referrals from local ECI programs or other community referral sources. The project will also make consistent use of an agreed upon referral system when making referrals to other providers for children determined to be eligible for or in need of services from other community resources.
d) Conduct quality improvement for project: as this project rolls out over the 6 county area, it will be implemented using plan-do-study-act (PDSA) principles. Each successive area of service will build on the experiences and lessons learned from the preceding establishment of a service area. Areas of improvement identified will be applied to all services as appropriate, understanding that different geographic areas may have unique challenges and needs. Due to the scope of the project and the need to provide services to all 6 counties, the initial phase of PDSA will necessitate rapid cycle improvement to ensure highest quality outcomes for the entire project. Ongoing quality improvement initiatives will be identified through the examination of data and documentation and consultation/collaboration with consumers and community partners. Given the young age, rapid rate of developmental change and limited time to receive services of the target population, rapid cycle improvement when addressing identified challenges will be key in ensuring enacted improvements benefit the maximum number of children.

Unique community need identification number the project addresses and how it is a new initiative:

- CN.2-Inadequate access to specialty care: the proposed project is an expansion to the established Early Childhood Intervention services hosted by Texana Center in 2 of the 6 county (Fort Bend, Waller) service area. It will expand access to available services and supports for infants and toddlers 0-3. It is a new initiative for Texana in 4 of the 6 county area (Wharton, Matagorda, Austin, Colorado) as Texana does not provide services nor host an ECI program that serves this population.

Related Category 3 Outcome Measure(s):
IT-2.13 Other: Potentially Preventable Admissions
Reasons/rationale for selecting the outcome measure:

The Category 3 Quality Improvement Measure, Potentially Preventable Admissions, relates to the Category 1.9.2 project of improved access to specialty care (occupational therapy, physical therapy, speech therapy, and behavior analysis/therapy). These therapies are designed to improve the developmental functioning of infants and toddlers with developmental delays and to provide supports to children at-risk, thus preventing future delays. In the private marketplace, each of the therapies often costs in excess of $100 per hour. For families that are uninsured or under insured, the costs are prohibitive. By helping children develop age appropriate skills, they acquire the independence and school readiness that best prepares them for success educationally and socially. By providing parent training and support during service delivery, families feel better able to meet the needs of their child.

It is challenging to find evidenced-based answers to specific questions about assessment and intervention for young children with developmental delays.[107] This project proposes to use the Battelle Developmental Inventory 2nd Edition (BDI-2) to establish eligibility for enrollment and an individual baseline score on each child on entry into services. The developmental test will be administered a second time prior to exiting services. The BDI-2 provides a measure of progress during the preschool years and has been designed to help assess the effects of various intervention strategies for individual children and for groups of children.[108]

Relationship to Other Projects: The development and improvement of programs providing specialty care to all individuals is a focus of multiple projects throughout the RHP, including those in Category 1 expanding access to services for children with autism spectrum disorder (ASD). Identifying and addressing needs in infants and toddlers has the primary goal of decreasing the need for ongoing specialized services but also serves to link children to additional available services meeting a wide variety of needs through existing and expanded programs throughout the state.

Relationship to Other Performing Providers' Projects in the RHP:
Local Authorities for intellectual and developmental disabilities (IDD) services throughout the state are proposing the implementation of projects to improve access to services for individuals with IDD for their respective RHP areas. The Department of Aging and Disabilities Services (DADS) has encouraged local authorities to propose projects to address the needs of the IDD

[107] Noyes-Grossner, D.M., Holland, J. P.., Lyos, Dl, Holland, C.I., Romanczyk, R. G., Gillis, J,M.(2005), Rationale and methodology for developing guidelines for early intervention service for young children with developmental disabilities. *Infants & Young Children, Vol. 18, No. 2. Pp 119-135.*
[108] Newborg, J, (2005) *Battelle Developmental Inventory 2nd Edition, Examiner's Manual. Rolling Meadows, IL: Riverside Publishing.*

population. Both Harris County MHMRA and Andrews Center MHMRA are proposing increased services to children through expanded provision of applied behavioral analysis. Increased access to specialty care (OT, PT, ST, and BCBA) for infants and toddlers with developmental delays is an important component in the continuum of needed services available to individuals provided by Texana Center.

Children are the future of healthcare and will dictate the treatments needed as well as the cost of healthcare in future years so it is critical that they receive the access needed throughout their pediatric lives. The focus of pediatric specialty care is similar throughout the region with a concentrated focus in the Harris county proper geographic region and allows for the expansion of access to numerous specialties such as cardiology, neurology, ENT, and many more. The outcome measures focus to appropriate length of stay, per episode cost of care, and improved cost savings. The Region 3 Initiative grid allows for a cross reference of similar initiatives in our region. (addendum)

Plan for Learning Collaborative: Texana Center plans to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris County Health Systems as appropriate. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system. This exchange will facilitate effective processes, efficient use of resources, and consistent data benchmarking across similar projects statewide.

Texana Center also plans to develop a referral collaboration with Region III Educational Service Center ECI and Project GROW ECI to coordinate the referral processes, ensure appropriate access to services for children referred and monitor the proposed projects progress toward meeting the needs of the identified population.

Outcome Project Valuation: This project addresses the need for children to have easy and affordable access to specialty care services (occupational therapy, physical therapy, speech therapy and behavioral intervention). The goal of this program is to avert the need for special education services at age 3 years and increase school readiness and success in grades K-5 by intervening early and maximizing developmental scores and early learning.

The proposed project plans to identify and serve at least 24 children during demonstration year 2 for a potential savings of $427,584 to local school districts for those children. Demonstration years 3-5 plan for an increase to 60 children identified and served at any given time. Without adjusting planned enrollment numbers for children exiting the program while increasing total enrollment, potential savings to public education would be approximately $3.9 million. Replacing children exiting the program while increasing overall enrollment would increase total number of unique children served to 106. Anticipating that 70% of children exiting the waiver program would not qualify for special education services, this would bring anticipated savings to $4.9 million.

In addition to the long term savings to community educational systems, Medicaid will realize an immediate savings of 50% on the level of recommended therapy employing the parent training model of service delivery rather than the medical model of service delivery. Exact savings will be dependent on percentage of total enrollment who are Medicaid eligible children and the level of services recommended.

081522701.1.3	1.9.2	N/A	THERAPEUTIC INTERVENTION FOR INFANTS AND TODDLERS AT RISK
Performing Provider: Texana Center			TPI: 081522701
Related Category 3 Outcome Measure(s):	081522701.3.4	IT-2.13	Potentially Preventable Admissions

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1 [P-1]: Conduct specialty care gap assessment based on population density and % infant/toddler population. Metric 1 [P-1.1]: Documentation of gap assessment. Baseline/Goal: estimated number of potential referrals for services Data Source: Needs assessment based on US Census, ECI referral/enrollment patterns Milestone 1 Estimated Incentive Payment *(maximum amount): $487,255* **Milestone 2** [P-6]: Develop and implement standardized referral and work-up guidelines. Metric 1 [P-6.1]: Documentation of referral and work-up guidelines. Baseline/Goal: Existing protocols for current setting Data Source: Referral and work-up policies and procedures Milestone 2: Estimated Incentive Payment*: $487,255*	**Milestone 3** [P-11]: Launch a specialty care clinic/system of services Metric 1 [P-11.1]: Establish specialty care clinic/system of services Baseline/Goal: establish baseline number of children served Data Source: documentation of number of children enrolled for services Milestone 3 Estimated Incentive Payment: $519,509 **Milestone 4** [I-23]: Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 [I-23.2]: Documentation of increased number of unique patients or size of patient panel demonstrate improvement over prior reporting period (baseline for DY2) Baseline: DY 2 serve projected number 24 unique patients Goal: Serve 48 unique patients encountered for reporting period Data Source: Documentation of patient encounters Milestone 4 Estimated Incentive	**Milestone 5** [P-19]: Participate in at least bi-weekly interactions with other providers, and the RHP to promote collaborative learning around shared or similar projects. Metric 1 [P-19.1]: Number of bi-weekly meetings, conference calls, or webinars organized by the RHP that the provider participated in. Data Source: Documentation of weekly or bi-weekly phone meetings, conference calls, or webinars including agendas for phone calls, slides from webinars, and/or meeting notes. Metric 2 [P-19.2]: Share challenges and solutions successfully implemented during this bi-weekly interaction. Data Source: Catalogue of challenges, solutions, tests, and progress shared by the participating provider during each bi-weekly interaction, with at least quarterly summary. Milestone 5 Estimated Incentive Payment (maximum amount): $562,182	**Milestone 7** [P-19]: Participate in at least bi-weekly interactions with other providers, and the RHP to promote collaborative learning around shared or similar projects. Metric 1 [P-19.1]: Number of bi-weekly meetings, conference calls, or webinars organized by the RHP that the provider participated in. Data Source: Documentation of weekly or bi-weekly phone meetings, conference calls, or webinars including agendas for phone calls, slides from webinars, and/or meeting notes. Metric 2 [P-19.2]: Share challenges and solutions successfully implemented during this bi-weekly interaction. Data Source: Catalogue of challenges, solutions, tests, and progress shared by the participating provider during each bi-weekly interaction, with at least quarterly summary. Milestone 7 Estimated Incentive Payment (maximum amount): $541,249

081522701.1.3	*1.9.2*	*N/A*	***THERAPEUTIC INTERVENTION FOR INFANTS AND TODDLERS AT RISK***
Performing Provider: Texana Center			*TPI: 081522701*
Related Category 3 Outcome Measure(s):	*081522701.3.4*	*IT-2.13*	*Potentially Preventable Admissions*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	Payment*: $519,509*	**Milestone 6** [I-23]: Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 [I-23.2]: Documentation of increased number of unique patients or size of patient panel demonstrate improvement over prior reporting period (baseline for DY2) Baseline: DY 2 serve projected number 24 unique patients Goal: Serve 56 unique patients encountered for reporting period Data Source: Documentation of patient encounters Milestone 6 Estimated Incentive Payment *(maximum amount):* Milestone 4 Estimated Incentive Payment: $562,182	**Milestone 8** [I-23]: Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 [I-23.2]: Documentation of increased number of unique patients or size of patient panel demonstrate improvement over prior reporting period (baseline for DY2) Baseline: DY 2 serve projected number 20 unique patients Goal: Serve 60 unique patients encountered for reporting period Data Source: Documentation of patient encounters Milestone 8 Estimated Incentive Payment *(maximum amount):$541,249*
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $974,511	Year 3 Estimated Milestone Bundle Amount: $1,039,018	Year 4 Estimated Milestone Bundle Amount: $1,124,364	Year 5 Estimated Milestone Bundle Amount: $1,082,497
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)**:*** $ 4,220,390			

Texana Center

Pass 3

Project Option 1.12.2 – Expand the Number of Community Based Settings where Behavioral Health Services may be Delivered in Underserved Areas: Enhance Service Availability of appropriate levels of behavioral health care (i.e., applied behavior analysis and speech-language pathology for children diagnosed with autism).
Unique RHP Project Identification Number: 081522701.1.4
Performing Provider Name/TPI: Texana Center / 081522701
Project Description:
Enhance service availability of appropriate levels of behavioral health care (applied behavior analysis and speech-language pathology for children diagnosed with autism spectrum disorders) to expand the number of community based settings where behavioral health services may be delivered in underserved areas.
Provider Description:
Texana Center is the Local Authority for Behavioral Healthcare and Intellectual Developmental Disabilities Services for 6 counties within the RHP 3 area: Austin, Colorado, Fort Bend, Matagorda, Waller and Wharton. Texana Center serves approximately 9,800 people annually (an estimated 7,000 in BH services and 3,000 in IDD services), employs 742, and has an annual operating budget of $39,211,988.
Intervention(s):
This project will develop and implement evidence-based interventions of applied behavior analysis (ABA) and speech-language pathology (SLP) in an additional location for children with a diagnosis of autism spectrum disorder. Interventions include assessment, treatment development, and intervention overseen by Board Certified Behavior Analyst and SLP as well as training care givers using ABA.
Need for the Project:
There are increasing numbers of children diagnosed with ASD as evidenced by the latest statistics from the Center for Disease Control indicating 1:88 children have an ASD diagnosis. Texana Children's Center for Autism only has 1 setting, currently serving 42 children. This pass 3 project proposes to serve and additional 20 children. Waiting lists in the area can be as high as 200 per clinic and waits can be up to 2 years or until the child ages out of eligibility.
Target population:
Children with ASD diagnosis or related condition from age of diagnosis through the age of 10.
Category 1 expected patient benefits:
Our goal is to increase utilization of community behavioral healthcare (i.e., ABA and SLP services for ASD). Capacity in DY1 was 42 at current site. Texana has proposed an 1115 Waiver project in pass 1 to serve 39 additional unique children. The goal of this pass 3 project is in DY3 to add 1 additional site. At the proposed third location Texana would serve the following numbers of additional unique children beginning with 9 children DY3, 11 children DY 4, and at least 20 cumulative unique children by DY 5. A 24 month treatment cap will be imposed allowing for more unique children to be served by the 1115 waiver through DY5.
Category 3 Outcomes:
The project seeks to increase the quality of life for individuals served specifically these treatments are designed to increase functional skills, language/communication, social interactions, pre-academic achievement, as well as decrease problem behaviors as measured by an evidence-based and validated assessment tool for children diagnosed with ASD.

Project Option 1.12.2 - Expand the number of community based settings where behavioral health services may be delivered in underserved areas: Enhance service availability of appropriate levels of behavioral health care (applied behavior analysis and speech-language pathology for children diagnosed with autism spectrum disorders)

Unique RHP Project Identification Number: 081522701.1.4 / Pass 3
Performing Provider Name/TPI: Texana Center / 081522701

Project Description:
This category 1 project, 1.12.2, will provide specialized behavioral health care services to the complex behavioral health population of children with diagnoses of autism spectrum disorders and related conditions.

Texana Children's Center for Autism will add a third location to provide access to Applied Behavior Analysis (ABA) and Speech Language Pathology (SLP) interventions to serve 11 additional children at a time (from a current level of approximately 40 children at a time) as a 1115 Waiver pass 3 project. This will result in a minimum of 20 unique children to receive this type of service through year 5 in as the pass 3 project. Texana previously proposed a pass 1 project of adding a second location to provide access to ABA and SLP interventions to serve 22 additional children at a time as a pass 1 project, resulting in a minimum of 39 additional children receiving services through year 5 in the pass 1 project. With adding both new locations from pass 1 and pass 3, Texana will be able to serve an additional 59 though both sites, offering life changing intervention. The identified children with an autism diagnosis or related condition children require 1:1 intensive services for 25-40 hours per week for at least 2 years. Treatment is most effective if initiated before the age of 4 but it is effective for all ages. The proposed age group includes age of diagnosis through age 10. Treatment will be provided in a clinic/day treatment, community, or home setting. Treatment will be limited to up to 24 months per child so that more children can benefit from the program.

The population of children with an autism diagnosis often has key health challenges and multiple issues such as lack of daily living skills, cognitive challenges, and limited support in the community. The State's mental health system provides some minimal services, but can only serve a fraction of the population. The existing behavioral healthcare environment does not provide the necessary range of specialized therapies needed to address the complex needs of a child with autism. Positive healthcare outcomes are contingent on the ability of the patients to obtain services as soon as possible after diagnosis. However, many Texas children are unable to access these much needed services.

There are increasing numbers of individuals diagnosed with Autism Spectrum Disorders (ASD). The latest statistics from the Center for Disease Control (CDC) indicate that 1 in 88 children have a diagnosis of autism. Repeated studies by special tasks forces and others such as the US Surgeon General and the National Autism Standards Project have consistently found that Applied Behavior Analysis (ABA) intervention is the most effective intervention for children with ASD. In fact, research indicates that approximately 50% of children that receive 1:1 intensive ABA before the age of 4 for 25-40 hours a week for at least 2 years will no longer meet the diagnostic criteria for an ASD diagnosis (Howard, et al. 2005). Recent research, including the National Standards Project, emphasizes the importance of empirically based Speech Language Pathology (SLP) intervention in addition to the primary mode of intervention of ABA.

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With a success rate of 47 percent for early intensive behavioral intervention (Lovaas, 1987), one study found that cost savings following intensive ABA are estimated to be from $2,439,710 to $2,816,535 with inflation to age 55 per child served (Jacobson, Mulik, & Green, 1998).

This project proposes to enhance availability of specialized therapies, ABA and SLP treatment, for children with ASD consistent with best practices (Howard et al. 2005, National Autism Center's National Standard's Report 2009). The innovative care model proposed includes interventions to increase language and communication, social skills, play skills, group participation skills, self-help skills, pre-academics skills, natural environment training, feeding intervention, community skills, pre-vocational skills, school-readiness skills, and parent training. Treatment will be developed and supervised by Board Certified Behavior Analysts (BCBA) and licensed Speech and Language Pathologists. Treatment will be provided in a clinic/day treatment, community, or home setting. Eligible persons are individuals with ASD from the age of diagnosis through the age of 10.

This project is consistent with several of the regional goals. First, it contributes to development of a regional approach to health care delivery that leverages and improves on existing programs and infrastructure, is responsive to patient needs throughout the region, and improves health care outcomes. Second, the project is consistent with the goal of developing a culture of ongoing transformation and innovation that maximizes the use of technology and best-practices, facilitates regional collaboration and sharing, and engages patients, providers, and other stakeholders in the planning, implementation, and evaluation processes. Lastly, it increases access to specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their condition, with more available locations regardless of their ability to pay.

Starting Point/Baseline:

The Texana Children's Center for Autism currently only has 1 setting. In this setting, Texana currently serves 42 children diagnosed with Autism Spectrum Disorders or related conditions. Twenty of these children are able to access treatment via private funds or private insurance. The remaining twenty-two children are able to access services through an existing grant from the Department of Assistive and Rehabilitative Services, DARS. The Children's Center for Autism anticipates serving approximately 50 total children by the end of this fiscal year (September 2012-August 31, 2012). These children receive between 15 and 32 hours of intensive ABA per week. Despite this, waiting lists in the area range from 30 to 200 per clinic and waits can be up to 2 years or until the child ages out of eligibility.

Texana Center submitted an 1115 Waiver pass 1 project to serve an additional 22 children at a time, with admission and discharges resulting in 39 children through DY5. With this pass 3 project Texana plans to expand to a third location in year 3. There will be only 1 additional site as part of pass 3 across the 5 years. This pass 3 project proposes serving an additional 11 children at a time beginning with 9 children in DY 3, with admissions and discharges, serving at least 20 total unique children through DY5. Children will be limited to up to 24 months in the program in order to increase the absolute number of children served. See table below.

	Year 1	Year 2	Year 3	Year 4	Year 5
Number of NEW community-based settings where children are served as part of pass 3	0	0	1	NA	NA

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Total Cumulative Number of Unique Children Served at community-based site pass 3	0	0	9	11	20
Child census at NEW community-based sites pass 2	0	0	9	11	11
Children Admitted to NEW community-based site pass 3	0	0	9	2	9
Children Discharged from NEW community-based site pass 3	0	0	0	0	9
Projected total Texana Children's Center census at any one time (3 sites: original, pass 1 and pass 3)	42	49	68	73	75

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Rationale:

Texana Center selected this project for the following reasons:

- This project is data driven. As previously mentioned, there are an increasing numbers of individuals diagnosed with Autism Spectrum Disorders (ASD). Current statistics from the CDC indicate that 1 in 88 children have a diagnosis of ASD. In fiscal year 2012, through Strategic Planning, Texana Center recognized the need to shift some resources from adult services to children services. Eighty-five percent of the individuals waiting for eligibility determination are under 21, and are seeking behavior supports and/or respite as a primary service. The 25 school districts in our local area reported that in the 2011-2012 school year, 4,332 students with IDD were served and 2,374 of these children had a diagnosis of ASD. As the number of children diagnosed with ASD increases, the need for treatment also increases. ABA and SLP are the treatments with the most evidence supporting their effectiveness (National Autism Center's National Standards Report, 2009). In 1999, the Surgeon General named ABA, the treatment of choice for children diagnosed with Autism. Lovaas (1987) documented 9/19 or 47% children who received early intensive (40 hr per week) ABA before the age of 4 for at least 2 years had cognitive and language scores in the normal range by age of 6-7 years. Numerous additional studies have supported this finding (e.g. Howard, et. al., 2005).
- This project addresses the needs of the community for expanded behavioral healthcare. RHP CN 2 - Insufficient access to behavioral health care services, resulting in lack of care or delay of care, delivery of inappropriate and insufficient care, unnecessary and preventable complications, and increased demand on criminal justice system. Children with ASD diagnoses in our area frequently never access services due to lack of funding or are placed on a waiting list for 1-3 years or until they age out of eligibility. This is highly detrimental to the trajectory of their future outcomes.
- This project is cost effective. In 1998, Jacobson et al found that cost savings following intensive ABA are estimated to be from $2,439,710 to $2,816,535 with inflation to *age 55 per child* served (Jacobson, Mulik, & Green, 1998). Additionally, in 2007, Chasson et al results indicate that the state of Texas will save $208,500 *per child across eighteen years of education* with early intensive ABA.
- Texana center has the experience to implement this project. Since 2004, Texana has been operating an intensive ABA program for children diagnosed with Autism, the Children's

Center for Autism. Texana has the administrative support and clinical expertise as well as the existing infrastructure to ensure a smooth and successful expansion.

Related Category 3 Outcome Measure(s):

The Category 3 Quality Improvement Outcome Measure, Quality of Life, relates to the Category 1.12.2 project of increased utilization of community behavioral healthcare services of ABA and SLP for individuals with ASD. These treatments are specifically designed to improve symptoms and function, two essential components of quality of life. Early intensive ABA treatment results in increased language and communication skills, improved social skills, achievement in pre-academic and academic areas, and decreased problem behaviors (Howard et al. 2005). Early intensive ABA as described above can be costly, exceeding $50,000 per year. This project will improve access to needed behavioral health services for low income families.

Baseline data will be collected during years 2 and 3 using a variety of the below and related assessment tools. One or a combination of 2 or 3 of these tools will be utilized to demonstrate progress during years 3-5 based on baseline data collected during years 2 and 3.

- Demonstrated improvement in quality of life scores on evidence-based, validated standardized assessment tools for the target population. Previous instruments used in the Children's Center for Autism include the Pervasive Developmental Disorders Behavior Inventory (PDDBI) and Psychoeducational Profile-3 (PEP-3). Other recommended instruments include the Developmental Profile-Third Edition (DP-3), Peabody Picture Vocabulary Test-Fourth Edition (PPVT-4), Expressive Vocabulary Test-Second Edition (EVT-2), Bayley Scales of Infant Development-Revised (BSID-R), Wechsler Primary Preschool Scales of Intelligence-Revised (WPPSI-R), Differential Abilities Scale (DAS), Developmental Assessment of Young Children (DAYC), Vineland Adaptive Behavior Scales (VABS), Reynell Developmental Language Scales, and the Merrill-Palmer Scale of Mental Tests (Howard, et al. 2005).
- Demonstrated improvement in quality of life on the Assessment of Basic Language and Learning Skills (ABLLS-R), Verbal Behavior Milestones Assessment and Placement Program (VB-MAPP), and/or the Assessment of Functional Living Skills (AFLS). Progress can be measured by examining changes in the student's scores from one administration to the next (e.g., Goin-Kochel, Myers, Hendricks, Carr, &Wiley, 2007;Sullivan & Perry, 2006). The ABLLS-R and similar tools were selected because they are now commonly used by educators, school personnel, and psychologists to assess and monitor skills of children with autism who are receiving behavior therapy (e.g., Bradley-Johnson, Johnson, & Vladescu, 2008; Goin-Kochel et al., 2007; Schwartz, Boulware, McBride, & Sandall, 2001) and, according to Aman et al. (2004), the ABLLS-R has been selected as an outcome measure by the National Institute of Mental Health Research Units in Pediatric Psychopharmacology and Psychological Intervention Autism Network.

Relationship to other Projects:

The development and improvement of services for patients with behavioral health disorders, such as ASD, is a focus of multiple projects throughout the RHP, including those in Category I for expanding access and Category II for developing innovative solutions to priority issues. This project supports expanding specialty care capacity, developing behavioral health crisis stabilization as alternatives to hospitalization, providing an intervention for targeted behavioral health population to prevent unnecessary use of services in a specified setting, and recruiting, training, and supporting consumers of mental health services to provide peer support services.

Relationship to Other Performing Providers' Projects in the RHP:

Intellectual and developmental disabilities (IDD) are a large focus of our community including our local mental health authorities in the region. There are additional initiatives in the RHP plan with a focus on IDD and are represented in the addendum (Region 3 Initiative Grid). The IDD initiatives primarily support outcome measures of patient satisfaction scores, and admission/re-admission rates. Local Authorities for intellectual and developmental disabilities (IDD) services throughout the state are proposing the implementation of projects to improve access to services for individuals with IDD for their respective RHP areas. The Department of Aging and Disabilities Services (DADS) has encouraged local authorities to propose projects to address the needs of the IDD population including ASD. Specifically, Harris County MHMRA is proposing 2 projects that included ABA services, STARS and in-home services. The Andrews Center MHMRA is also proposing ABA services for children with autism.

Plan for Learning Collaborative:

Through this project, Texana Center and MHMRA of Harris County will expand the existing collaboration to include monthly telephone conferences to share best practices, new ideas and solutions for the autism intervention project. The established provider meetings will provide an effective forum for gathering input of stakeholders in the project processes. Through this expanded learning collaborative, Texana and participating Local Authorities will share challenges and testing of new ideas and solutions. Additionally, Texana plans to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System as appropriate. Texana's participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system. This exchange will facilitate effective processes, efficient use of resources, and consistent data benchmarking across similar projects statewide.

Outcome Project Valuation:

This project addresses a priority need for the population of individuals with ASD to receive intensive ABA and SLP services in the community. One of the goals of this project is to avert outcomes such as potentially avoidable inpatient admissions and readmissions in settings including general acute and psychiatric hospitals, state supported living centers, and self-contained special education classrooms; to promote wellness and adherence to treatment; to promote independence in the community; and to improve quality of life. The vision will be realized throughout the child's lifetime, however, the reduction in the need for self-contained special education classrooms and in some cases the elimination of the need for special education for children served in this project would be realized during the 4 year DSRIP project.

By providing ABA services to children with autism, it allows for cost avoidance. The current project proposes to serve at least 20 unique children in years 2-5. Based on the figures derived from the 2007 Chasson study, the state of Texas could save $4,170,000 across 18 years of education by providing ABA treatment to these 20 children. Furthermore, based on the figures derived from the 1998 Jacobson study, the state of Texas could save $48,794,200 through age 55 for these 20 children by providing early intensive ABA treatment.

Total Five Year Valuation: $ 4,449,821.

Resources:

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081522701.1.4	*1.12.2*	*N/A*	*Enhance service availability of appropriate levels of behavioral health care (applied behavior analysis and speech-language pathology for children diagnosed with autism spectrum disorders)*
Texana Center			*081522701*
Related Category 3 Outcome Measure(s):	*081522701.3.5*	*IT-10.1*	*Quality of Life/Functional Status*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1[P-3]: Develop administrative protocols and clinical guidelines for projects selected (i.e. protocols for additional community based setting) Metric 1[P-3.1]: Manual of operations for the project detailing administrative protocols and clinical guidelines Baseline- existing protocols for the current setting Goal-to modify/customize these protocols and create any necessary subsequent protocols for the additional setting Data Source: Administrative protocols; clinical guidelines Milestone 1Estimated Incentive Payment *(maximum amount):* $1,013,492	**Milestone 2**[P-8]: Participate in at least bi-weekly interactions (meeting, conference calls, or webinars) with other providers, and RHP to promote collaborative learning around shared or similar projects. Participation includes: 1) sharing challenges and any solutions; 2) sharing results and quantitative improvement that the provider is testing; and 3) identifying a new improvement and publically commit to test it in the week to come. Metric 1 [P-8.1]: Number of bi-weekly meetings, conference calls, or webinars organized by the RHP that the provider participated in. Data Source: Documentation of bi-weekly phone meetings, conference calls, or webinars including agendas for phone calls, slides from webinars, and/or meeting notes. Metric 2 [P-8.2]: Share challenges and solutions successfully implemented during this bi-weekly interaction. Data Source: Catalogue of challenges, solutions, tests, and progress shared by the participating provider during each bi-weekly	**Milestone 5**[P-8]: Participate in at least bi-weekly interactions (meeting, conference calls, or webinars) with other providers, and the RHP to promote collaborative learning around shared or similar projects. Participation includes: 1) sharing challenges and any solutions; 2) sharing results and quantitative improvement that the provider is testing; and 3) identifying a new improvement and publically commit to testing it in the week to come. Metric 1 [P-8.1]: Number of bi-weekly meetings, conference calls, or webinars organized by the RHP that the provider participated in. Data Source: Documentation of weekly or bi-weekly phone meetings, conference calls, or webinars including agendas for phone calls, slides from webinars, and/or meeting notes. Metric 2 [P-8.2]: Share challenges and solutions successfully implemented during this bi-weekly interaction. Data Source: Catalogue of challenges, solutions, tests, and	**Milestone 7**[P-8]: Participate in at least bi-weekly interactions (meeting, conference calls, or webinars) with other providers, and the RHP to promote collaborative learning around shared or similar projects. Participation includes: 1) sharing challenges and any solutions; 2) sharing results and quantitative improvement that the provider is testing; and 3) identifying a new improvement and publically commit to testing it in the week to come. Metric 1 [P-8.1]: Number of bi-weekly meetings, conference calls, or webinars organized by the RHP that the provider participated in. Data Source: Documentation of weekly or bi-weekly phone meetings, conference calls, or webinars including agendas for phone calls, slides from webinars, and/or meeting notes. Metric 2 [P-8.2]: Share challenges and solutions successfully implemented during this bi-weekly interaction. Data Source: Catalogue of challenges, solutions, tests, and

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081522701.1.4	*1.12.2*	*N/A*	*Enhance service availability of appropriate levels of behavioral health care (applied behavior analysis and speech-language pathology for children diagnosed with autism spectrum disorders)*
Texana Center			*081522701*
Related Category 3 Outcome Measure(s):	*081522701.3.5*	*IT-10.1*	*Quality of Life/Functional Status*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	interaction, with at least quarterly summary. Milestone 2 Estimated Incentive Payment: $364,344 **Milestone 3**[P-6]: Establish behavioral health services in new community-based settings in underserved areas Metric 2[P-6.1]: Number of new community based settings where behavioral health services are delivered (i.e. applied behavior analysis and speech and language pathology) Baseline/Goal: 2 settings (original and pass 1) Goal: add 1 additional setting to total 3 settings Data source: Project Documentation Milestone 3 Estimated Incentive Payment *(maximum amount):* $364,343 **Milestone 4** [I-11]: Increased utilization of community behavioral healthcare (i.e., ABA and SLP services for autism).	progress shared by the participating provider during each bi-weekly interaction, with at least quarterly summary. Milestone 5 Estimated Incentive Payment: $ 597,220 **Milestone 6** [I-11]: Increased utilization of community behavioral healthcare (i.e., ABA and SLP services for autism). Metric 1 [I-11.1]: Percent utilization of new community behavioral healthcare services. Baseline: 9 children Goal: 11 children served will be funded by the expansion Data Source: Claims data and encounter data Milestone 6 Estimated Incentive Payment: $597,219	progress shared by the participating provider during each bi-weekly interaction, with at least quarterly summary. Milestone 7 Estimated Incentive Payment: $574,431 **Milestone 8** [I-11]: Increased utilization of community behavioral healthcare (i.e., ABA and SLP services for autism). Metric 1 [I-11.1]: Percent utilization of new community behavioral healthcare services. Baseline: 11 children Goal: 20 children served will be funded by the expansion Data Source: Claims data and encounter data Milestone 8 Estimated Incentive Payment: $ 574,430

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081522701.1.4	***1.12.2***	***N/A***	*Enhance service availability of appropriate levels of behavioral health care (applied behavior analysis and speech-language pathology for children diagnosed with autism spectrum disorders)*
Texana Center			*081522701*
Related Category 3 Outcome Measure(s):	*081522701.3.5*	*IT-10.1*	*Quality of Life/Functional Status*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	Metric 1 [I-11.1]: Percent utilization of new community behavioral healthcare services. Baseline: 0 children at new setting Goal: 9 children served will be funded by the expansion Data Source: Claims data and encounter data Milestone 4 Estimated Incentive Payment: $363,343		
Year 2 Estimated Milestone Bundle Amount*:* $ 1,013,491	Year 3 Estimated Milestone Bundle Amount: $ 1,093,030	Year 4 Estimated Milestone Bundle Amount: $ 1,194,439	Year 5 Estimated Milestone Bundle Amount: $1,148,861
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:**$ 4,449,821			

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Texas Children's Hospital

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Project Option-1.9.2 Expand Access to Specialty Care: Expand Pediatric Neurology

Unique Project ID: 139135109.1.1

Performing Provider Name/ TPI: Texas Children's Hospital/139135109

Project Summary:
This project will increase capacity in our Neurology Clinic at Texas Children's Hospital. Referrals into the TCH pediatric neurology clinic increased significantly from a monthly average of 600 in 2010 to a monthly average of 760 in 2012. The focus of this project is to equip the clinical service with the resources needed to address the significant patient care need for pediatric neurological services in the area.

Provider:
Texas Children's Hospital, located in Houston, is the largest free standing children's hospital in the county specializing in the care of medically fragile children in Houston and across the country as a regional safety net provider. We currently are licensed for 564 beds and in 2011 we had over 2.7 million patient encounters. Our mission is to provide the finest possible pediatric patient care, education, and research. Texas Children's is an integrated delivery system comprising of a health plan for Medicaid and CHIP pregnant women and children, the nation's largest general pediatrician group and two world class hospitals.

Volume Statistics - FY2012	**Patient Payor Mix**	**Patient Demographics**
Hospital Admissions- 25,966 Births (babies delivered)- 2,181 Emergency visits-113,586 Outpatient visits- 3,066,765	Medicaid and CHIP- 53.6% Commercial Insurance- 40.6% Self-Pay- 1.8% Medicare- 1.2%	Hispanic- 35.9% African American- 16.6% Caucasian- 31.0% Asian- 3.8% Other- 12.4% American Indian- 0.3%

Intervention(s):
The Neurology Service will focus on provider productivity and hire additional clinical providers in order to expand internal capacity. Current scheduling processes will be reviewed to increase the availability of providers to increase volumes, and the service will evaluate increasing services at the five additional community locations to increase the volume of patients seen through pediatric neurology clinics across the Houston area.

Need for the project:
Pediatric neurology is an identified subspecialty, both at the national and state level, to have a shortage of resources to meet consumer demands (Children's Hospital Association - Pediatric Specialist Physician Shortages Affect Access to Care, August 2012).

Target Population:
The areas of clinical focus include multiple sclerosis, muscular dystrophy, Rhett syndrome, cerebral palsy, epilepsy, seizure disorders, headaches, movement disorders, neurogenetics, pediatric stroke, and peripheral nerve disorders or injuries.

Category 1 or 2 expected patient benefits:
Our DY3 goal is to improve upon DY2 baseline of patient volume by 2.5%. Our DY4 goal is for 5% increase of patient visits above DY2 baseline. Our DY5 goal is for 7.5% increase of patient visits above DY2 baseline.

Category 3 outcomes:
IT-5.1 Improve Cost of Care

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Project Option-1.9.2 Expand Access to Specialty Care: Expand Pediatric Neurology

Unique Project ID: 139135109.1.1
Performing Provider Name/ TPI: Texas Children's Hospital/139135109

Project Description
Texas Children's Hospital proposes to increase capacity for care in Pediatric Neurology Clinic.

Texas Children's Hospital, located in Houston, is the largest free standing children's hospital in the county specializing in the care of medically fragile children in Houston and across the country as a regional safety net provider. We currently are licensed for 564 beds at our main campus and West Houston facilities. In 2011 we had over 2.7 million patient encounters. Our mission is to provide the finest possible pediatric patient care, education, and research. Texas Children's is an integrated delivery system comprising of a health plan for Medicaid and CHIP pregnant women and children, the nation's largest general pediatrician group and two world class hospitals. Texas Children's supports a commitment to quality service and cost-effective care to enhance the health and well-being of children locally, nationally and internationally.

Specifically this project will increase capacity in our Neurology Clinic. Pediatric neurology is an identified subspecialty, both at the national and state level, to have a shortage of resources to meet consumer demands (Children's Hospital Association - Pediatric Specialist Physician Shortages Affect Access to Care, August 2012). Referrals into the TCH pediatric neurology clinic increased significantly from a monthly average of 600 in 2010 to a monthly average of 760 in 2012. The focus of this project is to equip the clinical service with the resources needed to address the significant patient care need for pediatric neurological services in the area.

The Neurology Service at TCH offers a wide range of clinical services for pediatric neurologic conditions in six locations across the Houston metropolitan area. In addition to general needs related to pediatric neurology, areas of clinical focus include multiple sclerosis, muscular dystrophy, Rhett syndrome, cerebral palsy, epilepsy, seizure disorders, headaches, movement disorders, neurogenetics, pediatric stroke, and peripheral nerve disorders or injuries.
The Neuroscience programs at TCH provide outstanding multidisciplinary programs in clinical child neurology training and basic science research training. Areas of clinical training include pediatric neurology, neurodevelopmental pediatrics and behavioral pediatrics. Basic science programs focus upon the genetic and molecular basis of neurodevelopmental disorders and brain development. Training fellows benefit from close interaction with faculty, state of the art facilities and diverse patient populations. The division is committed to nurturing the careers of individuals entering these training programs.

Neuroscience sponsors innovative clinical and basic science research into the underlying causes of childhood neurological and developmental disorders. A wide array of clinical research is underway to improve the understanding and treatment of several neurological conditions, including epilepsy, autism, muscular dystrophy, headaches, pediatric stroke, and sleep disorders. Basic science research is being conducted in the Cain Foundation Laboratories into the underlying mechanisms of brain development and the genesis of early life seizures and epilepsy.

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Researchers at the Jan and Dan Duncan Neurological Research Institute at Texas Children's are now working on new breakthroughs in the treatment of childhood neurological diseases.

Goals and Relationship to Regional Goals:

Project Goals: To meet the growing demand for specialized pediatric services TCH will:

- Focus on provider productivity to optimize clinical time for all providers
- Establish an initiative to review scheduling processes to increase the availability of these targeted providers
- Expand internal capacity by hiring additional clinical providers
- Enhance service availability by targeting new providers to not only work in the Texas Medical Center but to also serve and increase hours at the five additional community locations for specialty care.

This project meets the following Region 3 Goals:

- Increased access to specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their conditions, regardless of where they reside or their ability to pay for care.
- Develop a regional approach to healthcare delivery that leverages and improves on existing programs and infrastructure, is responsive to patients' needs throughout the entire region, and improves health care outcomes and patient satisfaction

Challenges:

In Texas, limited Medicaid reimbursement is an ongoing challenge for children's hospitals and the workforce that provides health care services for the pediatric population enrolled in this program. As advocates for improving and sustaining quality children's health care, our organization informs and educates elected officials and community leaders about the importance of Medicaid and the need to adequately fund the program. We will continue these efforts throughout the duration of waiver to ensure existing programs and services will be maintained and expanded. While we continue to increase our overall volumes at all of our locations by an average of about 13% in the last 3 years, the service struggles to keep up with increased demand given that Neurology serves patients locally, statewide, across the nation and internationally. By reconfiguring clinic processes, scheduling and the addition of more providers, we will try to improve this measure. Ultimately, the overall success of this project is dependent upon the compliance rate of our patients and primary caretakers arriving for their appointments. If the compliance rate is poor, it will be a challenge to realize a reduction in the cost of care and improved access.

Five year expected outcome for provider and patients:

Texas Children's Hospital expects to see improvements in access to subspecialty care for our pediatric patients; this in turn will improve patient satisfaction due to the delivery of the right care at the right place at the right time.

Pediatric neurology is an identified subspecialty, both at the national and state level, to have a shortage of resources to meet consumer demands (Children's Hospital Association - Pediatric Specialist Physician Shortages Affect Access to Care, August 2012). Referrals into the TCH pediatric neurology clinic increased significantly from a monthly average of 600 in 2010 to a

monthly average of 760 in 2012. Given the high demand and provider shortage, for the majority of FY10 and FY11, access to neurological services remains a challenge.

Starting Point/Baseline: The baseline of patient volumes for FY 12 is 20,031 across all service locations. Our fiscal year is from October 1st to September 30th.

Rationale:
The significant increase in access to specialty care created by this project attempts to address the growing demands in our community for specialized pediatric providers. This project will create increased capacity through more efficient operations and new physician recruitment. Our project significantly enhances TCH's existing neurology services to improve patient satisfaction by aspiring to provide the right care in the right setting at the right time. The Neurology service line at TCH has consistently ranked in the top ten programs nationally in US News and World Report, with a ranking of 5th in its latest report. Specifically, this service will provide comprehensive care for children within focused specialty programs across six locations of care including: multiple sclerosis, muscular dystrophy, Rhett syndrome, cerebral palsy, epilepsy, seizure disorders, headaches, movement disorders, neurogenetics, pediatric stroke, and peripheral nerve disorders or injuries.

Our project significantly enhances TCH's existing neurology services. Region 3 RHP summit identified inadequate number of specialty providers as an area of community need (CN.2). This project aims to tackle this issue from multiple angles. The service plans to recruit nationally for these highly specialized clinicians. The strong clinical, research, and academic programs within TCH and Baylor College of Medicine provides an advantage for recruitment of these experts. Additionally, the service will look within its own clinical service lines to examine the activity levels of the providers and look to more efficiently utilize clinician schedules so as to increase access to patient care. The service will also examine roles and responsibilities of physician and clinical support to ensure that individuals are working as efficiently as possible within the scope of their license so that clinical time can be focused on providing additional clinical services to patients.

Project Components:
Through the expanded access to specialty care, we propose to meet all required project components listed and these selected milestones and metrics do relate to project components.

a. Conduct specialty care gap assessment based on community need for subspecialty.
b. Implement transparent standardized referrals across the system
c. Increase specialty care volume of visits and evidence of improved access for patients seeking services
d. Increase service availability hours and increase number of specialty clinic locations.
e. Conduct quality improvement for projects including rapid cycle and learning collaborative exchanges.

Inadequate access to specialty care has contributed to the limited scope and size of safety net health systems. For children with health care needs that exceed the abilities of the primary care

provider, access to and coordination with subspecialty care is critical to ensuring the provision of efficient and effective health care and in securing a comprehensive medical home.[109]

Milestones and Metrics
The following milestones and metrics have been chosen for the project based on the core components and the needs of the targeted pediatric population.

- Process milestone and metrics: P-1 (P-1.1); P-8 (P-8.1); P-17 (P-17.1)
- Improvement milestones and metrics: I-23 (I-23.1)

Unique community need identification number the project addresses: CN.2: Inadequate access to specialty care, CN.6: Inadequate access to treatment and services designed for children.

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
This project will allow Texas Children's to significantly enhance our existing Neurology appointment availability. The providers working within the Neurology service at TCH are experts in their field. Part of the reason for increased referrals and the need for greater access stems from the fact that children statewide, nationally, and internationally would like access to the professionals working at TCH and specifically In the area of neurology. Adding to the pool of expert clinicians, as well as working within the current service lines to identify how current providers can expand their clinical practices will greatly enhance the services currently offered to our patients by not only reaching more children, but also enhancing the types of clinical services we can offer those children.

Related Category 3 Outcome Measure(s):
OD-5 Cost of Care
IT- 5.1 Improved Cost Savings
IT- 5.2 Per episode cost of care
IT-5.3 Length of stay

Reasons/rationale for selecting the outcome measures:
Our project will increase appropriate access to care. Increased access to appropriate subspecialty care leads to better long term outcomes in children and reduction in unnecessary health care services and subsequent costs.[110] We recognize that while increasing access to care we need to continue to focus on delivering quality, efficient and cost effective care. Medicaid is an entitlement program, but there is only a finite amount of money. The affordable Care Act focused on the triple aim- improving quality, reducing costs and improving access. This project strives to meet those same goals. We agree that increased access should be coupled with controlling unnecessary costs.

[109] Redlener, Irwin, Grant Roy, and Krol David M. "Beyond Primary Care: Ensuring Access to Subspecialists, Special Services, and Health Care Systems for Medically Underserved Children." *Advances in Pediatrics*. 52 (2005): 9-22.
[110] *Reducing Costs Through the Appropriate Use of Specialty Services*. Cambridge: Institute for Healthcare Improvement, 2007.

Relationship to other Projects: All of Texas Children's projects are working to expand access to subspecialty care for the pediatric population. Texas continues to have a growing pediatric population and a shortage of specialized pediatric providers.

Children are the future of healthcare and will dictate the treatments needed as well as the cost of healthcare in future years so it is critical that they receive the access needed throughout their pediatric lives. The focus of pediatric specialty care is similar throughout the region with a concentrated focus in the Harris county proper geographic region and allows for the expansion of access to numerous specialties such as cardiology, neurology, ENT, and many more. The outcome measures focus to appropriate length of stay, per episode cost of care, and improved cost savings. The Region 3 Initiative grid allows for a cross reference of similar initiatives in our region. (addendum)

Plan for Learning Collaborative: We plan to participate in a region-wide learning collaborative as offered by the anchor for Region 3, Harris Health System. Our participation in this collaborative with other performing providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our region's health care system.

Project Valuation: This project's value is based on the benefits related to cost avoidance of medical expenses and improved quality of life. For example, increased provider capacity leads to reduction in emergency room visits and reduction in inpatient hospital visits.[111] Our valuation also includes an increase in the patient's quality of life. We are using a conservative Quality Adjusted Life Year ("QALY") per year and a percentage of that QALY for the pediatric population.[112] The QALY is used as a one-time improvement in the quality of life, even though we know the patient's quality of life will be improved for many years. We recognize that this is a government funded waiver and thus we chose to have conservative valuations out of respect for the taxpayer funded program. We have academic literature citing the link between access to appropriate pediatric subspecialty care and decrease in hospital visits, both inpatient and emergency room.[3]

[111] Smith, John T, Price, Christopher, Stevens Peter M., Masters, Kevin S., and Young, Mark. "Selected Topics - Does Pediatric Orthopedic Subspecialization Affect Hospital Utilization and Charges?" *Journal of Pediatric Orthopedics*. 19.4 (1999): 553-555.

[112] Brannon, Ike. "Risk - What Is a Life Worth? Despite Its Prima Facie Callousness, Determining the Value of a Human Life Is Necessary for Good Public Policy." *Regulation*. 27.4 (2004): 60-63.

139135109.1.1	1.9.2	A-D	EXPAND ACCESS TO SPECIALTY CARE: EXPAND PEDIATRIC NEUROLOGY
Texas Children's Hospital			139135109
Related Category 3 Outcome Measure(s):	139135109.3.1 139135109.3.2 139135109.3.3	IT- 5.1 IT-5.2 IT-5.3	Improved Cost Savings Per episode cost of care Length of stay

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1 (P-1): Conduct specialty care gap assessment to determine barriers to accessing subspecialty care. Develop plan and identify key initiatives for changes in provider schedules in DY3. Metric 1 P-1.1 Documentation of gap assessment Data Source: Gap Assessment Milestone 1 Estimated Incentive Payment: $1,074,322 **Milestone 2 (P-8):** Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements. Metric 1 [P-8.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP.	**Milestone 3 (I-23):** Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 (I-23.1): Documentation of increased number of visits. Demonstrate improvement over prior reporting period (baseline established in FY12). a. Total number of visits for reporting period b. Data Source: EPIC Medical Record Goal: Increase specialty care clinic volume of visits by 2.5% of baseline and evidence of improved access for patients seeking services. Milestone 3 Estimated Incentive Payment: $1,172,082.50 **Milestone 4 [P-8]:** Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these	**Milestone 5 (I-23):** Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 (I-23.1): Documentation of increased number of visits. Demonstrate improvement over prior reporting period (baseline established in FY12). a. Total number of visits for reporting period b. Data Source: EPIC Medical Record Goal: Increase specialty care clinic volume of visits by 5% of baseline and evidence of improved access for patients seeking services. Milestone 5 Estimated Incentive Payment: $1,175,489 **Milestone 6 [P-8]:** Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple	**Milestone 7 (I-23):** Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 (I-23.1): Documentation of increased number of visits. Demonstrate improvement over prior reporting period (baseline established in FY12). a. Total number of visits for reporting period b. Data Source: EPIC Medical Record Goal: Increase specialty care clinic volume of visits by 7.5% of baseline and evidence of improved access for patients seeking services. Milestone 7 Estimated Incentive Payment: $971,056.50 **Milestone 8 [P-8]:** Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance).

139135109.1.1	*1.9.2*	*A-D*	*EXPAND ACCESS TO SPECIALTY CARE: EXPAND PEDIATRIC NEUROLOGY*
Texas Children's Hospital			139135109
Related Category 3 Outcome Measure(s):	*139135109.3.1* *139135109.3.2* *139135109.3.3*	*IT- 5.1* *IT-5.2* *IT-5.3*	*Improved Cost Savings* *Per episode cost of care* *Length of stay*

Year 2 (10/1/2012 – 9/30/2013)	**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: Participate in all semi-annual face-to-face meetings or seminars. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Milestone 2 Estimated Incentive Payment: $1,074,322	improvements. Metric 4 [P-8.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: Participate in all semi-annual face-to-face meetings or seminars. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Milestone 4 Estimated Incentive Payment: $1,172,082.50	initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements. Metric 1 [P-8.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: Participate in all semi-annual face-to-face meetings or seminars. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Milestone 6 Estimated Incentive Payment: $1,175,489	Each participating provider should publicly commit to implementing these improvements. Metric 1 [P-8.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: Participate in all semi-annual face-to-face meetings or seminars. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Milestone 8 Estimated Incentive Payment: $971,056.50
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $2,148,744	Year 3 Estimated Milestone Bundle Amount: $2,344,165	Year 4 Estimated Milestone Bundle Amount: $2,350,979	Year 5 Estimated Milestone Bundle Amount: $1,942,113
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)****:*** $8,786,001			

DRAFT

Project Option- 1.9.2 Expand Access to Specialty Care: Pediatric Hematology/Cancer

Unique Project ID: 139135109.1.2

Performing Provider Name/TPI: Texas Children's Hospital/ 139135109

Project Summary: This project will increase capacity in our Cancer and Hematology Clinic as the demand for health care services grows in the state of Texas. It will fulfill our tri-part mission of providing quality pediatric care, training the next generation of pediatric providers and investigating ways to improve care through innovative therapies specific to Sickle Cell Disease.

Provider:

Texas Children's Hospital, located in Houston, is the largest free standing children's hospital in the county specializing in the care of medically fragile children in Houston and across the country as a regional safety net provider. We currently are licensed for 564 beds and in 2011 we had over 2.7 million patient encounters. Texas Children's is an integrated delivery system comprising of a health plan for Medicaid and CHIP pregnant women and children, the nation's largest general pediatrician group and two world class hospitals.

Volume Statistics - FY2012	**Patient Payor Mix**	**Patient Demographics**
Hospital Admissions- 25,966 Births (babies delivered)- 2,181 Emergency visits-113,586 Outpatient visits- 3,066,765	Medicaid and CHIP- 53.6% Commercial Insurance- 40.6% Self-Pay- 1.8% Medicare- 1.2%	Hispanic- 35.9% African American- 16.6% Caucasian- 31.0% Asian- 3.8% Other- 12.4% American Indian- 0.3%

Intervention(s):

This project will increase capacity in our Cancer and Hematology Clinic as the demand for health care services grows in the state of Texas. It will fulfill our tri-part mission of providing quality pediatric care, training the next generation of pediatric providers and investigating ways to improve care through innovative therapies specific to Sickle Cell Disease.

Need for the project:

The pediatric population continues to grow in Texas resulting in an increase in demand of health care services for the treatment of rare blood and tissue disorders. The demand for services for Sickle Cell patients continues to increase due to the growing African American and Hispanic populations. Additionally, Pediatric hematologists and oncologists have been identified as a subspecialty facing a workforce shortage.

Target Population:

All patients diagnosed with Sickle Cell Disease within the Texas Children's Cancer and Hematology Service line.

Category 1 or 2 expected patient benefits:

DY3 goal is to reduce overall cycle time for office visit appointments by 15% from baseline. Our goal is to increase the number of visits by 3% in DY4, and by 6% in DY5 compared to baseline established in DY2.

Category 3 outcomes:

IT- 5 Improving Cost of Care

Project Option- 1.9.2 Expand Access to Specialty Care: Pediatric Hematology/Cancer

Unique Project ID: 139135109.1.2
Performing Provider Name/TPI: Texas Children's Hospital/ 139135109

Project Description:

Increase access to care by providing comprehensive, integrated, multidisciplinary and family-centered care to children with non-malignant blood disorders.

Texas Children's Hospital, located in Houston, is the largest free standing children's hospital in the county specializing in the care of medically fragile children in Houston and across the country as a regional safety net provider. We currently are licensed for 564 beds at our main campus and West Houston facilities. In 2011 we had over 2.7 million patient encounters. Our mission is to provide the finest possible pediatric patient care, education, and research. Texas Children's is an integrated delivery system comprising of a health plan for Medicaid and CHIP pregnant women and children, the nation's largest general pediatrician group and two world class hospitals. Texas Children's supports a commitment to quality service and cost-effective care to enhance the health and well-being of children locally, nationally and internationally.

Specifically, this project will increase capacity in our Cancer and Hematology Clinic. Funding for this project will allow Texas Children's to fulfill our tri-part mission of providing quality pediatric care, training the next generation of pediatric providers and investigating ways to improve care through innovative therapies. Texas Children's Cancer and Hematology Center is ranked # 4 in the *2012 U.S. News and World Report Best Children's Hospitals* and is the only pediatric cancer center in Texas ranked in the top 10. As the pediatric population continues to grow in Texas, so does the demand for health care services, especially, programs that treat rare blood and tissue disorders. Pediatric hematologists and oncologists are identified as subspecialty facing a workforce shortage and their profession's growth lags consumer demand both at the national and state levels (Children's Hospital Association - Pediatric Specialist Physician Shortages Affect Access to Care, August 2012). This is a high Medicaid population, currently our cancer clinic is 70% Medicaid. The Cancer and Hematology Center aspires to provide comprehensive, integrated, multidisciplinary and family-centered care to children with non-malignant blood disorders. This center is the largest hematology-oncology service line in the nation and the only Sickle Cell Center in the Harris County area. Specifically, the Hematology Center offers a state-of-the-art, team-based program which will provide comprehensive care for children within focused specialty programs including:

- Hemoglobinopathies (sickle cell disease and thalassemias)
- Hemostasis and Thrombosis Disorders (HAT) (bleeding and clotting disorders)
- Bone Marrow Failure Syndromes
- General Disorders of red blood cells, Platelets, and Neutrophils
- Conduct clinical and basic science research to seek to develop new knowledge and treatment options that lead to a cure
- Train future leaders in areas of non-malignant blood disorders.

The integrated approach includes the development and implementation of a series of clinical practice guidelines to ensure patients receive the best possible care. One of the areas of focus will be the treatment and management of Sickle Cell Disease. Currently there are an estimated 7,000 people in the state of Texas with this disease. For children afflicted with this disease, Texas Children's Sickle Cell Center is the only comprehensive Sickle Cell Center in the region. The shortage of hematologists that can provide care to both adolescents and young adults is already creating major problems for the transition of these patients into adult life. Demand for services for sickle cell patients continues to increase due to the growing African American and Hispanic populations. In addition, recent data demonstrates that increased patient encounters improves patient compliance and better management of the disease - thus decreases mortality and morbidity, while preserving productivity.

Goals and Relationship to Regional Goals:

Project Goals**:** To meet the growing demand for acute pediatric hematology/oncology services, TCH will:

- Focus on provider productivity to optimize clinical time for all providers and enhance training of subspecialists and fellows, including the training of dual board certified physicians (adult and pediatric hematology and/or oncology)
- Establish an initiative to review scheduling processes to increase the appointment availability of these targeted providers that aligns with new clinic capacity,
- Expand provider capacity by hiring additional clinicians and support staff,
- Expand service availability through the designing and building of a Comprehensive Hematology Center at Texas Children's Hospital.

This project meets the following Region 3 Goals:

- Increased access to specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their conditions, regardless of where they reside or their ability to pay for care.
- Develop a regional approach to healthcare delivery that leverages and improves on existing programs and infrastructure, is responsive to patients' needs throughout the entire region, and improves health care outcomes and patient satisfaction

Challenges: There is an acute shortage of hematologists and oncologists who can provide care to our older adolescents and young adults. Recent data from the American Society of Clinical Oncology's Workforce Study published in 2007 has shown that by the year 2020 there will be a shortage of between 2,350 and 3,800 oncologists, a problem that will be magnified by a 48% increase in the overall demand for oncology visits. Since physicians trained in adult hematology also see patients with "malignant" hematological disorders (such as leukemias), there will be few hematologists that will have the capacity to see "benign" hematological disorders, such as sickle cell disease. Due to the aging of the population and the associated increase in the prevalence of cancers in the elderly population will drastically limit the availability of trained oncologists to take care of young adults with cancer. Furthermore, many young adults have better treatment outcomes when treated according to pediatric protocols. There is thus a growing need to train physicians in both pediatrics and medicine (med/peds) who then also can specialize in taking care of adolescents and young adults (up to 25 years of age) with cancer or blood disorders. In

Texas, limited Medicaid reimbursement is an ongoing challenge for children's hospitals and the workforce that provides health care services for the pediatric population enrolled in this program. As advocates for improving and sustaining quality children's health care, our organization informs and educates elected officials and community leaders about the importance of Medicaid and the need to adequately fund the program. We will continue these efforts throughout the duration of waiver to ensure existing programs and services will be maintained and expanded.

Five year expected outcome for provider and patients:
Texas Children's Hospital expects to see improvements in access to subspecialty care for our pediatric patients; this in turn will improve patient satisfaction due to the delivery of the right care at the right place at the right time.

Starting Point/Baseline: The baseline of patients in FY 2012 is 4,000. Our fiscal year runs from October 1st to September 30th. The baseline for patient cycle time is 150 minutes.

Rationale:
The significant increase in access to specialty care created by this project attempts to address the growing demands in our community for specialized pediatric providers. This project will create increased capacity through more efficient operations and new physician recruitment. Our project significantly enhances TCH's existing pediatric cancer and hematology services to improve patient satisfaction by aspiring to provide the right care in the right setting at the right time. In order to increase access The Cancer and Hematology Center aspires to provide comprehensive, integrated, multidisciplinary and family-centered care to children with non-malignant blood disorders. The center is renowned for its research and therapies for blood disorders. This center employs faculty who are extensively published and who are sought after for national conference speaking opportunities to educate the medical community at large of hematologic/oncologic disorders. Specifically, the hematology faculty presented locally, nationally and internationally 53 oral presentations, authored 25 manuscripts and/or book chapters and led 2 national symposiums on the care of hematology patients.

Specifically, the Hematology Center will provide comprehensive care for children within focused specialty programs including:

- Hemoglobinopathies (sickle cell disease and thalassemias)
- Hemostasis and Thrombosis Disorders (HAT) (bleeding and clotting disorders)
- Bone Marrow Failure Syndromes
- General Disorders of red blood cells, Platelets, and Neutrophils
- Conduct clinical and basic science research to develop new knowledge and treatment options that lead to a cure
- Train future leaders in areas of non-malignant blood disorders.

Project Components:
Through the expanded access to specialty care, we propose to meet all required project components listed and these selected milestones and metrics do relate to project components.

f. Conduct specialty care gap assessment based on community need for subspecialty.
g. Implement transparent standardized referrals across the system
h. Increase specialty care volume of visits and evidence of improved access for patients seeking services

i. Increase service availability hours and increase number of specialty clinic locations.
j. Conduct quality improvement for projects including rapid cycle and learning collaborative exchanges. It is our goal to reach the industry standard of less than 14 days for the 3rd available appointment.

Inadequate access to specialty care has contributed to the limited scope and size of safety net health systems. For children with health care needs that exceed the abilities of the primary care provider, access to and coordination with subspecialty care is critical to ensuring the provision of efficient and effective health care and in securing a comprehensive medical home.[113]

The following milestones and metrics have been chosen for the project based on the core components and the needs of the targeted pediatric population.

- Process milestone and metrics: P-1 (P-1.1); P-8 (P-8.1); P-17 (P-17.1)
- Improvement milestones and metrics: I-23 (I-23.1)

Customizable Improvement Milestone and Metric was chosen in order to specifically tailor the intent of project to the targeted pediatric population.

- Unique community need identification number the project addresses: CN.2: Inadequate access to specialty care., CN.6: Inadequate access to treatment and services designed for children.

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

Our initiative will increase our capacity to see a growing population of children, adolescents and young adults with blood disorders or cancer through increased efficiencies. The expanded program will not only provide services to larger population of children in need but will also provide much needed services for the vulnerable population of older adolescents and young adults by increasing the age range of patients served from 21 to 25 years. The program will help train a future generation of pediatric hematologists/oncologists that can provide care to a large segment of the population of Harris County with blood disorders or cancer.

Related Category 3 Outcome Measure(s):

OD-5 Cost of Care
IT 5.1: Improved Cost Savings
IT 5.2: Per Episode of Care
IT 5.3: Other Outcome Improvement Target

Reasons/rationale for selecting the outcome measures:

Our project will increase appropriate access to care. Increased access to appropriate subspecialty care leads to better long term outcomes in children, adolescents and young adults and reduction in unnecessary health care costs.[114] We recognize that while increasing access to care we need to continue to focus on delivering quality, efficient and cost effective care. Medicaid is an entitlement program, but there is only a finite amount of money. The affordable Care Act

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[113] Redlener, Irwin, Grant Roy, and Krol David M. "Beyond Primary Care: Ensuring Access to Subspecialists, Special Services, and Health Care Systems for Medically Underserved Children." *Advances in Pediatrics*. 52 (2005): 9-22.
[114] *Reducing Costs Through the Appropriate Use of Specialty Services*. Cambridge: Institute for Healthcare Improvement, 2007.

focused on the triple aim- improving quality, reducing costs and improving access. This project strives to meet those same goals. We agree that increased access should be coupled with controlling unnecessary costs.

Relationship to other Projects: All of Texas Children's projects are working to expand access to subspecialty care for the pediatric population. Texas continues to have a growing pediatric population and a shortage of specialized pediatric providers.

This project will compliment other projects designed to improve appropriate access to specialty care, improve chronic care management, facilitate transition to adulthood and those designed to improve the patient experience.

Children are the future of healthcare and will dictate the treatments needed as well as the cost of healthcare in future years so it is critical that they receive the access needed throughout their pediatric lives. The focus of pediatric specialty care is similar throughout the region with a concentrated focus in the Harris county proper geographic region and allows for the expansion of access to numerous specialties such as cardiology, neurology, ENT, and many more. The outcome measures focus to appropriate length of stay, per episode cost of care, and improved cost savings. The Region 3 Initiative grid allows for a cross reference of similar initiatives in our region. (addendum)

Plan for Learning Collaborative: We plan to participate in a region-wide learning collaborative as offered by the anchor for Region 3, Harris Health System. Our participation in this collaborative with other performing providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our region's health care system.

Project Valuation: This project's value is based on the benefits related to cost avoidance of medical expenses and improved quality of life. For example, increased provider capacity leads to reduction in emergency room visits and reduction in inpatient hospital visits.[115] Our valuation also includes an increase in the patient's quality of life. We are using a conservative Quality Adjusted Life Year ("QALY") per year and a percentage of that QALY for the pediatric population.[116] The QALY is used as a one-time improvement in the quality of life, even though we know the patient's quality of life will be improved for many years. We recognize that this is a government funded waiver and thus we chose to have conservative valuations out of respect for the taxpayer funded program. We have academic literature citing the link between access to appropriate pediatric subspecialty care and decrease in hospital visits, both inpatient and emergency room.[3]

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[115] Smith, John T, Price, Christopher, Stevens Peter M., Masters, Kevin S., and Young, Mark. "Selected Topics - Does Pediatric Orthopedic Subspecialization Affect Hospital Utilization and Charges?" *Journal of Pediatric Orthopedics*. 19.4 (1999): 553-555.

[116] Brannon, Ike. "Risk - What Is a Life Worth? Despite Its Prima Facie Callousness, Determining the Value of a Human Life Is Necessary for Good Public Policy." *Regulation*. 27.4 (2004): 60-63.

139135109.1.2	1.9.2	A-D	EXPAND ACCESS TO SPECIALTY CARE: PEDIATRIC HEMATOLOGY/CANCER
Texas Children's Hospital			139135109
Related Category 3 Outcome Measure(s):	139135109.3.4 139135109.3.5 139135109.3.6	IT- 5.1 IT-5.2 IT-5.3	Improved Cost Savings Per Episode of Care Other Outcome Improvement Target

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1 (P-1): Conduct specialty care gap assessment to determine barriers to accessing subspecialty care Metric 1 P-1.1 Documentation of gap assessment Data Source: Gap Assessment Milestone 1 Estimated Incentive Payment: $658,403.50 **Milestone 2 (P-8):** Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements. Metric 1 [P-8.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: Participate in all semi-annual face-to-face meetings or seminars. Data Source: Documentation of	**Milestone 3 (P-17):** Implement the re-design of Texas Children's Hematology Clinic to increase operational efficiency, shorten patient cycle time and increase provider productivity. Metric 1 (P-17.1): Number of medical specialty clinics that have completed clinic redesign. a. Numerator: Average cycle time of appointments in hematology clinic that has undergone re-design. b. Denominator: Overall average cycle time of appointments in the Cancer and Hematology Clinic c. Data Source: Specialty clinic appointment tracking system (EPIC) Goal: Reduce cycle time by 15% from baseline of 150 minutes. Milestone 3 Estimated Incentive Payment: $718,283 **Milestone 4 [P-8]:** Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements	**Milestone 5 (I-23):** Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 (I-23.1): Documentation of increased number of visits. Demonstrate improvement over prior reporting period (baseline established in FY12). a. Total number of visits for reporting period b. Data Source: Registry, EHR Goal: Increase patient visits by 3% over baseline. Milestone 5 Estimated Incentive Payment: $720,371.50 **Milestone 6 [P-8]:** Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to	**Milestone 7 (I-23):** Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 (I-23.1): Documentation of increased number of visits. Demonstrate improvement over prior reporting period (baseline established in FY12). a. Total number of visits for reporting period b. Data Source: Registry, EHR Goal: Increase patient visits by 6% over baseline. Milestone 7 Estimated Incentive Payment: $595,089.00 **Milestone 8 [P-8]:** Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing

139135109.1.2	1.9.2	A-D	*EXPAND ACCESS TO SPECIALTY CARE: PEDIATRIC HEMATOLOGY/CANCER*
Texas Children's Hospital			139135109
Related Category 3 Outcome Measure(s):	*139135109.3.4* *139135109.3.5* *139135109.3.6*	*IT- 5.1* *IT-5.2* *IT-5.3*	*Improved Cost Savings* *Per Episode of Care* *Other Outcome Improvement Target*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Milestone 2 Estimated Incentive Payment: $658,403.50	(simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements. Metric 1 [P-8.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: Participate in all semi-annual face-to-face meetings or seminars. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Milestone 4 Estimated Incentive Payment: $718,283	implementing these improvements. Metric 1 [P-8.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: Participate in all semi-annual face-to-face meetings or seminars. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Milestone 6 Estimated Incentive Payment: $720,371.50	these improvements. Metric 1 [P-8.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: Participate in all semi-annual face-to-face meetings or seminars. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Milestone 8 Estimated Incentive Payment: $595,089.00
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $1,316,807	Year 3 Estimated Milestone Bundle Amount: $1,436,566	Year 4 Estimated Milestone Bundle Amount: $1,440,743	Year 5 Estimated Milestone Bundle Amount: $1,190,178
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)****:*** $5,384,294			

Project Options-1.9.2 Expand Specialty Access: Pediatric Rheumatology Care

Unique Project ID: 139135109.1.3

Performing Provider Name and TPI: Texas Children's Hospital/ 139135109

Project Summary: Increase critical access for the Harris County and surrounding communities to care for pediatric patients with diseases characterized by inflammation of the joints, muscles, and/or tendons.

Provider:

Texas Children's Hospital, located in Houston, is the largest free standing children's hospital in the county specializing in the care of medically fragile children in Houston and across the country as a regional safety net provider. We currently are licensed for 564 beds and in 2011 we had over 2.7 million patient encounters. Our mission is to provide the finest possible pediatric patient care, education, and research. Texas Children's is an integrated delivery system comprising of a health plan for Medicaid and CHIP pregnant women and children, the nation's largest general pediatrician group and two world class hospitals.

Volume Statistics - FY2012	Patient Payor Mix	Patient Demographics
Hospital Admissions- 25,966 Births (babies delivered)- 2,181 Emergency visits-113,586 Outpatient visits-	Medicaid and CHIP- 53.6% Commercial Insurance- 40.6% Self-Pay- 1.8% Medicare- 1.2%	Hispanic- 35.9% African American- 16.6% Caucasian- 31.0% Asian- 3.8% Other- 12.4% American Indian- 0.3%

Intervention(s):

Increase critical access for the Harris County and surrounding communities to care for pediatric patients with diseases characterized by inflammation of the joints, muscles, and/or tendons.

Need for the project:

Pediatric Rheumatology is an identified subspecialty, both at the national and state level, to have a shortage of resources to meet consumer demands (Children's Hospital Association - Pediatric Specialist Physician Shortages Affect Access to Care, August 2012).

Target Population:

In addition to general pediatric rheumatologic needs, there is a substantial need for increased access for pediatric patients that suffer from multiple forms of high risk Lupus and those requiring semi-urgent/urgent outpatient care.

Category 1 or 2 expected patient benefits:

I-23.1: Our goal is to increase the number of visits by 5% in DY3, by 10% in DY4, and by 15% in DY5 compared to baseline.

Category 3 outcomes:

IT-5 Improving cost of care

Project Options-1.9.2 Expand Specialty Access: Pediatric Rheumatology Care

Unique Project ID: 139135109.1.3
Performing Provider Name and TPI: Texas Children's Hospital/ 139135109

Project Description:
Texas Children's Hospital proposes to increase capacity, improve care and reduce appointment wait time in our Rheumatology Clinic.

Texas Children's Hospital, located in Houston, is the largest free standing children's hospital in the county specializing in the care of medically fragile children in Houston and across the country as a regional safety net provider. We currently are licensed for 564 beds at our main campus and West Houston facilities. In 2011 we had over 2.7 million patient encounters. Our mission is to provide the finest possible pediatric patient care, education, and research. Texas Children's is an integrated delivery system comprising of a health plan for Medicaid and CHIP pregnant women and children, the nation's largest general pediatrician group and two world class hospitals. Texas Children's supports a commitment to quality service and cost-effective care to enhance the health and well-being of children locally, nationally and internationally.

Our project proposal will significantly improve access to pediatric subspecialty care. Specifically this project will increase capacity in our Rheumatology Clinic. Pediatric Rheumatology is an identified subspecialty, both at the national and state level, to have a shortage of resources to meet consumer demands (Children's Hospital Association - Pediatric Specialist Physician Shortages Affect Access to Care, August 2012). Our clinic provides critical access for the Harris County and surrounding communities to care for pediatric patients with diseases characterized by inflammation of the joints, muscles, and/or tendons. Referrals into the TCH pediatric rheumatology clinic increased significantly from a monthly average of 60 in 2010 to a monthly average of 125 in 2012.

There are two specific areas where we intend to focus the expansion of our access to care. First, there is a substantial need for increased access for pediatric patients that suffer from multiple forms of high risk Lupus in our community. In addition, there is a need to expand access for a semi-urgent/urgent clinic, which will divert them from presenting unnecessarily in our Emergency Center. Part of the task of the urgent/semi-urgent clinic would also include community physician education for rheumatologic diseases. The intention of the education would be to provide the physicians with a comprehensive understanding of initial treatment for possible rheumatology diagnosis and when referrals should be initiated. Education sessions would include exclusive visits to those practices in the west and south side of Houston (these areas account for 80% of the referrals to our service).

Goals and Relationship to Regional Goals:

Project Goals: To meet the growing demand for specialized pediatric services TCH will:

1. Focus on provider productivity to optimize clinical time for all providers
2. Establish an initiative to review scheduling processes to increase the availability of these targeted providers

3. Expand internal capacity by hiring additional clinical providers
4. Enhance service availability by targeting new providers to not only work in the Texas Medical Center but to also serve 1-3 additional community locations for rheumatology care
5. Provide education to community providers
6. Enhance training of subspecialists and fellows
7. Decrease unnecessary Emergency Center visits

This project meets the following Region 3 Goals:

- Increased access to specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their conditions, regardless of where they reside or their ability to pay for care.
- Develop a regional approach to healthcare delivery that leverages and improves on existing programs and infrastructure, is responsive to patients' needs throughout the entire region, and improves health care outcomes and patient satisfaction

Challenges:

There are less than 300 active pediatric rheumatologists in the country and many of the providers are approaching retirement (*The Rheumatologist,* July 2012- "Pediatric Rheumatologist Increasing in Number but still Rare"). In Texas, limited Medicaid reimbursement is an ongoing challenge for children's hospitals and the workforce that provides health care services for the pediatric population enrolled in this program. As advocates for improving and sustaining quality children's health care, our organization informs and educates elected officials and community leaders about the importance of Medicaid and the need to adequately fund the program. We will continue these efforts throughout the duration of waiver to ensure existing programs and services will be maintained and expanded. There are currently only 20 active pediatric rheumatology fellowship programs in the United States, which train and graduate a maximum of 15 board-eligible, fellowship-trained pediatric rheumatologists each year.

Five year expected outcome for provider and patients:

Texas Children's Hospital expects to see improvements in access to subspecialty care for our pediatric patients; this in turn will improve patient satisfaction due to the delivery of the right care at the right place at the right time.

Starting Point/Baseline:

The baseline of patient volumes in FY 12 is 1650. Our fiscal year runs from October 1st through September 30th.

Rationale:

The significant increase in access to specialty care created by this project attempts to address the growing demands in our community for specialized pediatric providers. This project will create increased capacity through more efficient operations and new physician recruitment. Our project significantly enhances TCH's existing pediatric rheumatology services to improve patient satisfaction by aspiring to provide the right care in the right setting at the right time. Specifically, we will provide comprehensive care for children within focused specialty programs including: diseases characterized by inflammation of the joints, muscles, and/or tendons, including high risk Lupus and Juvenile Rheumatoid Arthritis.

Inadequate access to specialty care has contributed to the limited scope and size of safety net health systems. For children with health care needs that exceed the abilities of the primary care provider, access to and coordination with subspecialty care is critical to ensuring the provision of efficient and effective health care and in securing a comprehensive medical home.[117] Increasing pediatric population and continued lack of pediatric subspecialists due to the inequity in reimbursement between Medicaid and Medicare is an ongoing problem for children's hospitals and the pediatric health care workforce. Our project significantly enhances TCH's existing developmental pediatric services. Region 3 RHP summit identified inadequate number of specialty providers as an area of community need (CN.2).

Project Components:
Through the expanded access to specialty care, we propose to meet all required project components listed and these selected milestones and metrics do relate to project components.

k. Conduct specialty care gap assessment based on community need for subspecialty.
l. Implement transparent standardized referrals across the system
m. Increase specialty care volume of visits and evidence of improved access for patients seeking services
n. Increase the number of specialty clinic locations
o. Conduct quality improvement for projects including rapid cycle and learning collaborative exchanges.

Milestones and Metrics
The following milestones and metrics have been chosen for the project based on the core components and the needs of the targeted pediatric population.

- Process milestone and metrics: P-1 (P-1.1); P-8 (P-8.1); P-17 (P-17.1)
- Improvement milestones and metrics: I-23 (I-23.1)

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
This project will enhance current services by expanding and maximizing provider accessibility that will result in a greater number of patients served. In addition it will result in prompt service and allow more children access to rheumatology subspecialty care.

<u>Related Category 3 Outcome Measure(s):</u>
OD-5: Cost of Care
IT-5.1: Improved cost savings
IT-5.2: Per Episode Cost of Care
IT-5.3: Length of Stay

Reasons/rationale for selecting the outcome measures:

[117] Redlener, Irwin, Grant Roy, and Krol David M. "Beyond Primary Care: Ensuring Access to Subspecialists, Special Services, and Health Care Systems for Medically Underserved Children." *Advances in Pediatrics*. 52 (2005): 9-22.

Our project will increase appropriate access to care. Increased access to appropriate subspecialty care leads to better long term outcomes in children and reduction in unnecessary health care costs.[118]

Relationship to other Projects:
All of Texas Children's projects are working to expand access to subspecialty care for the pediatric population. Texas continues to have a growing pediatric population and a shortage of specialized pediatric providers.

Children are the future of healthcare and will dictate the treatments needed as well as the cost of healthcare in future years so it is critical that they receive the access needed throughout their pediatric lives. The focus of pediatric specialty care is similar throughout the region with a concentrated focus in the Harris county proper geographic region and allows for the expansion of access to numerous specialties such as cardiology, neurology, ENT, and many more. The outcome measures focus to appropriate length of stay, per episode cost of care, and improved cost savings. The Region 3 Initiative grid allows for a cross reference of similar initiatives in our region. (addendum)

Relationship to Other Performing Providers' Projects and Plan for Learning Collaboratives:
This project will compliment other projects designed to improve appropriate access to specialty care, improve chronic care management, and those designed to improve the patient experience. We plan to participate in a region-wide learning collaborative as offered by the anchor for Region 3, Harris Health System. Our participation in this collaborative with other performing providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our region's health care system.

Project Valuation: This project's value is based on the benefits related to cost avoidance of medical expenses and improved quality of life. For example, increased provider capacity leads to reduction in emergency room visits and reduction in inpatient hospital visits.[119] Our valuation also includes an increase in the patient's quality of life. We are using a conservative Quality Adjusted Life Year ("QALY") per year and a percentage of that QALY for the pediatric population.[120] The QALY is used as a one-time improvement in the quality of life, even though we know the patient's quality of life will be improved for many years. We recognize that this is a government funded waiver and thus we chose to have conservative valuations out of respect for the taxpayer funded program. We have academic literature citing the link between access to appropriate pediatric subspecialty care and decrease in hospital visits, both inpatient and emergency room.[3]

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[118] *Reducing Costs Through the Appropriate Use of Specialty Services*. Cambridge: Institute for Healthcare Improvement, 2007.
[119] Smith, John T, Price, Christopher, Stevens Peter M., Masters, Kevin S., and Young, Mark. "Selected Topics - Does Pediatric Orthopedic Subspecialization Affect Hospital Utilization and Charges?" *Journal of Pediatric Orthopedics*. 19.4 (1999): 553-555.
[120] Brannon, Ike. "Risk - What Is a Life Worth? Despite Its Prima Facie Callousness, Determining the Value of a Human Life Is Necessary for Good Public Policy." *Regulation*. 27.4 (2004): 60-63.

139135109.1.3	1.9.2	A-D	EXPAND PEDIATRIC ACCESS TO RHEUMATOLOGY CARE
Texas Children's Hospital			139135109
Related Category 3 Outcome Measure(s):	139135109.3.7 139135109.3.8 139135109.3.9	IT-5.1 IT-5.2 IT-5.3	Improved cost savings Per Episode Cost of Care Length of Stay

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1 (P-1): Conduct specialty care gap assessment to determine barriers to accessing subspecialty care Metric 1 (P-1.1): Documentation of gap assessment Data Source: Gap Assessment Milestone 1 Estimated Incentive Payment: $503,264.50 **Milestone 2 (P-8):** Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements. Metric 1 (P-8.1): Participate in semi-annual face-to-	**Milestone 3 (I-23):** Implement the re-design of Texas Children's Gastroenterology Clinic to increase operational efficiency, increase provider productivity and increase clinic visits. Metric 1 (I-23.1): Documentation of increased number of visits. Demonstrate improvement over baseline reporting period (established in FY12). Data Source: Registry, EHR Goal: 5% increase over baseline Milestone 3 Estimated Incentive Payment: $549,034.50 **Milestone 4 (P-8):** Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements.	**Milestone 5 (I-23):** Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 (I-23.1): Documentation of increased number of visits. Demonstrate improvement over baseline reporting period (baseline established in FY12). Data Source: EPIC medical record Goal: 10% increase over baseline Milestone 5 Estimated Incentive Payment: $550,630.50 **Milestone 6 (P-8):** Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements.	**Milestone 7(I-23.1):** Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 (I-23.1): Documentation of increased number of visits. Demonstrate improvement over baseline reporting period (baseline established in FY12). Data Source: EPIC medical record Goal:15% increase over baseline Milestone 7 Estimated Incentive Payment: $ 454,868.50 **Milestone 8 (P-8):** Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements.

139135109.1.3	1.9.2	A-D	*Expand Pediatric Access to Rheumatology care*
Texas Children's Hospital			*139135109*
Related Category 3 Outcome Measure(s):	*139135109.3.7* 139135109.3.8 139135109.3.9	*IT-5.1* *IT-5.2* *IT-5.3*	*Improved cost savings* *Per Episode Cost of Care* *Length of Stay*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
face meetings or seminars organized by the RHP. Goal: Participate in all semi-annual face-to-face meetings or seminars. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Milestone 2 Estimated Incentive Payment: $503,264.50	Metric 1 (P-8.1): Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: Participate in all semi-annual face-to-face meetings or seminars. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Milestone 4 Estimated Incentive Payment: $549,034.50	Metric 1 (P-8.1): Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: Participate in all semi-annual face-to-face meetings or seminars. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Milestone 6 Estimated Incentive Payment: $550,630.50	Metric 1 (P-8.1): Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: Participate in all semi-annual face-to-face meetings or seminars. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Milestone 8 Estimated Incentive Payment: $454,868.50
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone)*: $1,006,529	Year 3 Estimated Milestone Bundle Amount: $1,098,069	Year 4 Estimated Milestone Bundle Amount: $1,101,261	Year 5 Estimated Milestone Bundle Amount: $909,737
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:** $4,115,596			

Project Option- 1.9.2 Expand Access to Specialty Care: Pediatric Cardiology Care

Unique Project ID: 139135109.1.4

Performing Provider and TPI: Texas Children's Hospital/139135109

Project Summary: Increase outpatient access for Harris County and the surrounding communities to care for pediatric patients with congenital heart disease.

Provider:

Texas Children's Hospital, located in Houston, is the largest free standing children's hospital in the county specializing in the care of medically fragile children in Houston and across the country as a regional safety net provider. We currently are licensed for 564 beds and in 2011 we had over 2.7 million patient encounters. Our mission is to provide the finest possible pediatric patient care, education, and research. Texas Children's is an integrated delivery system comprising of a health plan for Medicaid and CHIP pregnant women and children, the nation's largest general pediatrician group and two world class hospitals.

Volume Statistics - FY2012	**Patient Payor Mix**	**Patient Demographics**
Hospital Admissions- 25,966 Births (babies delivered)- 2,181 Emergency visits-113,586 Outpatient visits- 3,066,765	Medicaid and CHIP- 53.6% Commercial Insurance- 40.6% Self-Pay- 1.8% Medicare- 1.2%	Hispanic- 35.9% African American- 16.6% Caucasian- 31.0% Asian- 3.8% Other- 12.4% American Indian- 0.3%

Intervention(s):

Increase outpatient access for Harris County and the surrounding communities to care for pediatric patients with congenital heart disease.

Need for the project:

Pediatric Cardiology is an identified subspecialty, both at the national and state level, to have a shortage of resources to meet consumer demands (Children's Hospital Association - Pediatric Specialist Physician Shortages Affect Access to Care, August 2012).

Target Population:

All children with congenital heart disease ranging from neonate all the way through adulthood.

Category 1 or 2 expected patient benefits:

I-23.1: Our goal is to increase the number of visits by 3% in DY3, by 5% in DY4, and by 7% in DY5 compared to baseline established in DY2.

Category 3 outcomes:

IT-5 Improving Cost of Care

Project Option- 1.9.2 Expand Access to Specialty Care: Pediatric Cardiology Care

Unique Project ID: 139135109.1.4
Performing Provider and TPI: Texas Children's Hospital/139135109

Project Description:
Texas Children's Hospital proposes to increase capacity in Cardiology Clinic.

Texas Children's Hospital, located in Houston, is the largest free standing children's hospital in the county specializing in the care of medically fragile children in Houston and across the country as a regional safety net provider. We currently are licensed for 564 beds at our main campus and West Houston facilities. In 2011 we had over 2.7 million patient encounters. Our mission is to provide the finest possible pediatric patient care, education, and research. Texas Children's is an integrated delivery system comprising of a health plan for Medicaid and CHIP pregnant women and children, the nation's largest general pediatrician group and two world class hospitals. Texas Children's supports a commitment to quality service and cost-effective care to enhance the health and well-being of children locally, nationally and internationally.

Specifically this project will increase capacity in our Cardiology Clinic. Through recruitment of additional highly-specialized Pediatric Cardiologists with focused training in sub-specialized areas such as fetal cardiology, heart failure, adult congenital cardiology, pediatric electrophysiology, and pediatric interventional cardiology along with focused attention on existing provider productivity and increased efficiencies in patient throughput, this project will enable us to open clinics and increase appointment availability. In doing so, we will begin to improve access for the pediatric community needing general pediatric cardiac care as well as those populations who need the ultra-specialized pediatric and adult congenital cardiac care that we provide at Texas Children's Hospital. This project also focuses on increasing Pediatric Cardiology presence at the 5 satellite locations across the greater Houston area to ensure we target the larger greater Houston population. Through partnerships with other organizations across the city and state, we will be expanding our specialized pediatric and adult congenital cardiac services to additional facilities throughout the greater Houston area as well as central Texas. Pediatric cardiology is an identified subspecialty, both at the national and state level, to have a shortage of resources to meet consumer demands (Children's Hospital Association - Pediatric Specialist Physician Shortages Affect Access to Care, August 2012). The Texas Children's ("TCH") Cardiology Service line is ranked #3 in the 2012 U.S. News and World Report Best Children's Hospitals and is the only pediatric cardiology service line ranked in the top 10 in Texas. Referrals into the TCH pediatric cardiology clinic increased significantly from a monthly average of 600 in 2010 to a monthly average of 760 in 2012.

Goals and Relationship to Regional Goals:
Project Goals: To meet the growing demand for specialized pediatric services TCH will:

- Focus on provider productivity to optimize clinical time for all providers
- Establish an initiative to review scheduling processes to increase the availability of these targeted providers
- Expand internal capacity by hiring additional clinical providers

- Enhance service availability by targeting new providers to not only work in the Texas Medical Center but to also increase availability and scope of services in 1-3 additional community locations.

This project meets the following Region 3 Goals:

- Increased access to specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their conditions, regardless of where they reside or their ability to pay for care.
- Develop a regional approach to healthcare delivery that leverages and improves on existing programs and infrastructure, is responsive to patients' needs throughout the entire region, and improves health care outcomes and patient satisfaction

As the demand for pediatric subspecialty services grows, TCH aims to maintain a consistent and significant presence for services at every subspecialty outpatient location in the TCH system. This increase in cardiology services capacity will allow children in our region to have more timely and appropriate access to much needed subspecialty care. We know from research that increased access to appropriate subspecialty care leads to better long term outcomes in children and reduction in unnecessary health care costs.

Challenges:

Recruitment of pediatric Cardiologists will be one of the larger challenges for this project due to the limited number of pediatric Cardiologists in the country which is compounded with the decreasing number of those currently in residency and fellowships focusing on pediatric cardiology. In order to attempt to resolve this challenge, TCH, and specifically pediatric cardiology, is funding additional fellowship training slots. This increase in trainees not only adds support for current patient care needs but helps face the challenge of declining pediatric cardiologists-in-training. Another challenge we will face with this project is the recruitment and retention of diagnostic and testing technologists. These technologists are highly specialized for pediatric cardiac diagnostics and are extremely difficult to recruit. With increased volume of patients, an increase in diagnostic studies is projected. We are developing partnerships with local training programs/schools to assist in on-site learning opportunities which will aid us in ultimately recruiting top students from those programs to support our additional patient capacity. In Texas, limited Medicaid reimbursement is an ongoing challenge for children's hospitals and the workforce that provides health care services for the pediatric population enrolled in this program. As advocates for improving and sustaining quality children's health care, our organization informs and educates elected officials and community leaders about the importance of Medicaid and the need to adequately fund the program. We will continue these efforts throughout the duration of waiver to ensure existing programs and services will be maintained and expanded.

Five year expected outcome for provider and patients:

Texas Children's Hospital expects to see improvements in access to subspecialty care for our pediatric patients; this in turn will improve patient satisfaction due to the delivery of the right care at the right place at the right time.

Starting Point/Baseline:

The baseline for patient volumes in FY 12 is 17100. Our fiscal year runs from October 1st to September 30th.

Rationale:

The significant increase in access to specialty care created by this project attempts to address the growing demands in our community for specialized pediatric providers. This project will create increased capacity through more efficient operations and new physician recruitment. Our project significantly enhances TCH's existing pediatric and adult congenital cardiac services to improve patient satisfaction by aspiring to provide the right care in the right setting at the right time. Specifically, we will provide comprehensive care for children within focused specialty programs, many of which are not offered at other local institutions, including: fetal cardiac imaging and consultation, adult congenital cardiology, heart failure/cardiomyopathy and transplantation, cardiac genetics follow-up, cardiac developmental outcomes for children who have undergone open-heart surgery, pediatric electrophysiology and pacing including the use of stereotaxis, and advanced pediatric interventional cardiology. For children with health care needs that exceed the abilities of the primary care provider, access to and coordination with subspecialty care is critical to ensuring the provision of efficient and effective health care and in securing a comprehensive medical home.[121] Increased access to appropriate care leads to better long term outcomes in children and reduction in unnecessary health care costs.[122]

Project Components:

Through the expanded access to specialty care, we propose to meet all required project components listed and these selected milestones and metrics do relate to project components.

p. Conduct specialty care gap assessment based on community need for subspecialty.
q. Implement transparent standardized referrals across the system
r. Increase specialty care volume of visits and evidence of improved access for patients seeking services
s. Increase service availability hours and increase number of specialty clinic locations.
t. Conduct quality improvement for projects including rapid cycle and learning collaborative exchanges.

Milestones and Metrics:

The following milestones and metrics have been chosen for the project based on the core components and the needs of the targeted pediatric population.

- Process milestone and metrics: P-1 (P-1.1); P-8 (P-8.1); P-17 (P-17.1)
- Improvement milestones and metrics: I-23 (I-23.1)

Unique community need identification number the project addresses:

- CN.2: Inadequate access to specialty care,
- CN.6: Inadequate access to treatment and services designed for children.

[121] Redlener, Irwin, Grant Roy, and Krol David M. "Beyond Primary Care: Ensuring Access to Subspecialists, Special Services, and Health Care Systems for Medically Underserved Children." *Advances in Pediatrics*. 52 (2005): 9-22.

[122] *Reducing Costs Through the Appropriate Use of Specialty Services*. Cambridge: Institute for Healthcare Improvement, 2007.

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
Patients often experience lengthy wait times from the time they schedule the appointment to the time of the appointment; it can take weeks and, in some cases, months to see one of our providers. Funding for this project will allow us to significantly enhance our ability to see additional patients in a timelier manner and ensure the right patients are scheduled with the appropriate provider based on their specific specialized needs which will increase patient satisfaction and increase access to pediatric cardiac care. Our project will enable us to continue to grow our services at additional locations throughout the greater Houston area as well as some growth in Central Texas which is important because we are able to provide highly-specialized pediatric cardiac services that are not usually available at other institutions.

Related Category 3 Outcome Measure(s):
OD-5 Cost of Care

- IT 5.1: Improved Cost of Care
- IT 5.2: Per Episode Cost of Care
- IT 5.3: Lengthy of Stay

Reasons/rationale for selecting the outcome measures:
Our project will increase appropriate access to care. Increased access to appropriate subspecialty care leads to better long term outcomes in children and reduction in unnecessary health care services and subsequent costs.[123] We recognize that while increasing access to care we need to continue to focus on delivering quality, efficient and cost effective care. Medicaid is an entitlement program, but there is only a finite amount of money. The affordable Care Act focused on the triple aim- improving quality, reducing costs and improving access. This project strives to meet those same goals. We agree that increased access should be coupled with controlling unnecessary costs.

Relationship to other Projects: All of Texas Children's projects are working to expand access to subspecialty care for the pediatric population. Texas continues to have a growing pediatric population and a shortage of specialized pediatric providers.

Children are the future of healthcare and will dictate the treatments needed as well as the cost of healthcare in future years so it is critical that they receive the access needed throughout their pediatric lives. The focus of pediatric specialty care is similar throughout the region with a concentrated focus in the Harris county proper geographic region and allows for the expansion of access to numerous specialties such as cardiology, neurology, ENT, and many more. The outcome measures focus to appropriate length of stay, per episode cost of care, and improved cost savings. The Region 3 Initiative grid allows for a cross reference of similar initiatives in our region. (addendum)

Plan for Learning Collaborative: We plan to participate in a region-wide learning collaborative as offered by the anchor for Region 3, Harris Health System. Our participation in this collaborative with other performing providers within the region that have similar projects

[123] *Reducing Costs Through the Appropriate Use of Specialty Services*. Cambridge: Institute for Healthcare Improvement, 2007.

will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our region's health care system.

Project Valuation: This project's value is based on the benefits related to cost avoidance of medical expenses and improved quality of life. For example, increased provider capacity leads to reduction in emergency room visits and reduction in inpatient hospital visits.[124] Our valuation also includes an increase in the patient's quality of life. We are using a conservative Quality Adjusted Life Year ("QALY") per year and a percentage of that QALY for the pediatric population.[125] The QALY is used as a one-time improvement in the quality of life, even though we know the patient's quality of life will be improved for many years. We recognize that this is a government funded waiver and thus we chose to have conservative valuations out of respect for the taxpayer funded program.

[124] Smith, John T, Price, Christopher, Stevens Peter M., Masters, Kevin S., and Young, Mark. "Selected Topics - Does Pediatric Orthopedic Subspecialization Affect Hospital Utilization and Charges?" *Journal of Pediatric Orthopedics*. 19.4 (1999): 553-555.

[125] Brannon, Ike. "Risk - What Is a Life Worth? Despite Its Prima Facie Callousness, Determining the Value of a Human Life Is Necessary for Good Public Policy." *Regulation*. 27.4 (2004): 60-63.

139135109.1.4	**1.9.2**	**A-D**	**EXPAND ACCESS TO SPECIALTY CARE: PEDIATRIC CARDIOLOGY CARE**
Texas Children's Hospital			*139135109*
Related Category 3 Outcome Measure(s):	*139135109.3.10* *139135109.3.11* *139135109.3.12*	*IT-5.1* *IT-5.2* *IT-5.3*	*Improved Cost of Care* *Per Episode Cost of Care* *Length of Stay*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-1]: Conduct specialty care gap assessment to determine barriers to accessing subspecialty care Metric 1 [P-1.1]: Documentation of gap assessment Goal: Perform and document gap assessment Data Source: Gap Assessment Milestone 1 Estimated Incentive Payment: $547,009 **Milestone 2** [P-8]: Participate in face-to-face learning at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements. Each participating provider should publicly commit to implementing these improvements. Metric 1 [P-8.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: Participate in all semi-annual face-to-face meetings or seminars. Data Source: Documentation of semiannual meetings including meeting agendas, slides from	**Milestone 3** [I-23]: Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 [I-23.1]: Documentation of increased number of visits. Demonstrate improvement over prior reporting period (baseline established in FY12). Goal: Increase clinic volume by 3% over baseline Data Source: Registry, EHR Milestone 3 Estimated Incentive Payment: $596,757.50 **Milestone 4** [P-8]: Participate in face-to-face learning at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements. Each participating provider should publicly commit to implementing these improvements. Metric 1 [P-8.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: Participate in all semi-annual	**Milestone 5** [I-23]**:** Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 (I-23.1): Documentation of increased number of visits. Demonstrate improvement over prior reporting period (baseline established in FY12). a. Total number of visits for reporting period b. Data Source: Registry, EHR Goal**:** Increase clinic volume by 5% over baseline Milestone 5 Estimated Incentive Payment: $598,492 **Milestone 6** [P-8]: Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to	**Milestone 7 (I-23):** Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 (I-23.1): Documentation of increased number of visits. Demonstrate improvement over prior reporting period (baseline established in FY12). a. Total number of visits for reporting period b. Data Source: Registry, EHR Goal: Increase clinic volume by 7% over baseline Milestone 7 Estimated Incentive Payment: $494,406.50 **Milestone 8** [P-8]: Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing

139135109.1.4	**1.9.2**	**A-D**	**EXPAND ACCESS TO SPECIALTY CARE: PEDIATRIC CARDIOLOGY CARE**
Texas Children's Hospital			*139135109*
Related Category 3 Outcome Measure(s):	*139135109.3.10* *139135109.3.11* *139135109.3.12*	*IT-5.1* *IT-5.2* *IT-5.3*	*Improved Cost of Care* *Per Episode Cost of Care* *Length of Stay*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
presentations, and/or meeting notes. Milestone 2 Estimated Incentive Payment: $547,009	face-to-face meetings or seminars. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Milestone 4 Estimated Incentive Payment: $596,757.50	implementing these improvements. Metric 6 [P-8.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: Participate in all semi-annual face-to-face meetings or seminars. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Milestone 6 Estimated Incentive Payment: $598,492	these improvements. Metric 6 [P-8.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: Participate in all semi-annual face-to-face meetings or seminars. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Milestone 8 Estimated Incentive Payment: $494,406.50
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $1,094,018	Year 3 Estimated Milestone Bundle Amount: $1,193,515	Year 4 Estimated Milestone Bundle Amount: $1,196,984	Year 5 Estimated Milestone Bundle Amount: $988,813
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)**:*** $4,473,330			

Project Options- 1.9.2 Expand Specialty Care Access: Pulmonology Pediatric Care

Unique Project ID: 139135109.1.5

Performing Provider and TPI: Texas Children's Hospital/139135109

Project Summary: Increase outpatient access for Harris County, specifically North Houston, to care for pediatric patients with conditions affecting the lungs and respiratory tract.
Provider:
Texas Children's Hospital, located in Houston, is the largest free standing children's hospital in the county specializing in the care of medically fragile children in Houston and across the country as a regional safety net provider. We currently are licensed for 564 beds and in 2011 we had over 2.7 million patient encounters. Our mission is to provide the finest possible pediatric patient care, education, and research. Texas Children's is an integrated delivery system comprising of a health plan for Medicaid and CHIP pregnant women and children, the nation's largest general pediatrician group and two world class hospitals.

Volume Statistics - FY2012	Patient Payor Mix	Patient Demographics
Hospital Admissions- 25,966 Births (babies delivered)- 2,181 Emergency visits-113,586 Outpatient visits- 3,066,765	Medicaid and CHIP- 53.6% Commercial Insurance- 40.6% Self-Pay- 1.8% Medicare- 1.2%	Hispanic- 35.9% African American- 16.6% Caucasian- 31.0% Asian- 3.8% Other- 12.4% American Indian- 0.3%

Intervention(s):
Increase outpatient access for Harris County, specifically North Houston, to care for pediatric patients with conditions affecting the lungs and respiratory tract.
Need for the project:
Pediatric Pulmonology is an identified subspecialty, both at the national and state level, to have a shortage of resources to meet consumer demands (Children's Hospital Association - Pediatric Specialist Physician Shortages Affect Access to Care, August 2012).

Target Population:
Our target population is patients seeking the full spectrum of services from general pumonary care to treatment for life threatening conditions such cystic fibrosis and life threatening athsma.

Category 1 or 2 expected patient benefits:
I-23.1: Our goal is to increase the number of visits by 5% in DY3, by 8% in DY4, and by 10% in DY5 compared to baseline established in DY2.

Category 3 outcomes:
IT-5 Improving Cost of Care

Project Options- 1.9.2 Expand Specialty Care Access: Pulmonology Pediatric Care

Unique Project ID: 139135109.1.5
Performing Provider and TPI: Texas Children's Hospital/139135109

Project Description:
Texas Children's Hospital proposes to increase capacity in the Pulmonology Clinic, which will improve access to care and ensure reduce appointment wait time.

Texas Children's Hospital, located in Houston, is the largest free standing children's hospital in the county specializing in the care of medically fragile children in Houston and across the country as a regional safety net provider. We currently are licensed for 564 beds at our main campus and West Houston facilities. In 2011 we had over 2.7 million patient encounters. Our mission is to provide the finest possible pediatric patient care, education, and research. Texas Children's is an integrated delivery system comprising of a health plan for Medicaid and CHIP pregnant women and children, the nation's largest general pediatrician group and two world class hospitals. Texas Children's supports a commitment to quality service and cost-effective care to enhance the health and well-being of children locally, nationally and internationally.

Specifically this project will increase capacity in our Pulmonology Clinic. Pediatric pulmonology is an identified subspecialty, both at the national and state level, to have a shortage of resources to meet consumer demands (Children's Hospital Association - Pediatric Specialist Physician Shortages Affect Access to Care, August 2012). The TCH Pulmonary Clinic receives an average of over 2,000 new patient referrals annually and that number can increase significantly during years of severe flu and respiratory virus outbreaks. The primary focus for this project will be increased availability at our community health centers in North Houston and surrounding areas where we currently have an average wait of 58 days for a new pulmonary appointment. This expansion into the community will also greatly benefit a significant number of our patients who do not have reliable transportation into the medical center and find it easier to access care in their own community at one of the above mentioned health centers. This increased availability will be accomplished by adding additional providers at those locations as well as optimizing current provider schedules to allow them so see more patients each day.

Additionally, we will focus on maintaining the accessibility of our lung transplant program by recruiting an additional faculty member to help care for this population of patients. Texas Children's is one of busiest pediatric lung transplant programs in the country and has performed 9 transplants year to date in 2012. Only a handful of these programs exist in the United States and Texas Children's is the only pediatric lung transplant program in the Southern region. Because there are so few pediatric lung programs in the country, there are inadequate training opportunities which have lead to a severe shortage of lung transplant trained physicians available to treat these patients. Our program helps children from around the country and the recruitment of an additional provider is vitally important if we are to maintain the viability of this program.

Goals and Relationship to Regional Goals:

Project Goals: To meet the growing demand for specialized pediatric services TCH will:

8. Focus on provider productivity to optimize clinical time for all providers
9. Establish an initiative to review scheduling processes to increase the availability of these targeted providers
10. Expand internal capacity by hiring additional clinical providers
11. Enhance service availability by targeting new providers to not only work in the Texas Medical Center but to also serve the five additional community locations for specialty care.

This project meets the following Region 3 Goals:

- Increased access to specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their conditions, regardless of where they reside or their ability to pay for care
- Develop a regional approach to healthcare delivery that leverages and improves on existing programs and infrastructure, is responsive to patients' needs throughout the entire region, and improves health care outcomes and patient satisfaction

As the demand for pediatric subspecialty services grows, TCH aims to maintain a consistent and significant presence for services at every subspecialty outpatient location in the TCH system. This increase in pulmonology services capacity will allow children in our region to have more timely and appropriate access to much needed subspecialty care. We know from research that increased access to appropriate subspecialty care leads to better long term outcomes in children and reduction in unnecessary health care costs.

Challenges:
In Texas, limited Medicaid reimbursement is an ongoing challenge for children's hospitals and the workforce that provides health care services for the pediatric population enrolled in this program. As advocates for improving and sustaining quality children's health care, our organization informs and educates elected officials and community leaders about the importance of Medicaid and the need to adequately fund the program. We will continue these efforts throughout the duration of the waiver to ensure existing programs and services will be maintained and expanded.

Five year expected outcome for provider and patients:
Texas Children's Hospital expects to see improvements in access to subspecialty care for our pediatric patients; this in turn will improve patient satisfaction due to the delivery of the right care at the right place at the right time.

Starting Point/Baseline:
The average wait time for an appointment for pulmonology at our two northern TCH health center locations is 58 days. The baseline for patient volumes in FY 12 is 5,450. Our fiscal year runs from October 1st to September 30th.

Rationale:
The significant increase in access to specialty care created by this project attempts to address the growing demands in our community for specialized pediatric providers. This project will create

increased capacity through more efficient operations and new physician recruitment. Our project significantly enhances TCH's existing pulmonology services to improve patient satisfaction by aspiring to provide the right care in the right setting at the right time. The Texas Children's ("TCH") Pulmonology Service line is ranked # 3 in the 2012 *U.S. News and World Report* Best Children's Hospitals and is the only pediatric pulmonology service line ranked in the top 10 in Texas. The TCH Pulmonary Service Line also boasts one of the largest lung transplant programs in the country and is currently recruiting an additional lung transplant physician in order to maintain access to this vital program for patients from across the country.

For children with health care needs that exceed the abilities of the primary care provider, access to and coordination with subspecialty care is critical to ensuring the provision of efficient and effective health care and in securing a comprehensive medical home.[126] Increased access to appropriate care leads to better long term outcomes in children and reduction in unnecessary health care costs.[127] Increasing pediatric population and continued lack of pediatric subspecialists due to the inequity in reimbursement between Medicaid and Medicare is an ongoing problem for children's hospitals and the pediatric health care workforce.

Project Components:
Through the expanded access to specialty care, we propose to meet all required project components listed and these selected milestones and metrics do relate to project components.

u. Conduct specialty care gap assessment based on community need for subspecialty.
v. Implement transparent standardized referrals across the system
w. Increase specialty care volume of visits and evidence of improved access for patients seeking services
x. Increase service availability hours and increase number of specialty clinic locations. Conduct quality improvement for projects including rapid cycle and learning collaborative exchanges.

Milestones and Metrics
The following milestones and metrics have been chosen for the project based on the core components and the needs of the targeted pediatric population.

- Process milestone and metrics: P-1 (P-1.1); P-8 (P-8.1); P-17 (P-17.1)
- Improvement milestones and metrics: I-23 (I-23.1)

Unique community need identification numbers the project addresses:

- CN.2: Inadequate access to specialty care.
- CN.6: Inadequate access to treatment and services designed for children.

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

[126] Redlener, Irwin, Grant Roy, and Krol David M. "Beyond Primary Care: Ensuring Access to Subspecialists, Special Services, and Health Care Systems for Medically Underserved Children." *Advances in Pediatrics*. 52 (2005): 9-22.
[127] *Reducing Costs Through the Appropriate Use of Specialty Services*. Cambridge: Institute for Healthcare Improvement, 2007.

Patients often experience lengthy wait times from the time they schedule the appointment to the time of the appointment; it can take weeks and, in some cases, months to see one of our providers. Funding for this project will allow us to significantly enhance our ability to see additional patients in a timelier manner and ensure the right patients are scheduled with the appropriate provider based on their specific specialized needs which will increase patient satisfaction and increase access to care. Our project will enable us to continue to grow our services at additional locations throughout the greater Houston area which is important because we are able to provide highly-specialized pediatric pulmonary services that are not usually available at other institutions.

Related Category 3 Outcome Measure(s):
OD-5 Cost of Care
IT-5.1: Improved cost savings
IT-5.2: Per episode of care cost
IT-5.3: Length of stay

Reasons/rationale for selecting the outcome measures:
Our project will increase appropriate access to care. Increased access to appropriate subspecialty care leads to better long term outcomes in children and reduction in unnecessary health care services and subsequent costs.[128] We recognize that while increasing access to care we need to continue to focus on delivering quality, efficient and cost effective care. Medicaid is an entitlement program, but there is only a finite amount of money. The affordable Care Act focused on the triple aim- improving quality, reducing costs and improving access. This project strives to meet those same goals. We agree that increased access should be coupled with controlling unnecessary costs.

Relationship to other Projects: All of Texas Children's projects are working to expand access to subspecialty care for the pediatric population. Texas continues to have a growing pediatric population and a shortage of specialized pediatric providers.

Children are the future of healthcare and will dictate the treatments needed as well as the cost of healthcare in future years so it is critical that they receive the access needed throughout their pediatric lives. The focus of pediatric specialty care is similar throughout the region with a concentrated focus in the Harris county proper geographic region and allows for the expansion of access to numerous specialties such as cardiology, neurology, ENT, and many more. The outcome measures focus to appropriate length of stay, per episode cost of care, and improved cost savings. The Region 3 Initiative grid allows for a cross reference of similar initiatives in our region. (addendum).

Plan for Learning Collaborative: We plan to participate in a region-wide learning collaborative as offered by the anchor for Region 3, Harris Health System. Our participation in this collaborative with other performing providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our region's health care system.

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[128] *Reducing Costs Through the Appropriate Use of Specialty Services*. Cambridge: Institute for Healthcare Improvement, 2007.

Project Valuation: This project's value is based on the benefits related to cost avoidance of medical expenses and improved quality of life. For example, increased provider capacity leads to reduction in emergency room visits and reduction in inpatient hospital visits.[129] Our valuation also includes an increase in the patient's quality of life. We are using a conservative Quality Adjusted Life Year ("QALY") per year and a percentage of that QALY for the pediatric population.[130] The QALY is used as a one-time improvement in the quality of life, even though we know the patient's quality of life will be improved for many years. We recognize that this is a government funded waiver and thus we chose to have conservative valuations out of respect for the taxpayer funded program.

[129] Smith, John T, Price, Christopher, Stevens Peter M., Masters, Kevin S., and Young, Mark. "Selected Topics - Does Pediatric Orthopedic Subspecialization Affect Hospital Utilization and Charges?" *Journal of Pediatric Orthopedics*. 19.4 (1999): 553-555.
[130] Brannon, Ike. "Risk - What Is a Life Worth? Despite Its Prima Facie Callousness, Determining the Value of a Human Life Is Necessary for Good Public Policy." *Regulation*. 27.4 (2004): 60-63.

139135109.1.5	***1.9.2***	***A-D***	***EXPAND SPECIALTY CARE ACCESS: PULMONOLOGY PEDIATRIC CARE***
Texas Children's Hospital			*139135109*
Related Category 3 Outcome Measure(s):	139135109.3.15 139135109.3.16 139135109.3.17	*IT- 5.1* *IT-5.2* *IT-5.3*	*Improved cost savings* *Per episode of care cost* *Length of stay*

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1 (P-1): Conduct specialty care gap assessment to determine barriers to accessing subspecialty care Metric 1 (P-1.1): Documentation of gap assessment Data Source: Gap Assessment Milestone 1 Estimated Incentive Payment: $539,963 **Milestone 2 (P-8):**_Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements. Metric 1 (P-8.1): Participate in semi-annual face-to-face meetings or seminars organized by the RHP.	**Milestone 3 (I-23):** Implement the re-design of Texas Children's Pulmonary Clinic to increase provider productivity and increase specialty care clinic visits and evidence of improved access for patients seeking services. Metric 1 (I-23.1): Documentation of increased number of visits. Demonstrate improvement over prior reporting period (baseline established in FY12). Goal: 5% increase above the baseline Data Source: EPIC medical record Milestone 3 Estimated Incentive Payment: $589,070.50 **Milestone 4 (P-8):** Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements.	**Milestone 5 (I-23):** Continue to increase specialty care clinic visits and evidence of improved access for patients seeking services. Metric 1 (I-23.1): Documentation of increased number of visits. Demonstrate improvement over baseline reporting period (baseline established in FY12). Goal: 8% increase above the baseline Data Source: EPIC medical record Milestone 5 Estimated Incentive Payment: $590,783 **Milestone 6 (P-8):** Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating	**Milestone 7 (I-23):** Continue to increase specialty care clinic volume visits and evidence of improved access for patients seeking services. Metric 1 (I-23.1): Documentation of increased number of visits. Demonstrate improvement over baseline reporting period (baseline established in FY12). Goal: 10% increase above the baseline Data Source: EPIC medical record Milestone 7 Estimated Incentive Payment: $ 488,038 **Milestone 8 (P-8):** Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to

139135109.1.5	***1.9.2***	***A-D***	***EXPAND SPECIALTY CARE ACCESS: PULMONOLOGY PEDIATRIC CARE***
Texas Children's Hospital			*139135109*
Related Category 3 Outcome Measure(s):	139135109.3.15 139135109.3.16 139135109.3.17	*IT- 5.1* *IT-5.2* *IT-5.3*	*Improved cost savings* *Per episode of care cost* *Length of stay*

Year 2 (10/1/2012 – 9/30/2013)	**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: Participate in all semi-annual face-to-face meetings or seminars. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Milestone 2 Estimated Incentive Payment: $539,963	<u>Metric 1 (P-8.1):</u> Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: Participate in all semi-annual face-to-face meetings or seminars. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Milestone 4 Estimated Incentive Payment: $589,070.50	provider should publicly commit to implementing these improvements. <u>Metric 1 (P-8.1):</u> Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: Participate in all semi-annual face-to-face meetings or seminars. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Milestone 6 Estimated Incentive Payment: $590,783	implementing these improvements. <u>Metric 1 (P-8.1):</u> Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: Participate in all semi-annual face-to-face meetings or seminars. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Milestone 8 Estimated Incentive Payment: $ 488,038
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $1,079,926	Year 3 Estimated Milestone Bundle Amount: $1,178,141	Year 4 Estimated Milestone Bundle Amount: $1,181,566	Year 5 Estimated Milestone Bundle Amount: $976,076
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)**:** 4,415,709*			

Project Option- 1.9.2 Expand Access to Specialty Care: Pediatric Ophthalmology Care

Unique Project ID: 139135109.1.6

Performing Provider and TPI: Texas Children's Hospital/139135109

Project Summary: Increase outpatient access for Harris County and the surrounding communities to care for pediatric patients with Ophthalmological needs which may possibly include surgical interventions.

Provider:
Texas Children's Hospital, located in Houston, is the largest free standing children's hospital in the county specializing in the care of medically fragile children in Houston and across the country as a regional safety net provider. We currently are licensed for 564 beds and in 2011 we had over 2.7 million patient encounters. Our mission is to provide the finest possible pediatric patient care, education, and research. Texas Children's is an integrated delivery system comprising of a health plan for Medicaid and CHIP pregnant women and children, the nation's largest general pediatrician group and two world class hospitals.

Volume Statistics - FY2012	**Patient Payor Mix**	**Patient Demographics**
Hospital Admissions- 25,966 Births (babies delivered)- 2,181 Emergency visits-113,586 Outpatient visits- 3,066,765	Medicaid and CHIP- 53.6% Commercial Insurance- 40.6% Self-Pay- 1.8% Medicare- 1.2%	Hispanic- 35.9% African American- 16.6% Caucasian- 31.0% Asian- 3.8% Other- 12.4% American Indian- 0.3%

Intervention(s): The division is working to expand its services and increase outpatinet access by utilizing the addition of an Optometrist. As well as in the next 5 years the Ophthalmology division would like to grow its services with programs such as Ocular Trauma, Occular Plastics, Pediatric Glaucoma, and focus of the Retina and Cornea pediatric Patients.
Need for the project: Pediatric Ophthalmology is an identified both at the national and state level to have a shortage of resources to meet consumer demands (Children's Hospital Association – Pediatric Specialist Physician Shortages Affect Access to Care, August 2012). There are providers who also not only focus on the pediatric population but also the adult
Target Population:
Our target population is pediatric patients with Ophthalmological needs which may possibly include surgical interventions. Untreated care of these patients due to the inability to provide quick access to our services, can lead to less or reduced eyesight.

Category 1 or 2 expected patient benefits:
I-23.1: Our goal is to increase the number of visits by 3% in DY3, by 3% in DY4, and by 6% in DY5 compared to baseline established in DY2.

Category 3 outcomes: IT-5 Improving Cost of Care

Project Option- 1.9.2 Expand Access to Specialty Care: Pediatric Ophthalmology Care

Unique Project ID: 139135109.1.6
Performing Provider and TPI: Texas Children's Hospital/139135109

Project Description:
Texas Children's Hospital will increase capacity in the Ophthalmology Clinic to expand access and reduce appointment wait times.

Texas Children's Hospital, located in Houston, is the largest free standing children's hospital in the county specializing in the care of medically fragile children in Houston and across the country as a regional safety net provider. We currently are licensed for 564 beds at our main campus and West Houston facilities. In 2011 we had over 2.7 million patient encounters. Our mission is to provide the finest possible pediatric patient care, education, and research. Texas Children's is an integrated delivery system comprising of a health plan for Medicaid and CHIP pregnant women and children, the nation's largest general pediatrician group and two world class hospitals. Texas Children's supports a commitment to quality service and cost-effective care to enhance the health and well-being of children locally, nationally and internationally.

Specifically this project will increase capacity in our Ophthalmology Clinic. Pediatric Ophthalmology is an identified subspecialty, both at the national and state level, to have a shortage of resources to meet consumer demands (Children's Hospital Association - Pediatric Specialist Physician Shortages Affect Access to Care, August 2012). Currently the division is working to expand its services by utilizing the addition of an Optometrist. The Optometrists are able see the division's lower acuity patients freeing up our Ophthalmic Surgeons to see more complex patients in clinic as well as increase their time spent in the Operating Room. They would be able to screen all the patients and determine if they are a surgical candidate or not. In the next 5 years the Ophthalmology division has several areas in which it would like to grow its services. These new programs include Ocular Trauma, Occular Plastics, Pediatric Glaucoma, and focus of the Retina and Cornea of pediatric patients. TCH uses the industry standard of 3rd available appointment as a measure of access to care - ideal access would be less than 14 days. For the majority of FY10 and FY11, the average 3rd available appointment at the TCH Ophthalmology clinic is greater than 14 days.

Goals and Relationships to Regional Goals:

Project Goals: To meet the growing demand for specialized pediatric services TCH will:

12. Focus on provider productivity to optimize clinical time for all providers
13. Establish an initiative to review scheduling processes to increase the availability of these targeted providers
14. Expand internal capacity by hiring additional clinical providers
15. Enhance service availability by targeting new providers to not only work in the Texas Medical Center but to also serve 1-3 additional community locations for rheumatology care Focus on provider productivity to optimize clinical time for all providers and enhance training of subspecialists and fellows.

This project meets the following Region 3 Goals:

- Increased access to specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their conditions, regardless of where they reside or their ability to pay for care.
- Develop a regional approach to healthcare delivery that leverages and improves on existing programs and infrastructure, is responsive to patients' needs throughout the entire region, and improves health care outcomes and patient satisfaction

Challenges:

One of the challenges we face is that these providers not only focus on the pediatric population but also the adult. Another challenge is the untreated or delay in care for these patients and if we are unable to provide quick access to our services, that can lead to less or reduced eyesight. For many patient families, vision problems aren't readily diagnosed at the primary care visit or discussed as other health problems may dominate the conversation during that patient visit. In Texas, limited Medicaid reimbursement is an ongoing challenge for children's hospitals and the workforce that provides health care services for the pediatric population enrolled in this program. As advocates for improving and sustaining quality children's health care, our organization informs and educates elected officials and community leaders about the importance of Medicaid and the need to adequately fund the program. We will continue these efforts throughout the duration of waiver to ensure existing programs and services will be maintained and expanded.

Five year expected outcome for provider and patients:

Texas Children's Hospital expects to see improvements in access to subspecialty care for our pediatric patients; this in turn will improve patient satisfaction due to the delivery of the right care at the right place at the right time.

Starting Point/Baseline:

The baseline for patient volumes in FY 12 is 12,150. Our fiscal year runs from October 1st through September 30th. The average patient cycle time in FY12 in minutes was
Clinical Care Center – 100 minutes; CyFair Health Center-90 minutes; The Woodlands Health Center – 75minutes; West Campus – 90minutes.

Rationale:

The significant increase in access to specialty care created by this project attempts to address the growing demands in our community for specialized pediatric providers. This project will create increased capacity through more efficient operations and new physician recruitment. Our project significantly enhances TCH's existing Ophthalmology pediatric services to improve patient satisfaction by aspiring to provide the right care in the right setting at the right time. Specifically, we will strive to provide comprehensive care for children within focused specialty programs and expand clinical focus upon small but very acute patient needs.

Increasing pediatric population and continued lack of pediatric subspecialists due to the inequity in reimbursement between Medicaid and Medicare is an ongoing problem for children's hospitals and the pediatric health care workforce.

Project Components:
Through the expanded access to specialty care, we propose to meet all required project components listed and these selected milestones and metrics do relate to project components.

y. Conduct specialty care gap assessment based on community need for subspecialty.
z. Implement transparent standardized referrals across the system
aa. Increase specialty care volume of visits and evidence of improved access for patients seeking services
bb. Increase service availability hours and increase number of specialty clinic locations.
cc. Conduct quality improvement for projects including rapid cycle and learning collaborative exchanges. It is our goal to reach the industry standard of less than 14 days for the 3rd available appointment.

Inadequate access to specialty care has contributed to the limited scope and size of safety net health systems. For children with health care needs that exceed the abilities of the primary care provider, access to and coordination with subspecialty care is critical to ensuring the provision of efficient and effective health care and in securing a comprehensive medical home.[131]

Milestones and Metrics
The following milestones and metrics have been chosen for the project based on the core components and the needs of the targeted pediatric population.

- Process milestone and metrics: P-1 (P-1.1); P-8 (P-8.1); P-17 (P-17.1)
- Improvement milestones and metrics: I-23 (I-23.1)

Unique community need identification number the project addresses:

- CN.2: Inadequate access to specialty care,
- CN.6: Inadequate access to treatment and services designed for children.

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
Our project will enable us to continue to grow our services at additional locations as well as increase capacity through programmatic growth and new Physician and NPP recruitment. We will be able to increase access to care so that patients are not left with untreatable conditions. In addition, with our project we would have pediatric focused MDs caring for Pediatric Patients.

Related Category 3 Outcome Measures:

OD-5 Cost of Care
IT-5.1: Improved cost savings
IT-5.2: Per episode of care cost
IT-5.3: Length of stay

Reasons/rationale for selecting the outcome measures:

[131] Redlener, Irwin, Grant Roy, and Krol David M. "Beyond Primary Care: Ensuring Access to Subspecialists, Special Services, and Health Care Systems for Medically Underserved Children." *Advances in Pediatrics*. 52 (2005): 9-22.

Our project will increase appropriate access to care. Increased access to appropriate subspecialty care leads to better long term outcomes in children and reduction in unnecessary health care costs.[132]

Children are the future of healthcare and will dictate the treatments needed as well as the cost of healthcare in future years so it is critical that they receive the access needed throughout their pediatric lives. The focus of pediatric specialty care is similar throughout the region with a concentrated focus in the Harris county proper geographic region and allows for the expansion of access to numerous specialties such as cardiology, neurology, ENT, and many more. The outcome measures focus to appropriate length of stay, per episode cost of care, and improved cost savings. The Region 3 Initiative grid allows for a cross reference of similar initiatives in our region. (addendum)

Relationship to Other Performing Providers' Projects and Plan for Learning Collaborative: This project will compliment other projects designed to improve appropriate access to specialty care, improve chronic care management, and those designed to improve the patient experience. We plan to participate in a region-wide learning collaborative as offered by the anchor for Region 3, Harris Health System. Our participation in this collaborative with other performing providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our region's health care system.

Project Valuation: This project's value is based on the benefits related to cost avoidance of medical expenses and improved quality of life. For example, increased provider capacity leads to reduction in emergency room visits and reduction in inpatient hospital visits.[133] Our valuation also includes an increase in the patient's quality of life. We are using a conservative Quality Adjusted Life Year ("QALY") per year and a percentage of that QALY for the pediatric population.[134] The QALY is used as a one-time improvement in the quality of life, even though we know the patient's quality of life will be improved for many years. We recognize that this is a government funded waiver and thus we chose to have conservative valuations out of respect for the taxpayer funded program.

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[132] *Reducing Costs Through the Appropriate Use of Specialty Services*. Cambridge: Institute for Healthcare Improvement, 2007.
[133] Smith, John T, Price, Christopher, Stevens Peter M., Masters, Kevin S., and Young, Mark. "Selected Topics - Does Pediatric Orthopedic Subspecialization Affect Hospital Utilization and Charges?" *Journal of Pediatric Orthopedics*. 19.4 (1999): 553-555.
[134] Brannon, Ike. "Risk - What Is a Life Worth? Despite Its Prima Facie Callousness, Determining the Value of a Human Life Is Necessary for Good Public Policy." *Regulation*. 27.4 (2004): 60-63.

139135109.1.6	*1.9.2*	*A-D*	***EXPAND ACCESS TO SPECIALTY CARE: PEDIATRIC OPHTHALMOLOGY CARE***
Texas Children's Hospital			139135109
Related Category 3 Outcome Measure(s):	*139135109.3.16* *139135109.3.17* *139135109.3.18*	*IT- 5.1* *IT-5.2* *IT-5.3*	*Improved cost savings* *Per episode of care cost* *Length of stay*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 (P-1): Conduct specialty care gap assessment to determine barriers to accessing subspecialty care Metric 1[P-1.1] Documentation of gap assessment Data Source: Gap Assessment Milestone 1 Estimated Incentive Payment: $614,780 **Milestone 2 [P-8]:** Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements. Metric 1 [P-8.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: Participate in all semi-annual face-to-face meetings or seminars. Data Source: Documentation of	**Milestone 3 (P-17):** Implement process improvements of Texas Children's Ophthalmology Clinic to increase operational efficiency, shorten patient cycle time and increase provider productivity. Metric 1 (P-17.1): Number of specialty clinics that have completed clinic redesign. Goal: Improve patient cycle time by 3% Data Source: Specialty clinic appointment tracking system. Milestone 3 Estimated Incentive Payment: $670,692.50 **Milestone 4 [P-8]:** Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements.	**Milestone 5 (I-23):** Increase clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 (I-23.1): Documentation of increased number of visits. Demonstrate improvement over prior reporting period (baseline established in FY12). Goal: Increase clinic volume 3% across all locations of care Data Source: Epic/EDW Milestone 5 Estimated Incentive Payment: $672,642 **Milestone 6 [P-8]:** Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements.	**Milestone 7(I-X):** Increase clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 (I-X.1): Documentation of increased number of visits. Demonstrate improvement over prior reporting period (baseline established in FY12). Goal: 6% over baseline Data Source: Epic/EDW Milestone 7 Estimated Incentive Payment: $ 555,661 **Milestone 8 [P-8]:** Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements. Metric 1 [P-8.1]: Participate in semi-annual face-to-face meetings or

139135109.1.6	***1.9.2***	***A-D***	***EXPAND ACCESS TO SPECIALTY CARE: PEDIATRIC OPHTHALMOLOGY CARE***
Texas Children's Hospital			139135109
Related Category 3 Outcome Measure(s):	*139135109.3.16* *139135109.3.17* *139135109.3.18*	*IT- 5.1* *IT-5.2* *IT-5.3*	*Improved cost savings* *Per episode of care cost* *Length of stay*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Milestone 2 Estimated Incentive Payment: $614,780	Metric 1 [P-8.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: Participate in all semi-annual face-to-face meetings or seminars. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Milestone 4 Estimated Incentive Payment: $670,692.50	Metric 1 [P-8.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: Participate in all semi-annual face-to-face meetings or seminars. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Milestone 6 Estimated Incentive Payment: $672,642	seminars organized by the RHP. Goal: Participate in all semi-annual face-to-face meetings or seminars. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Milestone 8 Estimated Incentive Payment: $ 555,661
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $1,229,560	Year 3 Estimated Milestone Bundle Amount: $1,341,385	Year 4 Estimated Milestone Bundle Amount: $1,345,284	Year 5 Estimated Milestone Bundle Amount: $1,111,322
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:** $5,027,551			

Project Option: 1.9.2 Improve access to specialty care: Expand Pediatric Gastroenterology Care

Unique Project ID: 139135109.1.7

Performing Provider and TPI: Texas Children's Hospital/139135109

Project Summary: Increase outpatient access for Harris County and the surrounding communities to care for pediatric patients with conditions affecting the digestive system.
Provider:
Texas Children's Hospital, located in Houston, is the largest free standing children's hospital in the county specializing in the care of medically fragile children in Houston and across the country as a regional safety net provider. We currently are licensed for 564 beds and in 2011 we had over 2.7 million patient encounters. Our mission is to provide the finest possible pediatric patient care, education, and research. Texas Children's is an integrated delivery system comprising of a health plan for Medicaid and CHIP pregnant women and children, the nation's largest general pediatrician group and two world class hospitals.

Volume Statistics - FY2012	**Patient Payor Mix**	**Patient Demographics**
Hospital Admissions- 25,966 Births (babies delivered)- 2,181 Emergency visits-113,586 Outpatient visits- 3,066,765	Medicaid and CHIP- 53.6% Commercial Insurance- 40.6% Self-Pay- 1.8% Medicare- 1.2%	Hispanic- 35.9% African American- 16.6% Caucasian- 31.0% Asian- 3.8% Other- 12.4% American Indian- 0.3%

Intervention(s):
Increase outpatient access for Harris County and the surrounding communities to care for pediatric patients with conditions affecting the digestive system.
Need for the project:
Pediatric Gastroenterology is an identified subspecialty, both at the national and state level, to have a shortage of resources to meet consumer demands (Children's Hospital Association - Pediatric Specialist Physician Shortages Affect Access to Care, August 2012).

Target Population:
Our target population is patients seeking the full spectrum of services from general digestive and liver care to quartenary programs for Inflammatory Bowel Disease, Intestinal Rehabilitation, Neurogastroenterology and Motility, Viral Hepatitis, Eosinophilic Gastrointestinal Disorders and Hepatobiliary Disease.

Category 1 or 2 expected patient benefits:
I-23.1: Our goal is to increase the number of visits by 10% in DY3, by 15% in DY4, and by 20% in DY5 compared to baseline established in DY2.

Category 3 outcomes:
IT-5 Improving Cost of Care

Project Option: 1.9.2 Improve access to specialty care: Expand Pediatric Gastroenterology Care

Unique Project ID: 139135109.1.7
Performing Provider and TPI: Texas Children's Hospital/139135109

Project Description:
Texas Children's Hospital proposes to increase access for children to pediatric subspecialty services in the gastroenterology, hepatology and nutrition (GHN) clinic.

Texas Children's Hospital, located in Houston, is the largest free standing children's hospital in the county specializing in the care of medically fragile children in Houston and across the country as a regional safety net provider. We currently are licensed for 564 beds at our main campus and West Houston facilities. In 2011 we had over 2.7 million patient encounters. Our mission is to provide the finest possible pediatric patient care, education, and research. Texas Children's is an integrated delivery system comprising of a health plan for Medicaid and CHIP pregnant women and children, the nation's largest general pediatrician group and two world class hospitals. Texas Children's supports a commitment to quality service and cost-effective care to enhance the health and well-being of children locally, nationally and internationally.

The proposed project seeks to increase access for children to pediatric subspecialty services in the gastroenterology, hepatology and nutrition (GHN) clinic at Texas Children's Hospital ("TCH"). Access to GHN services has been identified, both at the national and state level, as problematic (Children's Hospital Association - Pediatric Specialist Physician Shortages Affect Access to Care, August 2012); barriers include a shortage of trained subspecialists, the geographic concentration of subspecialists in major urban areas and growing patient demand. The Texas Children's Gastroenterology, Hepatology and Nutrition service is ranked # 4 in the 2012 *U.S. News and World Report* Best Children's Hospitals and is the only pediatric gastroenterology service line ranked in the top 10 in Texas. The GHN service provides care at Texas Children's Main Campus, Texas Children's West Campus, four community Health Centers located in Harris County as well as the pediatric subspecialty clinic of Harris Health System. Though GHN serves children with routine digestive and liver diseases such as abdominal pain, gastroesophageal reflux, failure-to-thrive and hepatitis, Texas Children's GHN service is also home to the largest pediatric liver transplant program in the United States (34 transplants performed year-to-date), and the only program in the Southwestern United States. A number of quaternary care programs have been developed, including Inflammatory Bowel Disease, Intestinal Rehabilitation, Neurogastroenterology and Motility, Viral Hepatitis, Eosinophilic Gastrointestinal Disorders and Hepatobiliary Disease. The GHN service also provides a complete range of diagnostic and therapeutic endoscopy procedures, many of which are not available anywhere else in Texas.

The number of children referred to Texas Children's GHN clinics increased significantly from a monthly average of 950 in 2010 to a monthly average of more than 1,300 in 2012. We anticipate this number will continue to grow due to recent external GHN practice reductions and closures in Texas and neighboring regions. The clinic now serves as a frequent regional referral site for multiple states in the south, including Arizona, New Mexico, Louisiana, Mississippi, Alabama

and Florida. The program currently accepts three pediatric gastroenterology fellows per training year (total of nine), and is thereby doing its part to train and replenish other communities with quality pediatric subspecialty physicians.

Specifically, this project will increase capacity in our gastroenterology, hepatology and nutrition (GHN) clinic. Pediatric gastroenterology is an identified subspecialty, both at the national and state level, to have a shortage of resources to meet consumer demands (Children's Hospital Association - Pediatric Specialist Physician Shortages Affect Access to Care, August 2012). TCH uses the industry standards of 3rd available appointment and total annual as measures of access to care.   However, given the high demand and provider shortage, for the majority of Fiscal Year 2010 and Fiscal Year 2011, the average 3rd available appointment at the TCH gastroenterology clinic is greater than 30 days. The increased focus on the prevalence of childhood obesity at both the national and state levels has added additional pressure on the clinic because 47.3% of children in Harris County are classified as either overweight or obese according to the 2012 FITNESSGRAM assessment (Children at Risk - *Growing Up in Houston: Assessing the Quality of Life of Our Children; 2012 -2014 edition).*

As the demand for pediatric subspecialty services grows, TCH aims to maintain a consistent and significant presence for services at every subspecialty outpatient location in the TCH system. This increase in gastroenterology service capacity will allow children in our region to have more timely and appropriate access to much needed subspecialty care. We know increased access to appropriate care leads to better long term outcomes in children and reduction in unnecessary health care costs.[135]

Goals and Relationship to Regional Goals:

Project Goals: To meet the growing demand for specialized pediatric services, TCH will enhance service availability by targeting new providers to not only work in the Texas Medical Center but to also serve 1-3 additional community locations for gastrointestinal specialty clinics and on provider productivity to optimize clinical time for all providers and enhance training of subspecialists and fellows by:

- Increase the number of patients seen in GHN clinics by focusing on provider productivity to optimize clinical time for all providers, and establishing an initiative to review scheduling processes to increase the availability of these targeted providers
- Decrease time from initial referral to appointment
- Expand internal capacity by hiring additional clinical providers
- Provide training and outreach to local and regional practitioners

This project meets the following Region 3 Goals:

- Increased access to specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their conditions, regardless of where they reside or their ability to pay for care

[135] *Reducing Costs Through the Appropriate Use of Specialty Services*. Cambridge: Institute for Healthcare Improvement, 2007.

- Develop a regional approach to healthcare delivery that leverages and improves on existing programs and infrastructure, is responsive to patients' needs throughout the entire region, and improves health care outcomes and patient satisfaction

Challenges:
The need for pediatric gastroenterology subspecialists is underserved nationally. The current number of gastroenterology fellows in training across the nation is inadequate to meet the growing demand. Our training program consistently seeks out and successfully recruits the brightest talent from across the country each year, due to its national reputation. Over the past five years, our trainees have gone on to not only serve in our community, but also in multiple underserved communities in South Texas. Additionally, in Texas, limited Medicaid reimbursement is an ongoing challenge for children's hospitals and the workforce that provides health care services for the pediatric population enrolled in this program. As advocates for improving and sustaining quality children's health care, our organization informs and educates elected officials and community leaders about the importance of Medicaid and the need to adequately fund the program. We will continue these efforts throughout the duration of the waiver to ensure existing programs and services will be maintained and expanded.

Five year expected outcome for provider and patients:
Texas Children's Hospital expects to see improvements in access to subspecialty care for our pediatric patients; this in turn will improve patient satisfaction due to the delivery of the right care at the right place at the right time.

Starting Point/Baseline:
The baseline for patient volumes in Fiscal Year 2012 across all locations of care is 19,780. Our fiscal year runs from October 1st to September 30th.

Rationale:
The significant increase in access to specialty care created by this project attempts to address the growing demands in our community for specialized pediatric providers. This project will create increased capacity through more efficient operations and new physician recruitment. Our project significantly enhances TCH's existing gastroenterology services to improve patient satisfaction by aspiring to provide the right care in the right setting at the right time. Specifically, we will provide comprehensive care for children within focused specialty programs such as: liver transplant, fatty liver, viral hepatitis, motility, inflammatory bowel disease or eosinophilic disease.

Increasing pediatric population and continued lack of pediatric subspecialists due to the inequity in reimbursement between Medicaid and Medicare is an ongoing problem for children's hospitals and the pediatric health care workforce.

Project Components: Through the expanded access to specialty care, we propose to meet all required project components listed and these selected milestones and metrics do relate to project components.

dd. Conduct specialty care gap assessment based on community need for subspecialty.
ee. Implement transparent standardized referrals across the system

ff. Increase specialty care volume of visits and evidence of improved access for patients seeking services
gg. Increase service availability hours and increase number of specialty clinic locations.
hh. Conduct quality improvement for projects including rapid cycle and learning collaborative exchanges.

Inadequate access to specialty care has contributed to the limited scope and size of safety net health systems. For children with health care needs that exceed the abilities of the primary care provider, access to and coordination with subspecialty care is critical to ensuring the provision of efficient and effective health care and in securing a comprehensive medical home.[136]

Milestones and Metrics
The following milestones and metrics have been chosen for the project based on the core components and the needs of the targeted pediatric population.

- Process milestone and metrics: P-1 (P-1.1); P-8 (P-8.1); P-17 (P-17.1)
- Improvement milestones and metrics: I-23 (I-23.1)

Unique community need identification number the project addresses:

- CN.2: Inadequate access to specialty care,
- CN.6: Inadequate access to treatment and services designed for children.

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
This project will enhance current services by expanding and maximizing provider accessibility that will result in a greater number of patients served. In addition it will result in prompt service and allow more children access to GI subspecialty care.

Related Category 3 Outcome Measure(s):
OD -5: Cost of Care
IT – 5.1: Improved Cost Savings
IT – 5.2: Per Episode Cost of Care
IT – 5.3: Length of Stay

Reasons/rationale for selecting the outcome measures:
Our project will increase appropriate access to care. Increased access to appropriate subspecialty care leads to better long term outcomes in children and reduction in unnecessary health care costs.[137]

Relationship to other Projects: All of Texas Children's projects are working to expand access to subspecialty care for the pediatric population. Texas continues to have a growing pediatric population and a shortage of specialized pediatric providers.

[136] Redlener, Irwin, Grant Roy, and Krol David M. "Beyond Primary Care: Ensuring Access to Subspecialists, Special Services, and Health Care Systems for Medically Underserved Children." *Advances in Pediatrics*. 52 (2005): 9-22.
[137] *Reducing Costs Through the Appropriate Use of Specialty Services*. Cambridge: Institute for Healthcare Improvement, 2007.

Children are the future of healthcare and will dictate the treatments needed as well as the cost of healthcare in future years so it is critical that they receive the access needed throughout their pediatric lives. The focus of pediatric specialty care is similar throughout the region with a concentrated focus in the Harris county proper geographic region and allows for the expansion of access to numerous specialties such as cardiology, neurology, ENT, and many more. The outcome measures focus to appropriate length of stay, per episode cost of care, and improved cost savings. The Region 3 Initiative grid allows for a cross reference of similar initiatives in our region. (addendum)

Plan for Learning Collaborative: We plan to participate in a region-wide learning collaborative as offered by the anchor for Region 3, Harris Health System. Our participation in this collaborative with other performing providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our region's health care system.

Project Valuation: This project's value is based on the benefits related to cost avoidance of medical expenses and improved quality of life. For example, increased provider capacity leads to reduction in emergency room visits and reduction in inpatient hospital visits.[138] Our valuation also includes an increase in the patient's quality of life. We are using a conservative Quality Adjusted Life Year ("QALY") per year and a percentage of that QALY for the pediatric population.[139] The QALY is used as a one-time improvement in the quality of life, even though we know the patient's quality of life will be improved for many years. We recognize that this is a government funded waiver and thus we chose to have conservative valuations out of respect for the taxpayer funded program. We have academic literature citing the link between access to appropriate pediatric subspecialty care and decrease in hospital visits, both inpatient and emergency room.[3]

[138] Smith, John T, Price, Christopher, Stevens Peter M., Masters, Kevin S., and Young, Mark. "Selected Topics - Does Pediatric Orthopedic Subspecialization Affect Hospital Utilization and Charges?" *Journal of Pediatric Orthopedics*. 19.4 (1999): 553-555.

[139] Brannon, Ike. "Risk - What Is a Life Worth? Despite Its Prima Facie Callousness, Determining the Value of a Human Life Is Necessary for Good Public Policy." *Regulation*. 27.4 (2004): 60-63.

139135109.1.7	***1.9.2***	***A-D***	***IMPROVE ACCESS TO SPECIALTY CARE: EXPAND PEDIATRIC GASTROENTEROLOGY CARE***
Texas Children's Hospital			139135109
Related Category 3 Outcome Measure(s):	*139135109.3.19* *139135109.3.20* *139135109.3.21*	*IT- 5.1* *IT-5.2* *IT-5.3*	*Improved Cost Savings* *Per Episode Cost of Care* *Length of Stay*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 (P-1): Conduct specialty care gap assessment to determine barriers to accessing subspecialty care Metric 1 (P-1.1): Documentation of gap assessment Data Source: Gap Assessment Milestone 1 Estimated Incentive Payment: $1,074,372.50 **Milestone 2 (P-8):** Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements. Metric 1 (P-8.1): Participate in semi-annual face-to-face meetings or seminars organized by the RHP.	**Milestone 3 (I-23):** Implement the re-design of Texas Children's Gastroenterology Clinic to increase operational efficiency, increase provider productivity and increase clinic visits. Metric 1 (I-23.1): Documentation of increased number of visits. Demonstrate improvement over baseline reporting period (established in FY12). a. Total number of visits for reporting period b. Data Source: Registry, EHR Goal: 10% increase Milestone 3 Estimated Incentive Payment:$1,172,083 **Milestone 4 (P-8):** Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating	**Milestone 5 (I-23):** Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 (I-23.1): Documentation of increased number of visits. Demonstrate improvement over baseline reporting period (baseline established in FY12). a. Total number of visits for reporting period b. Data Source: EPIC medical record Goal: 15% Milestone 5 Estimated Incentive Payment:$1,175,490 **Milestone 6 (P-8):** Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do	**Milestone 7 (I-23):** Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 (I-23.1): Documentation of increased number of visits. Demonstrate improvement over prior reporting period (baseline established in FY12). a. Total number of visits for reporting period b. Data Source: EPIC medical record Goal: 20% Milestone 7 Estimated Incentive Payment: $500,000 **Milestone 8 (P-8):** Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to

139135109.1.7	***1.9.2***	***A-D***	***IMPROVE ACCESS TO SPECIALTY CARE: EXPAND PEDIATRIC GASTROENTEROLOGY CARE***
Texas Children's Hospital			139135109
Related Category 3 Outcome Measure(s):	*139135109.3.19* *139135109.3.20* *139135109.3.21*	*IT- 5.1* *IT-5.2* *IT-5.3*	*Improved Cost Savings* *Per Episode Cost of Care* *Length of Stay*

Year 2 (10/1/2012 – 9/30/2013)	**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: Participate in all semi-annual face-to-face meetings or seminars. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Milestone 2 Estimated Incentive Payment: $1,074,372.50	provider should publicly commit to implementing these improvements. <u>Metric 1 (P-8.1):</u> Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: Participate in all semi-annual face-to-face meetings or seminars. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Milestone 4 Estimated Incentive Payment: $1,172,083	to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements. <u>Metric 1 (P-8.1):</u> Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: Participate in all semi-annual face-to-face meetings or seminars. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Milestone 6 Estimated Incentive Payment: $1,175,490	implementing these improvements. <u>Metric 1 (P-8.1):</u> Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: Participate in all semi-annual face-to-face meetings or seminars. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Milestone 8 Estimated Incentive Payment: $500,000
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone)*: $2,148,745	Year 3 Estimated Milestone Bundle Amount: $2,344,166	Year 4 Estimated Milestone Bundle Amount: $2,350,980	Year 5 Estimated Milestone Bundle Amount: $1,000,000
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)*: $7,843,891			

Project Option: 1.9.2 Expand Specialty Care Capacity Diabetes: Endocrinology Pediatric Care

<u>Unique Project ID:</u> 139135109.1.8

<u>Performing Provider Name/TPI:</u> Texas Children's Hospital/ 139135109

<u>Project Summary:</u> Increase outpatient access for Harris County and the surrounding communities to care for pediatric patients with conditions affecting the endocrine system.
<u>Provider:</u>
Texas Children's Hospital, located in Houston, is the largest free standing children's hospital in the county specializing in the care of medically fragile children in Houston and across the country as a regional safety net provider. We currently are licensed for 564 beds and in 2011 we had over 2.7 million patient encounters. Texas Children's is an integrated delivery system comprising of a health plan for Medicaid and CHIP pregnant women and children, the nation's largest general pediatrician group and two world class hospitals.

Volume Statistics - FY2012	Patient Payor Mix	Patient Demographics
Hospital Admissions- 25,966 Births (babies delivered)- 2,181 Emergency visits-113,586 Outpatient visits- 3,066,765	Medicaid and CHIP- 53.6% Commercial Insurance- 40.6% Self-Pay- 1.8% Medicare- 1.2%	Hispanic- 35.9% African American- 16.6% Caucasian- 31.0% Asian- 3.8% Other- 12.4% American Indian- 0.3%

<u>Intervention(s):</u>
Increase outpatient access for Harris County and the surrounding communities to care for pediatric patients with conditions affecting the endocrine system.
<u>Need for the project:</u>
Pediatric Diabetes/Endocrinology is an identified subspecialty, both at the national and state level, to have a shortage of resources to meet consumer demands (Children's Hospital Association - Pediatric Specialist Physician Shortages Affect Access to Care, August 2012).

<u>Target Population:</u>
Our target population is patients seeking the full spectrum of services for metabolic syndrome, type I, and type II diabetes. In particular, the focus is on patients who are at risk for diabetic retinopathy, the leading cause of blindness for those diagnosed with diabetes.

<u>Category 1 or 2 expected patient benefits:</u>
I-23.1: Our goal is to increase the number of visits by 10% in DY3, by 15% in DY4, and by 20% in DY5 compared to baseline established in DY2.

<u>Category 3 outcomes:</u>
IT-5 Improving Cost of Care

Project Option: 1.9.2 Expand Specialty Care Capacity Diabetes: Endocrinology Pediatric Care

Unique Project ID: 139135109.1.8
Performing Provider Name/TPI: Texas Children's Hospital/ 139135109

Project Description:
Texas Children's Hospital proposes to expand access to pediatric care in diabetes and endocrinology.

Texas Children's Hospital, located in Houston, is the largest free standing children's hospital in the county specializing in the care of medically fragile children in Houston and across the country as a regional safety net provider. We currently are licensed for 564 beds at our main campus and West Houston facilities. In 2011 we had over 2.7 million patient encounters. Our mission is to provide the finest possible pediatric patient care, education, and research. Texas Children's is an integrated delivery system comprising of a health plan for Medicaid and CHIP pregnant women and children, the nation's largest general pediatrician group and two world class hospitals. Texas Children's supports a commitment to quality service and cost-effective care to enhance the health and well-being of children locally, nationally and internationally.

Our project proposal will significantly improve access to pediatric subspecialty care in diabetes and endocrinology. Funding for this project will allow Texas Children's to fulfill our tri-part mission of providing quality pediatric care, training the next generation of pediatric providers and investigating ways to improve care through innovative therapies. Pediatric diabetes/endocrinology is an identified subspecialty, both at the national and state level, to have a shortage of resources to meet consumer demands (Children's Hospital Association - Pediatric Specialist Physician Shortages Affect Access to Care, August 2012). The Texas Children's ("TCH") Diabetes / Endocrine Service line is ranked # 14 in the 2012 *U.S. News and World Report* Best Children's Hospitals. The Diabetes/Endocrine Service at TCH has purchased a retinal camera for screening of patients ≥10 years of age. This camera will help to track and manage patients ≥10 years of age who have had diabetes for >5 years. These patients are at risk for diabetic retinopathy, the leading cause of blindness for those diagnosed with diabetes. The American Diabetes Association recommends yearly screening for diabetic retinopathy. The majority of our patients do not receive this screening due to socioeconomic challenges and lack of availability. Our improved service increases access to screening and minimizes impact on a parent's time away from work. The TCH Diabetes/Endocrine Section, next to Barbara Davis, will be the only outpatient clinic to provide this service to patients with Type I/II diabetes.

Referrals into the TCH pediatric diabetes/endocrinology clinic are at a monthly average of 500 in 2012. TCH uses 3rd available and total annual volume increase as two of the metrics to measure access.

Goals and Relationship to Regional Goals:

Project Goals:

To meet the growing demand for acute pediatric diabetes/endocrinology services, TCH will:

16. Initiate processes to increase provider productivity, optimizing provider clinical time and enhancing training of subspecialists and fellows.
17. Streamline processes for patient scheduling, thus increasing availability of provider appointments.
18. Expand provider capacity by hiring additional clinicians and support staff.
19. Enhance service availability by delivering patient care closer to where patients live rather than only in a centralized location (Texas Medical Center). We will continue to expand access at our community locations for specialty care.

This project meets the following Region 3 Goals:

- Increased access to specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their conditions, regardless of where they reside or their ability to pay for care.
- Develop a regional approach to healthcare delivery that leverages and improves on existing programs and infrastructure, is responsive to patients' needs throughout the entire region, and improves health care outcomes and patient satisfaction

Challenges:

In Texas, limited Medicaid reimbursement is an ongoing challenge for children's hospitals and the workforce that provides health care services for the pediatric population enrolled in this program. As advocates for improving and sustaining quality children's health care, our organization informs and educates elected officials and community leaders about the importance of Medicaid and the need to adequately fund the program. We will continue these efforts throughout the duration of the waiver to ensure existing programs and services will be maintained and expanded. Increased access to clinical care has unexpectedly led to increased demand for our services. Our goal is to match access to demand, which may require additional reconfigurations of clinic processes, schedules, and staffing.

Five year expected outcome for provider and patients:

Texas Children's Hospital expects to see improvements in access to subspecialty care for our pediatric patients; this in turn will improve patient satisfaction due to the delivery of the right care at the right place at the right time.

Starting Point/Baseline:

The baseline for patient volumes in FY 12 is 16,226 visits across all locations of care. Our fiscal year runs from October 1st to September 30th.

Rationale: As the pediatric patient population grows in our area so does the prevalence of diseases needing care and treatment by subspecialists. Specifically, in Texas, and in particular, Houston/Harris, more children are being diagnosed with metabolic syndrome, diabetes and obesity: 47.3% of children in Harris County are classified as either overweight or obese

according to the 2012 FITNESSGRAM assessment (Children at Risk - *Growing Up in Houston: Assessing the Quality of Life of Our Children; 2012 -2014 edition).*

Type II diabetes and other hormonal disorders can be attributed to this disease which in turn strains a health care system that lacks these highly trained subspecialists, especially, in a state whose population is dramatically increasing. Inadequate access to specialty care has contributed to the limited scope and size of safety net health systems. For children with health care needs that exceed the abilities of the primary care provider, access to and coordination with subspecialty care is critical to ensuring the provision of efficient and effective health care and in securing a comprehensive medical home. The significant increase in access to specialty care created by this project attempts to address the growing demands in our community for specialized pediatric providers. This project will create increased capacity through more efficient operations and new physician recruitment. Our project significantly enhances TCH's existing pediatric diabetes and endocrine services to improve patient satisfaction by aspiring to provide the right care in the right setting at the right time. In order to increase access

Project Components:
Through the expanded access to specialty care, we propose to meet all required project components listed and these selected milestones and metrics do relate to project components.

ii. Conduct specialty care gap assessment based on community need for subspecialty.
jj. Implement transparent standardized referrals across the system
kk. Increase specialty care volume of visits and evidence of improved access for patients seeking services
ll. Increase service availability hours and increase number of specialty clinic locations.
mm. Conduct quality improvement for projects including rapid cycle and learning collaborative exchanges.

Inadequate access to specialty care has contributed to the limited scope and size of safety net health systems. For children with health care needs that exceed the abilities of the primary care provider, access to and coordination with subspecialty care is critical to ensuring the provision of efficient and effective health care and in securing a comprehensive medical home.[140]

Milestones and Metrics
The following milestones and metrics have been chosen for the project based on the core components and the needs of the targeted pediatric population.

- Process milestone and metrics: P-1 (P-1.1); P-8 (P-8.1); P-17 (P-17.1)
- Improvement milestones and metrics: I-23 (I-23.1)

Customizable Improvement Milestone and Metric was chosen in order to specifically tailor the intent of project to the targeted pediatric population.

Unique community need identification number the project addresses:

- CN.2: Inadequate access to specialty care,
- CN.6: Inadequate access to treatment and services designed for children.

[140] Redlener, Irwin, Grant Roy, and Krol David M. "Beyond Primary Care: Ensuring Access to Subspecialists, Special Services, and Health Care Systems for Medically Underserved Children." *Advances in Pediatrics*. 52 (2005): 9-22.

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
The overall goal of this project is increased access. Expanding clinical appointments coupled with clinical efficiencies will significantly enhance delivery of patient care by providing unavailable and/or unprecedented levels of clinical service. Additional appointment availability will allow much more frequent interventions in diabetes and endocrinology patient care management, which result in improved clinical outcomes.

Related Category 3 Outcome Measure(s):
OD-5 Cost of Care
IT-5.1: Improved cost savings
IT-5.2: Per episode of care cost
IT-5.3: Length of stay

Reasons/rationale for selecting the outcome measures:
Our project will increase appropriate access to care. Increased access to appropriate subspecialty care leads to better long term outcomes in children and reduction in unnecessary health care costs.[141]

Relationship to other Projects: All of Texas Children's projects are working to expand access to subspecialty care for the pediatric population. Texas continues to have a growing pediatric population and a shortage of specialized pediatric providers.

Children are the future of healthcare and will dictate the treatments needed as well as the cost of healthcare in future years so it is critical that they receive the access needed throughout their pediatric lives. The focus of pediatric specialty care is similar throughout the region with a concentrated focus in the Harris county proper geographic region and allows for the expansion of access to numerous specialties such as cardiology, neurology, ENT, and many more. The outcome measures focus to appropriate length of stay, per episode cost of care, and improved cost savings. The Region 3 Initiative grid allows for a cross reference of similar initiatives in our region. (addendum)

Plan for Learning Collaborative: We plan to participate in a region-wide learning collaborative as offered by the anchor for Region 3, Harris Health System. Our participation in this collaborative with other performing providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our region's health care system.

Project Valuation: This project's value is based on the benefits related to cost avoidance of medical expenses and improved quality of life. For example, increased provider capacity leads to

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[141] *Reducing Costs Through the Appropriate Use of Specialty Services*. Cambridge: Institute for Healthcare Improvement, 2007.

reduction in emergency room visits and reduction in inpatient hospital visits.[142] Our valuation also includes an increase in the patient's quality of life. We are using a conservative Quality Adjusted Life Year ("QALY") per year and a percentage of that QALY for the pediatric population.[143] The QALY is used as a one-time improvement in the quality of life, even though we know the patient's quality of life will be improved for many years. We recognize that this is a government funded waiver and thus we chose to have conservative valuations out of respect for the taxpayer funded program. We have academic literature citing the link between access to appropriate pediatric subspecialty care and decrease in hospital visits, both inpatient and emergency room.[3]

[142] Smith, John T, Price, Christopher, Stevens Peter M., Masters, Kevin S., and Young, Mark. "Selected Topics - Does Pediatric Orthopedic Subspecialization Affect Hospital Utilization and Charges?" *Journal of Pediatric Orthopedics*. 19.4 (1999): 553-555.

[143] Brannon, Ike. "Risk - What Is a Life Worth? Despite Its Prima Facie Callousness, Determining the Value of a Human Life Is Necessary for Good Public Policy." *Regulation*. 27.4 (2004): 60-63.

139135109.1.8	**1.9.2**	**A-D**	**EXPAND SPECIALTY CARE CAPACITY DIABETES: ENDOCRINOLOGY PEDIATRIC CARE**
Texas Children's Hospital			139135109
Related Category 3 Outcome Measure(s):	*139135109.3.22* *139135109.3.23* *139135109.3.24*	*IT- 5.1* *IT-5.2* *IT-5.3*	*Improved cost savings* *Per episode of care cost* *Length of stay*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 (P-1): Conduct specialty care gap assessment to determine barriers to accessing subspecialty care Metric 1 (P-1.1): Documentation of gap assessment Data Source: Gap Assessment Milestone 1 Estimated Incentive Payment: $1,074,372.50 **Milestone 2 (P-8):** Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements. Metric 1 (P-8.1): Participate in semi-annual face-to-face meetings or seminars organized by the RHP.	**Milestone 3 (I-23):** Increase specialty care clinic volume and improve access for patients seeking services. Metric 1 (I-23.1): Documentation of increased number of visits. Demonstrate improvement over baseline reporting period (established in FY12). a. Total number of visits for reporting period b. Data Source: Registry, EHR Goal: 10% increase Milestone 3 Estimated Incentive Payment: $ 1,172,083 **Milestone 4 (P-8):** Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements.	**Milestone 5 (I-23):** Increase specialty care clinic volume and improve access for patients seeking services. Metric 1 (I-23.1): Documentation of increased number of visits. Demonstrate improvement over baseline reporting period (established in FY12). a. Total number of visits for reporting period b. Data Source: Registry, EHR Goal: 15% increase Milestone 5 Estimated Incentive Payment: $1,175,490 **Milestone 6 (P-8):** Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating	**Milestone7 (I-23):** Increase specialty care clinic volume and improve access for patients seeking services. Metric 1 (I-23.1): Documentation of increased number of visits. Demonstrate improvement over baseline reporting period (established in FY12). a. Total number of visits for reporting period b. Data Source: Registry, EHR Goal: 20% increase Milestone 7 Estimated Incentive Payment: $ 971,057 **Milestone 8 (P-8):** Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to

139135109.1.8	1.9.2	A-D	EXPAND SPECIALTY CARE CAPACITY DIABETES: ENDOCRINOLOGY PEDIATRIC CARE
Texas Children's Hospital			139135109
Related Category 3 Outcome Measure(s):	139135109.3.22 139135109.3.23 139135109.3.24	IT- 5.1 IT-5.2 IT-5.3	Improved cost savings Per episode of care cost Length of stay

Year 2 (10/1/2012 – 9/30/2013)	**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: Participate in all semi-annual face-to-face meetings or seminars. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Milestone 2 Estimated Incentive Payment: $1,074,372.50	Metric 1 (P-8.1): Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: Participate in all semi-annual face-to-face meetings or seminars. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Milestone 4 Estimated Incentive Payment: $ 1,172,083	provider should publicly commit to implementing these improvements. Metric 1 (P-8.1): Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: Participate in all semi-annual face-to-face meetings or seminars. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Milestone 6 Estimated Incentive Payment: $1,175,490	implementing these improvements. Metric 1 (P-8.1): Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: Participate in all semi-annual face-to-face meetings or seminars. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Milestone 8 Estimated Incentive Payment: $ 971,057
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $2,148,745	Year 3 Estimated Milestone Bundle Amount: $2,344,166	Year 4 Estimated Milestone Bundle Amount: $2,350,980	Year 5 Estimated Milestone Bundle Amount: $1,942,114
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:** $8,786,005			

Project Option- 1.9.2 Improve access to specialty care: Expand Child Abuse Care

Unique Project ID: 139135109.1.9

Performing Provider Name/TPI: Texas Children's Hospital/139135109

Project Summary: This project will allow us to increase the number of children evaluated for abuse and neglect by a child abuse specialist by increasing clinic appointments and the number of providers.

Provider:
Texas Children's Hospital, located in Houston, is the largest free standing children's hospital in the county specializing in the care of medically fragile children in Houston and across the country as a regional safety net provider. We currently are licensed for 564 beds and in 2011 we had over 2.7 million patient encounters. Texas Children's is an integrated delivery system comprising of a health plan for Medicaid and CHIP pregnant women and children, the nation's largest general pediatrician group and two world class hospitals.

Volume Statistics - FY2012	Patient Payor Mix	Patient Demographics
Hospital Admissions- 25,966 Births (babies delivered)- 2,181 Emergency visits-113,586 Outpatient visits- 3,066,765	Medicaid and CHIP- 53.6% Commercial Insurance- 40.6% Self-Pay- 1.8% Medicare- 1.2%	Hispanic- 35.9% African American- 16.6% Caucasian- 31.0% Asian- 3.8% Other- 12.4% American Indian- 0.3%

Intervention(s):
This project will allow us to increase the number of children evaluated for abuse and neglect by a child abuse specialist by increasing clinic appointments and the number of providers.

Need for the project:Child Maltreatment is the medical and psychological result of enormous social dysfunction in families. The system that strives to support or change this is based on improving and solidifying the social needs as well as the medical needs of these patients and their families and/or guardians. Providers with extensive training and experience in child maltreatment and family violence are a necessary component of this subspecialty.

Target Population:
All patients within the system who are suspected vicitms of child maltreatment may benefit from this project.
Category 1 or 2 expected patient benefits:
Our DY3 goal is to increase the percentage of patients evaluated for abuse and/or neglect by a child abuse pediatrician by 4%. Our DY4 goal is to increase the percentage of patients evaluated for abuse and/or neglect by a child abuse pediatrician by 6%. Our DY5 goal is to increase the percentage of patients evaluated for abuse and/or neglect by a child abuse pediatrician by 8%.
Category 3 outcomes:
IT-10.1 Improved quality of Life

Project Option- 1.9.2 Improve access to specialty care: Expand Child Abuse Care

Unique Project ID: 139135109.1.9
Performing Provider Name/TPI: Texas Children's Hospital/139135109

Project Description:
Texas Children's Hospital proposes to establish a specialty care program for children who have experienced abuse or neglect.

Texas Children's Hospital, located in Houston, is the largest free standing children's hospital in the county specializing in the care of medically fragile children in Houston and across the country as a regional safety net provider. We currently are licensed for 564 beds at our main campus and West Houston facilities. In 2011 we had over 2.7 million patient encounters. Our mission is to provide the finest possible pediatric patient care, education, and research. Texas Children's is an integrated delivery system comprising of a health plan for Medicaid and CHIP pregnant women and children, the nation's largest general pediatrician group and two world class hospitals. Texas Children's supports a commitment to quality service and cost-effective care to enhance the health and well-being of children locally, nationally and internationally.
This project will allow us to increase the number of children evaluated for abuse and neglect by a child abuse specialists. Child Maltreatment is the medical and psychological result of enormous social dysfunction in families. The system that strives to support or change this is based on improving and solidifying the social needs as well as the medical needs of these patients and their families and/or guardians. Providers with extensive training and experience in child maltreatment and family violence are a necessary component of this subspecialty.[144]

The patients evaluated by these providers are then connected with our nurse managers and social workers who act as patient navigators to help these high risk special needs children and families coordinate the care and services necessary to ensure the child's health and safety. Our program provides for accurate diagnosis, treatment, follow-up and ongoing care for these high risk and vulnerable patients. Our follow-up clinic is unique in its focus, as a majority of these children are medically complex with special needs as a result of the abuse inflicted upon them.

Over 4,000 children live in foster homes in this area and in 2010 the number of CPS investigations in Harris County was 28,549. Six thousand five hundred and thirty-five children were confirmed victims of abuse or neglect and 44 of these cases resulted in child deaths. Expanding the focus to the entire southeast Texas region from which our patients originate, that number is doubled to over 12,000 confirmed cases of abuse or neglect.

In 2006 the American Board of Pediatrics certified pediatric child abuse as a subspecialty, in recognition of the growing and multifaceted need for accurate diagnosis of child maltreatment, working with the community in ensuring child safety, providing medical expertise to the legal system, and overseeing child abuse prevention programs. The number of children evaluated by our physician specialists has steadily increased each year, totaling 1198 in 2012, which accounts

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[144] Block, R.W, and V.J Palusci. "Child Abuse Pediatrics: a New Pediatric Subspecialty." *The Journal of Pediatrics*. 148.6 (2006): 711-712.

for only 50% of all our child abuse evaluations. Due to the limited number of providers, many patients evaluated for child maltreatment are not seen by child abuse specialists. In most of these cases they are evaluated by non-child abuse specialists in an emergency center rather than a more appropriate clinic environment.[145] Currently clinic appointments for physical abuse and neglect are only available 2 half days a week, and for sexual abuse only 4 days a week resulting in the use of an emergency center when the outpatient facilities are unavailable or at capacity.

Goals and Relationship to Regional Goals:
Project Goals:

To meet the growing demand for **high impact** pediatric child abuse services, TCH will:

- Focus on provider productivity to **optimize** clinical time for all providers,
- Expand internal capacity by offering a child abuse fellowship to staff an additional clinic day and adding additional providers to evaluate patients and mentor fellowship level learners.

This project meets the following Region 3 Goals:

- Increased access to specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their conditions, regardless of where they reside or their ability to pay for care.
- Develop a regional approach to healthcare delivery that leverages and improves on existing programs and infrastructure, is responsive to patients' needs throughout the entire region, and improves health care outcomes and patient satisfaction

Challenges: In Texas, limited Medicaid reimbursement is an ongoing challenge for children's hospitals and the workforce that provides health care services for the pediatric population enrolled in this program, especially for the child victim population. As advocates for improving and sustaining quality children's health care, our organization informs and educates elected officials and community leaders about the importance of Medicaid and the need to adequately fund the program. We will continue these efforts throughout the duration of waiver to ensure existing programs and services will be maintained and expanded. Without additional funding provider by this project we have limited child abuse specialists, resulting in some children being evaluated in an emergency center by an emergency medicine physician rather than a child abuse specialist. In addition, many of our patients have long term consequences of maltreatment and it is important that their follow up care coordinated.
We anticipate difficulty in adding providers as the market for board certified or board eligible child abuse pediatricians is limited due to the newness of the specialty. Our child abuse fellowship program has been available since July 2012 and we have yet to fill our fellowship position in spite of vigorous recruitment efforts. With the assistance of our marketing team, a TCH Child Abuse Pediatrics fellowship news release was distributed on the wire on June 20, 2012, and was picked up by **252 placements**. The news was highlighted in numerous national outlets, key competitive markets and local/regional outlets. The release was even picked up by

[145] Arnold, D. H., Spiro, D. M., Nichols, M. H., & King, W. D. (2005). Availability and perceived competence of pediatricians to serve as child protection team

medical consultants: A survey of practicing pediatricians. *Southern Medical Journal*, *98*(4), 423–428.

international media including outlets in Japan, China, Germany, India, Philippines and Guam. In addition, recruitment for a pediatric nurse practitioner for the Child Abuse Pediatrics program has proven difficult to fill. After several months of recruiting, we hired a NP in August of last year only to lose her after a little more that a year in the position. The training time for both a fellow and a nurse practitioner is at least one year before they are ready to function independently in the realm of child abuse.

Five year expected outcome for provider and patients:
Texas Children's Hospital expects to see improvements in access to subspecialty care for our pediatric patients; this in turn will improve patient satisfaction due to the delivery of the right care at the right place at the right time.

Starting Point/Baseline: Number of children evaluated for abuse and neglect by a child abuse specialists in FY 12. 338 children were evaluated by a child abuse specialists in our clinic in FY 12. Our fiscal year runs from October 1st to September 30th.

Rationale:
Houston is one of the fastest growing communities with a Harris County total population of 4,092,459 according to 2010 US Census Bureau data, with almost 1.3 million under the age of 20 years. Re-designing medical specialty clinics in order to shorten appointment cycle time and maximize provider productivity allows the most efficient utilization of specialty provider resources. The number of physical abuse and neglect cases evaluated by our child abuse specialists has steadily increased each year, totaling 1198 (49.7% of all abuse evaluations). Our project significantly enhances TCH's existing child abuse services. Child Abuse Pediatrics is subspecialty that has been identified at both at the national and state levels to have a shortage of resources to meet consumer demands (Children's Hospital Association - Pediatric Specialist Physician Shortages Affect Access to Care, August 2012).

In many cases throughout the Houston area and throughout the southeast Texas region, children at risk or suspected to be victims of child abuse are often seen by general pediatricians, emergency medicine physicians or family practitioners due to availability of child abuse pediatricians. In the current state of our program we struggle to meet the needs of this patient population with only 2 dedicated physician specialists and the clinical demands of an inpatient consult service and 2 outpatient clinics as well as the additional community responsibilities of court appearances, outreach education, clinical research and directing prevention programs. This funding will allow our program to increase the availability of child abuse specialists for hospital consultations, clinic appointments for evaluations as well as for longer term follow-up care.

Project Components: Through the expanded access to specialty care, we propose to meet all required project components listed and these selected milestones and metrics relate to project components.

nn. Conduct specialty care gap assessment based on community need for subspecialty.
oo. Implement transparent standardized referrals across the system
pp. Increase specialty care volume of visits and evidence of improved access for patients seeking services
qq. Increase service availability hours and increase number of specialty clinic locations.

rr. Conduct quality improvement for projects including rapid cycle and learning collaborative exchanges. It is our goal to reach the industry standard of less than 14 days for the 3rd available appointment.

Inadequate access to specialty care has contributed to the limited scope and size of safety net health systems. For children with health care needs that exceed the abilities of the primary care provider, access to and coordination with subspecialty care is critical to ensuring the provision of efficient and effective health care and in securing a comprehensive medical home.[146]

Milestones and Metrics
The following milestones and metrics have been chosen for the project based on the core components and the needs of the targeted pediatric population.

- Process milestone and metrics: P-1 (P-1.1); P-8 (P-8.1); P-17 (P-17.1)
- Improvement milestones and metrics: I-23 (I-23.1); I

Unique community need identification number the project addresses:

- CN.2: Inadequate access to specialty care,
- CN.6: Inadequate access to treatment and services designed for children.

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
At present, the TCH child abuse pediatricians are a valuable part of the medical team in the time of a child's acute illness precipitated by child abuse or neglect in the cases of the most severely injured or neglected victims. Those children who may have suffered less grievous injury or had abusive injury go unrecognized by other subspecialists are not currently accommodated with our limited clinic infrastructure. An established system designed for the unique needs of this patient population, to address injury detection and repair, and also to bridge the gap for ongoing health needs while children are in foster care and will be most beneficial for the children and families, and can only be accomplished by increasing physician staffing and clinic resources[147].

<u>**Related Category 3 Outcome Measure(s):**</u>
OD-10 Quality of Life
The outcome for our project will increase the number of patients evaluated by a child abuse specialist by 4% in year 3, 6% in year 4 and 8% in year 5 as result of increased providers and clinic resources and improved efficiency in program processes. Many children are evaluated in the emergency center setting without the clinical expertise of a child abuse specialist. With additional providers, the expansion of clinic availability and improved processes, patients

[146] Redlener, Irwin, Grant Roy, and Krol David M. "Beyond Primary Care: Ensuring Access to Subspecialists, Special Services, and Health Care Systems for Medically Underserved Children." *Advances in Pediatrics*. 52 (2005): 9-22.
[147] Lane WG, Dubowitz H. Primary care pediatricians' experience, comfort and competence in the evaluation and management of child maltreatment: Do we need child abuse experts? Child Abuse & Neglect 33 (2009) 76–83

Ref: Anderst J, Kellog N, Jungo I. Is the diagnosis of physical abuse changed when Child Protective Services consults a Child Abuse Pediatrics subspecialty group as a second opinion? Child Abuse & Neglect 33 (2009) 481–489

who do not clinically meet the criteria for the emergency setting would be evaluated in the clinic by a child abuse specialist.

Reasons/rationale for selecting the outcome measures:
Our project will increase appropriate access to care. Increased access to appropriate subspecialty care leads to better long term outcomes in children and reduction in unnecessary health care costs.[148]

Relationship to other Projects: All of Texas Children's projects are working to expand access to subspecialty care for the pediatric population. Texas continues to have a growing pediatric population and a shortage of specialized pediatric providers.

Primary Care/Ambulatory Care clinics are a top priority to Region 3 due to the acuity of the regional patient mix, population concentration, and lack of primary care access points for our patient base. The regional approach of collaboration as well as existing patient referral pattern relationships allowed our team to properly identify the community needs based on the necessity of population, uninsured, and medically underserved patient bases. This program is consistent with our region and similar to numerous initiatives in our RHP plan sharing both concepts as well as outcome measures focused to percent improvement over baseline of patient satisfaction scores, reduction of inappropriate ED utilization, and third next available appointment status. The Region 3 Initiative Grid attached as a RHP Plan addendum reflects a grid of relationship for all initiatives.

Plan for Learning Collaborative: We plan to participate in a region-wide learning collaborative as offered by the anchor for Region 3, Harris Health System. Our participation in this collaborative with other performing providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our region's health care system.

Project Valuation: This project's value is based on the benefits related to cost avoidance of medical expenses and improved quality of life. For example, increased provider capacity leads to reduction in emergency room visits and reduction in inpatient hospital visits.[149] Our valuation also includes an increase in the patient's quality of life. We are using a conservative Quality Adjusted Life Year ("QALY") per year and a percentage of that QALY for the pediatric population.[150] The QALY is used as a one-time improvement in the quality of life, even though we know the patient's quality of life will be improved for many years. We recognize that this is a government funded waiver and thus we chose to have conservative valuations out of respect for the taxpayer funded program.

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[148] *Reducing Costs Through the Appropriate Use of Specialty Services*. Cambridge: Institute for Healthcare Improvement, 2007.

[149] Smith, John T, Price, Christopher, Stevens Peter M., Masters, Kevin S., and Young, Mark. "Selected Topics - Does Pediatric Orthopedic Subspecialization Affect Hospital Utilization and Charges?" *Journal of Pediatric Orthopedics*. 19.4 (1999): 553-555.

[150] Brannon, Ike. "Risk - What Is a Life Worth? Despite Its Prima Facie Callousness, Determining the Value of a Human Life Is Necessary for Good Public Policy." *Regulation*. 27.4 (2004): 60-63.

139135109.1.9	***1.9.2***	***A-D***	***EXPAND SPECIALTY ACCESS TO CHILD ABUSE SPECIALISTS***	
Texas Children's Hospital				139135109
Related Category 3 Outcome Measure(s):	*139135109.3.25*	*IT- 10.1*	*Quality of Life*	

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 (P-1): Conduct specialty care gap assessment to determine barriers to accessing subspecialty care Metric 1 [P-1.1]: Documentation of gap assessment Data Source: Gap Assessment Milestone 1 Estimated Incentive Payment: $250,307.50 **Milestone 2 (P-8):** Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements. Metric 1 [P-8.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: Participate in all semi-annual face-to-face meetings or seminars. Data Source: Documentation of semiannual meetings including meeting agendas, slides from	**Milestone 3 (I-23):** Increase specialty care evaluation visits and evidence of improved access for patients seeking services. **Metric 1 (I-23.1)**: Documentation of increased number of evaluations with a child abuse specialist. Demonstrate improvement over prior reporting period (baseline established in FY12). a. Total number of visits for reporting period b. Data Source: EPIC Electronic Medical Record Goal: 4% Milestone 3 Estimated Incentive Payment: $273,072 **Milestone 4 [P-8]:** Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements. Metric 1 [P-8.1]: Participate in semi-annual face-to-face meetings or	**Milestone 5 (I-23):** Increase specialty care evaluation visits and evidence of improved access for patients seeking services. **Metric 1 (I-23.1)**: Documentation of increased number of evaluations with a child abuse specialist. Demonstrate improvement over prior reporting period (baseline established in FY12). a. Total number of evaluations for reporting period b. Data Source: Registry, EHR Goal: 6% Milestone 5 Estimated Incentive Payment: $273,865.50 **Milestone 6 [P-8]:** Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements.	**Milestone 7 (I-23):** Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services. **Metric 1 (I-23.1)**: Documentation of increased number of evaluations with a child abuse specialist. Demonstrate improvement over prior reporting period (baseline established in FY12). a. Total number of evaluations for reporting period b. Data Source: Registry, EHR Goal: 8% Milestone 7 Estimated Incentive Payment: $226,237 **Milestone 8 [P-8]:** Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements. Metric 6 [P-8.1]: Participate in semi-

139135109.1.9	***1.9.2***	***A-D***	***EXPAND SPECIALTY ACCESS TO CHILD ABUSE SPECIALISTS***
Texas Children's Hospital			139135109
Related Category 3 Outcome Measure(s):	*139135109.3.25*	*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)**
presentations, and/or meeting notes. Milestone 2 Estimated Incentive Payment: $250,307.50	seminars organized by the RHP. Goal: Participate in all semi-annual face-to-face meetings or seminars. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Milestone 4 Estimated Incentive Payment: $273,072	Metric 1 [P-8.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: Participate in all semi-annual face-to-face meetings or seminars. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Milestone 6 Estimated Incentive Payment: $273,865.50	annual face-to-face meetings or seminars organized by the RHP. Goal: Participate in all semi-annual face-to-face meetings or seminars. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Milestone 8 Estimated Incentive Payment: $226,237
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $500,615	Year 3 Estimated Milestone Bundle Amount: $546,144	Year 4 Estimated Milestone Bundle Amount: $547,731	Year 5 Estimated Milestone Bundle Amount: $452,474
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)**:*** $2,046,964			

Project Option: 1.9.2 Expand Access to Specialty Care: Developmental Pediatrics

<u>Unique Project ID</u>: 139135109.1.10

<u>Performing Provider Name/ TPI</u>: Texas Children's Hospital/ 139135109

<u>Project Summary:</u>
The Meyer Center for Developmental Pediatrics works with children with suspected motor, cognitive, language, and/or social-emotional developmental delays, suspected developmental disabilities, and children at risk for developmental-behavioral disorders. This project will build the volume of services provided in developmental-behavioral health in order to better serve the high demand for these children.

<u>Provider:</u>
Texas Children's Hospital, located in Houston, is the largest free standing children's hospital in the county specializing in the care of medically fragile children in Houston and across the country as a regional safety net provider. We currently are licensed for 564 beds and in 2011 we had over 2.7 million patient encounters. Our mission is to provide the finest possible pediatric patient care, education, and research. Texas Children's is an integrated delivery system comprising of a health plan for Medicaid and CHIP pregnant women and children, the nation's largest general pediatrician group and two world class hospitals.

lume Statistics - FY2012	**tient Payor Mix**	**tient Demographics**
spital Admissions- 25,966 rths (babies delivered)- 2,181 nergency visits-113,586 tpatient visits- 3,066,765	edicaid and CHIP- 53.6% mmercial Insurance- 40.6% lf-Pay- 1.8% edicare- 1.2%	spanic- 35.9% rican American- 16.6% ucasian- 31.0% ian- 3.8% her- 12.4% nerican Indian- 0.3%

<u>Intervention(s):</u>
Interventions include expanding the training of subspecialists, expanding the role of a referral center to better allocate children with different needs to a provider that can best suit their needs, refine the role of a Primary Care Pediatrician to help provide long term care, and expanding internal provider capacity and hiring additional clinical providers.

<u>Need for the project:</u>
Developmental-behavioral disorders are by far the most common chronic problems faced in primary care pediatric practice, yet there is a severe shortage of fellowship trained subspecialists. In the United States, approximately 1 in 5 children have a condition that our specialists help treat.

<u>Target Population:</u>
The providers in the Meyer Center work with children with suspected motor, cognitive, language, and/or social-emotional developmental delays, children with suspected developmental disabilities, and children at risk for developmental-behavioral disorders.

<u>Category 1 or 2 expected patient benefits:</u>
Our DY3 goal is to improve upon DY2 baseline of patient volume by 3%. Our DY4 goal is for 6% of patients in registry have at least 1 contact in the prior year period. Our DY5 goal is to improve upon DY2 baseline of patient volume by 9%.

<u>Category 3 outcomes:</u>
IT-5.1 Improved Cost Savings

Project Option: 1.9.2 Expand Access to Specialty Care: Developmental Pediatrics

Unique Project ID: 139135109.1.10
Performing Provider Name/ TPI: Texas Children's Hospital/ 139135109

Project Description:
Texas Children's Hospital will increase capacity in the Developmental Pediatrics Clinic.

Texas Children's Hospital, located in Houston, is the largest free standing children's hospital in the county specializing in the care of medically fragile children in Houston and across the country as a regional safety net provider. We currently are licensed for 564 beds at our main campus and West Houston facilities. In 2011 we had over 2.7 million patient encounters. Our mission is to provide the finest possible pediatric patient care, education, and research. Texas Children's is an integrated delivery system comprising of a health plan for Medicaid and CHIP pregnant women and children, the nation's largest general pediatrician group and two world class hospitals. Texas Children's supports a commitment to quality service and cost-effective care to enhance the health and well-being of children locally, nationally and internationally.

Specifically this project will increase capacity in our Developmental Pediatrics Clinic. Developmental Pediatrics and Behavioral Medicine are identified subspecialties, both at the national and state level, to have a shortage of resources to meet consumer demands (Children's Hospital Association - Pediatric Specialist Physician Shortages Affect Access to Care, August 2012). The Meyer Center for Developmental Pediatrics consists of 9 Developmental Pediatricians, 1 Social Worker, 1 Nurse Practitioner, 1 Neuropsychologist and 1 Licensed Professional Counselor. This service is among the largest in the country to provide medically-based diagnostic services and longitudinal care to children with developmental-behavioral concerns. The providers in the Meyer Center work with children with suspected motor, cognitive, language, and/or social-emotional developmental delays, children with suspected developmental disabilities (learning disabilities, intellectual disabilities, AD/HD, autism spectrum disorders, cerebral palsy, spina bifida, vision impairments, hearing impairments), and children at risk for developmental-behavioral disorders (former premature infants and high risk term infants; children with congenital anomalies or genetic syndromes, such as Down syndrome or Fragile X syndrome). In the United States, approximately 1 in 5 children have a condition that our specialists help treat.

The most significant challenge in the field of developmental-behavioral pediatrics is that developmental-behavioral disorders are by far the most common chronic problems faced in primary care pediatric practice, yet there is a severe shortage of fellowship trained subspecialists to whom primary care pediatricians can refer their patients. Despite developmental-behavioral disorders affecting approximately 20% of children, less than 1% of board-certified pediatricians are subspecialty-certified in either Neurodevelopmental Disabilities or Developmental-Behavioral Pediatrics. Thus, a most critical mission of the Meyer Center remains educating pediatric residents, subspecialty fellows, and pediatric heath care professionals in practice. Of nearly 200 pediatric training programs in the country, since 2003, the Meyer Center has been one of only 8 programs nationally to provide residency training in Neurodevelopmental Disabilities. In 2011, the Meyer Center was approved by the Accreditation Council of Graduate

Medical Education to begin a new fellowship program in Developmental-Behavioral Pediatrics (one of only 35 programs nationally). This makes Texas Children's Hospital one of only two hospitals nationally to house accredited training programs in *both* Neurodevelopmental Disabilities and Developmental-Behavioral Pediatrics and the only one in the nation to have both of these programs led within a single Section of Developmental Pediatrics. In 2011, Meyer Center faculty also obtained grant funding to develop a new competency-based curriculum in developmental pediatrics to provide pediatric residents longitudinal training in developmental-behavioral pediatrics across their three years of residency, so that they will be equipped to identify and manage children with developmental and behavioral concerns in their future practices. Finally, Meyer Center faculty have continued to actively present at local, regional, national, and international continuing medical education venues to provide in-service developmental-behavioral education to pediatric health care professionals in practice.

Within the last three to five years, the referral triage mechanism for the Behavioral and Developmental Sciences at Texas Children's Hospital (TCH), which includes the Meyer Center for Developmental Pediatrics, has been somewhat loose, and tracking has been inconsistent. With the introduction of the Behavioral and Developmental Sciences Referral Center in 2011, which serves as a central portal for the receipt and tracking of all behavioral and developmental sciences clinical service requests, a clear understanding of the demand for service in Developmental Pediatrics has been established. Given the frequency of children impacted by conditions that the Meyer Center specialists treat (1 in 5 children in the United States), the wait time for a new patient appointment in this service line has been as high as 36 months. The Referral Center allows TCH to examine specific needs of patients asking for services through the Behavioral and Developmental Sciences. In the past, these referrals may have gone just to one service line. Now, the Referral Center can look to see if other behavioral specialists, like a Psychiatrist, Psychologist or a specialist through the Autism Center may serve the patient's needs. With this model, TCH can look sometimes match patients with alternate providers to meet their needs rather than wait the significant wait time for services specifically within Developmental Pediatrics. Looking at Behavioral and Developmental Sciences across service lines also allows TCH to monitor closely wait times across service areas (not just Developmental Pediatrics, but also Autism) work through leadership to shift provider resources or to clearly outline recruitment needs.

Goals and Relationship to Regional Goals:

Project Goals: To meet the growing demand for specialized pediatric services TCH will:

20. Focus on provider productivity to optimize clinical time for all providers and enhance training of subspecialists and fellows.
21. Expand the role of the Behavioral and Developmental Referral Center to refine algorithms to triage patients to the most appropriate providers based on patient need and provider availability to ensure that only the most appropriate patients for a Developmental Pediatrics evaluation are routed to this service line, thereby increasing the availability for new patient appointments of these targeted providers.

22. Refine new clinical care model to expand the role of the Primary Care Pediatrician so as to reduce the need for return patient appointments, increasing the availability for new patient appointments by current providers.
23. Expand internal capacity by hiring additional clinical providers.
24. Enhance service availability by targeting new providers to not only work in the Texas Medical Center but to also serve the five additional community locations for specialty care
25. Optimize clinical care through the use of social workers to reach out to families as they wait for formal medical assessments through our services.

<u>This project meets the following Region 3 Goals:</u>

- Increased access to specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their conditions, regardless of where they reside or their ability to pay for care.
- Develop a regional approach to healthcare delivery that leverages and improves on existing programs and infrastructure, is responsive to patients' needs throughout the entire region, and improves health care outcomes and patient satisfaction

Challenges:

In Texas, limited Medicaid reimbursement is an ongoing challenge for children's hospitals and the workforce that provides health care services for the pediatric population enrolled in this program. In Behavioral and Developmental Health, reimbursement is particularly challenging. Certain testing codes cannot be used on the same date as some medical codes, which forces TCH practices to choice between what is best for patient care in terms of convenience for families (to have all procedures performed on the same visit date so that parking, commuting, time off from work and other personal expenses related to the visit can be limited) or asking the patient to come in multiple times so that services can be billed in a manner that can be fully reimbursed. As advocates for improving and sustaining quality children's health care, our organization informs and educates elected officials and community leaders about the importance of Medicaid and the need to adequately fund the program. We will continue these efforts throughout the duration of waiver to ensure existing programs and services will be maintained and expanded.

TCH continues to increase our overall volumes at all of our locations by 5.7% year over year in our pediatric physician practices. In Developmental Pediatrics specifically, over the last year, the Service has been able to reduce wait time by 64% from its peak wait time of 36 months. However, there is still a significant amount of work that needs to be done to improve access to services in Developmental Pediatrics. By reconfiguring clinic processes, scheduling, and the addition of more providers (including maximizing clinical support like social workers and other mid-level providers to the top of their license), we will try to improve this measure.

Five year expected outcome for provider and patients:

Texas Children's Hospital expects to see an increase in the volume of patients who are able to access subspecialty care for our pediatric patients; this in turn will improve patient satisfaction due to the delivery of the right care at the right place at the right time.

<u>Starting Point/Baseline:</u>

The baseline for patient volumes in FY 12 is 1,977. TCH fiscal year is from October 1st to September 30th.

Rationale:

The significant increase in access to specialty care created by this project attempts to address the growing demands in our community for specialized pediatric providers. This project will create increased capacity through more efficient operations and new physician recruitment. Our project significantly enhances TCH's existing developmental pediatric services to improve patient satisfaction by aspiring to provide the right care in the right setting at the right time

For children, especially those with health care needs that exceed the abilities of the primary care provider, access to and coordination with subspecialty care is critical to ensuring the provision of efficient and effective health care and in securing a comprehensive medical home. Inadequate access to specialty care has contributed to the limited scope and size of safety net health systems. Increasing pediatric population and continued lack of pediatric subspecialists due to the inequity in reimbursement between Medicaid and Medicare is an ongoing problem for children's hospitals and the pediatric health care workforce.

Project Components:
Through the expanded access to specialty care, we propose to meet all required project components listed and these selected milestones and metrics do relate to project components.

ss. Conduct specialty care gap assessment based on community need for subspecialty.
tt. Implement transparent standardized referrals across the system
uu. Increase specialty care volume of visits and evidence of improved access for patients seeking services
vv. Increase service availability hours and increase number of specialty clinic locations.
ww. Conduct quality improvement for projects including rapid cycle and learning collaborative exchanges.

Inadequate access to specialty care has contributed to the limited scope and size of safety net health systems. For children with health care needs that exceed the abilities of the primary care provider, access to and coordination with subspecialty care is critical to ensuring the provision of efficient and effective health care and in securing a comprehensive medical home.[151]

Milestones and Metrics
The following milestones and metrics have been chosen for the project based on the core components and the needs of the targeted pediatric population.

- Process milestone and metrics: P-1 (P-1.1); P-8 (P-8.1); P-17 (P-17.1)
- Improvement milestones and metrics: I-23 (I-23.1)

Unique community need identification numbers the project addresses:

- CN2: Inadequate access to specialty care

[151] Redlener, Irwin, Grant Roy, and Krol David M. "Beyond Primary Care: Ensuring Access to Subspecialists, Special Services, and Health Care Systems for Medically Underserved Children." *Advances in Pediatrics*. 52 (2005): 9-22.

- CN6: Inadequate access to treatment and services designed for special needs populations, including disabled, homeless, children, elderly

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
As stated throughout this proposal, the special needs of children with developmental disabilities or delays are significant. This project will allow Texas Children's to significantly enhance our exisiting Neurosurgery appointment availability. With the shortage of specialists in this area, TCH has had work within the resources available nationwide to build a program that provides superior care for children with these conditions. This project, by focusing not only on national recruitment of the limited number of developmental pediatricians, but also focusing on the use of mid-level providers for care, aims at improving access to these services for children in the state of Texas.

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

Reasons/rationale for selecting the outcome measures:
Our project will increase appropriate access to care. Increased access to appropriate subspecialty care leads to better long term outcomes in children and reduction in unnecessary health care costs.[152] Additionally, increased access to care leads to faster evaluation and treatment which will lead to an improved quality of life for the children. This project will allow us to not only increase access to medical care for these children, but also community resources coordinated by our social work team.

Relationship to other Projects: All of Texas Children's projects are working to expand access to subspecialty care for the pediatric population. Texas continues to have a growing pediatric population and a shortage of specialized pediatric providers.

Children are the future of healthcare and will dictate the treatments needed as well as the cost of healthcare in future years so it is critical that they receive the access needed throughout their pediatric lives. The focus of pediatric specialty care is similar throughout the region with a concentrated focus in the Harris county proper geographic region and allows for the expansion of access to numerous specialties such as cardiology, neurology, ENT, and many more. The outcome measures focus to appropriate length of stay, per episode cost of care, and improved cost savings. The Region 3 Initiative grid allows for a cross reference of similar initiatives in our region. (addendum)

Plan for Learning Collaborative: We plan to participate in a region-wide learning collaborative as offered by the anchor for Region 3, Harris Health System. Our participation in this collaborative with other performing providers within the region that have similar projects

[152] *Reducing Costs Through the Appropriate Use of Specialty Services*. Cambridge: Institute for Healthcare Improvement, 2007.

will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our region's health care system.

Project Valuation: This project's value is based on the benefits related to cost avoidance of medical expenses and improved quality of life. For example, increased provider capacity leads to reduction in emergency room visits and reduction in inpatient hospital visits.[153] Our valuation also includes an increase in the patient's quality of life. We are using a conservative Quality Adjusted Life Year ("QALY") per year and a percentage of that QALY for the pediatric population.[154] The QALY is used as a one-time improvement in the quality of life, even though we know the patient's quality of life will be improved for many years. We recognize that this is a government funded waiver and thus we chose to have conservative valuations out of respect for the taxpayer funded program.

[153] Smith, John T, Price, Christopher, Stevens Peter M., Masters, Kevin S., and Young, Mark. "Selected Topics - Does Pediatric Orthopedic Subspecialization Affect Hospital Utilization and Charges?" *Journal of Pediatric Orthopedics*. 19.4 (1999): 553-555.

[154] Brannon, Ike. "Risk - What Is a Life Worth? Despite Its Prima Facie Callousness, Determining the Value of a Human Life Is Necessary for Good Public Policy." *Regulation*. 27.4 (2004): 60-63.

139135109.1.10	1.9.2	A-D	EXPAND ACCESS TO SPECIALTY CARE: DEVELOPMENTAL PEDIATRICS
Texas Children's Hospital			139135109
Related Category 3 Outcome Measure(s):	139135109.3.26	IT- 10.1	Quality of Life

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 (P-1): Conduct specialty care gap assessment to determine barriers to accessing subspecialty care Metric 1 P-1.1 Documentation of gap assessment Data Source: Gap Assessment Milestone 1 Estimated Incentive Payment: $416,570.50 **Milestone 2 (P-8):** Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements. Metric 1 [P-8.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: Participate in all semi-annual face-to-face meetings or seminars.	**Milestone 5 (I-23):** Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 (I-23.1): Documentation of increased number of visits. Demonstrate improvement over prior reporting period (baseline established in FY12). a. Total number of visits for reporting period b. Data Source: Registry, EHR Goal: 3% over baseline. Milestone 5 Estimated Incentive Payment: $454,456 **Milestone 6 [P-8]:** Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements. Metric 1 [P-8.1]: Participate in semi-	**Milestone 6 (I-23):** Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 (I-23.1): Documentation of increased number of visits. Demonstrate improvement over prior reporting period (baseline established in FY12). a. Total number of visits for reporting period b. Data Source: Registry, EHR Goal: 6% over baseline. Milestone 6 Estimated Incentive Payment: $455,777 **Milestone 7 [P-8]:** Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. 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.	**Milestone 8 (I-23):** Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 (I-23.1): Documentation of increased number of visits. Demonstrate improvement over prior reporting period (baseline established in FY12). a. Total number of visits for reporting period b. Data Source: Registry, EHR Goal: 9% over baseline. Milestone 8 Estimated Incentive Payment: $376,511.50 **Milestone 9 [P-8]:** Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At 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.

139135109.1.10	1.9.2	A-D	EXPAND ACCESS TO SPECIALTY CARE: DEVELOPMENTAL PEDIATRICS
Texas Children's Hospital			139135109
Related Category 3 Outcome Measure(s):	*139135109.3.26*	*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)**
Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Milestone 2 Estimated Incentive Payment: $416,570.50	annual face-to-face meetings or seminars organized by the RHP. Goal: Participate in all semi-annual face-to-face meetings or seminars. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Milestone 6 Estimated Incentive Payment: $454,456	Metric 1 [P-8.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: Participate in all semi-annual face-to-face meetings or seminars. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Milestone 7 Estimated Incentive Payment: $455,777	Metric 1 [P-8.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: Participate in all semi-annual face-to-face meetings or seminars. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Milestone 9 Estimated Incentive Payment: $376,511.50
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $833,141	Year 3 Estimated Milestone Bundle Amount: $908,912	Year 4 Estimated Milestone Bundle Amount: $911,554	Year 5 Estimated Milestone Bundle Amount: $753,023
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)**:** 3,406,630*			

Project Option- 1.9.2 Improve access to specialty care: Expand Pediatric Allergy/Immunology Care

Unique Project ID: 139135109.1.11
Performing Provider and TPI: Texas Children's Hospital/ 139135109

Project Summary: Increase outpatient access for Harris County and the surrounding communities to care for pediatric patients with allergy, asthma, primary immunodeficiency and secondary immunodeficiency.
Provider:
Texas Children's Hospital, located in Houston, is the largest free standing children's hospital in the county specializing in the care of medically fragile children in Houston and across the country as a regional safety net provider. We currently are licensed for 564 beds and in 2011 we had over 2.7 million patient encounters. Texas Children's is an integrated delivery system comprising of a health plan for Medicaid and CHIP pregnant women and children, the nation's largest general pediatrician group and two world class hospitals.

Volume Statistics - FY2012	Patient Payor Mix	Patient Demographics
Hospital Admissions- 25,966 Births (babies delivered)- 2,181 Emergency visits-113,586 Outpatient visits- 3,066,765	Medicaid and CHIP- 53.6% Commercial Insurance- 40.6% Self-Pay- 1.8% Medicare- 1.2%	Hispanic- 35.9% African American- 16.6% Caucasian- 31.0% Asian- 3.8% Other- 12.4% American Indian- 0.3%

Intervention(s):
Increase outpatient access for Harris County and the surrounding communities to care for pediatric patients with allergy, asthma, primary immunodeficiency and secondary immunodeficiency.
Need for the project:
The number of children referred into the TCH Allergy/Immunology clinic has increased by over 40% from 2010 to 2012 and subsequently is unable to meet the continually increasing demand.

Target Population:
Our target population is patients seeking the full spectrum of services from general allergy and immunology care to specialized treatment for Severe Combined Immunodeficiency Disorder and patients that are at risk for anaphylaxis. One particular area of focus is the diagnosis and care management of food allergies in the pediatric population.

Category 1 or 2 expected patient benefits:
I-23.1: Our goal is to increase the number of visits by 10% in DY3, by 15% in DY4, and by 20% in DY5 compared to baseline in DY2.

Category 3 outcomes:
IT-5 Improving cost of care

Project Option- 1.9.2 Improve access to specialty care: Expand Pediatric Allergy/Immunology Care

Unique Project ID: 139135109.1.11
Performing Provider and TPI: Texas Children's Hospital/ 139135109

Project Description:
Texas Children's Hospital proposes to expand access to care in the Allergy/Immunology clinic in order to meet increased demand for care and reduce appointment wait time.

Texas Children's Hospital, located in Houston, is the largest free standing children's hospital in the county specializing in the care of medically fragile children in Houston and across the country as a regional safety net provider. We currently are licensed for 564 beds at our main campus and West Houston facilities. In 2011 we had over 2.7 million patient encounters. Our mission is to provide the finest possible pediatric patient care, education, and research. Texas Children's is an integrated delivery system comprising of a health plan for Medicaid and CHIP pregnant women and children, the nation's largest general pediatrician group and two world class hospitals. Texas Children's supports a commitment to quality service and cost-effective care to enhance the health and well-being of children locally, nationally and internationally.

The TCH Allergy & Immunology (A&I) Service treats patients with allergy, asthma, primary immunodeficiency and secondary immunodeficiency and provides a variety of research and treatment options for infants, children and adolescents with immunodeficiency. TCH Allergy & Immunology Service also operates a full-function lab that examines cell function and surface markers that screen for and monitor immune deficiencies such as Severe Combined Immunodeficiency Disorder (SCID). The proposed project seeks to increase access for children to pediatric subspecialty services in the A&I clinic at Texas Children's Hospital. The number of children referred into the TCH Allergy/Immunology clinic has increased significantly from a monthly average of 185 in 2010 to a monthly average of 260 in 2012. One particular area of focus of the TCH A&I clinic is the diagnosis and care management of food allergies in the pediatric population. According to the Center for Disease Control and Prevention, there has been an 18% increase in food allergies among school-aged children from 1997 to 2007. Between 1 in 13 and 1 in 25 are now affected, with 40% reporting a severe reaction (Texas Department of State Health Services – "Guidelines for the Care of Students With Food Allergies At-Risk for Anaphylaxis: To Implement Senate Bill 27 (82nd Legislative Session)").

Goals and Relationship to Regional Goals:

Project Goals:

To meet the growing demand for specialized pediatric services, TCH will enhance service availability by targeting new providers to not only work in the Texas Medical Center but to also serve 1-3 additional community locations for allergy & immunology specialty clinics and on provider productivity to optimize clinical time for all providers and enhance training of subspecialists and fellows by:

1. Focusing on provider productivity to optimize clinical time for all providers
2. Establishing an initiative to review scheduling processes to increase the availability of these targeted providers
3. Expanding internal capacity by hiring additional clinical providers
4. Enhancing service availability by targeting new providers to not only work in the Texas Medical Center but to also serve 1-3 additional community locations for allergy and immunology care

This project meets the following Region 3 Goals:

- Increased access to specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their conditions, regardless of where they reside or their ability to pay for care
- Develop a regional approach to healthcare delivery that leverages and improves on existing programs and infrastructure, is responsive to patients' needs throughout the entire region, and improves health care outcomes and patient satisfaction

Challenges:
In Texas, limited Medicaid reimbursement is an ongoing challenge for children's hospitals and the workforce that provides health care services for the pediatric population enrolled in this program. As advocates for improving and sustaining quality children's health care, our organization informs and educates elected officials and community leaders about the importance of Medicaid and the need to adequately fund the program. We will continue these efforts throughout the duration of the waiver to ensure existing programs and services will be maintained and expanded.

Five year expected outcome for provider and patients:
Texas Children's Hospital expects to see improvements in access to subspecialty care for our pediatric patients; this in turn will improve patient satisfaction due to the delivery of the right care at the right place at the right time.

Starting Point/Baseline:
The baseline for patient volumes in fiscal year 2012 is 3,050. Our fiscal year runs from October 1st through September 30th.

Rationale:
The significant increase in access to specialty care created by this project attempts to address the growing demands in our community for specialized pediatric providers. This project will create increased capacity through more efficient operations and new physician recruitment. Our project significantly enhances TCH's existing allergy & immunology services to improve patient satisfaction by aspiring to provide the right care in the right setting at the right time. Specifically, we will provide comprehensive care for children within focused specialty programs such as: allergy, asthma, primary immunodeficiency and secondary immunodeficiency.

Increasing pediatric population and continued lack of pediatric subspecialists due to the inequity in reimbursement between Medicaid and Medicare is an ongoing problem for children's hospitals and the pediatric health care workforce.

Project Components:
Through the expanded access to specialty care, we propose to meet all required project components listed and these selected milestones and metrics do relate to project components.

xx. Conduct specialty care gap assessment based on community need for subspecialty
yy. Implement transparent standardized referrals across the system
zz. Increase specialty care volume of visits and evidence of improved access for patients seeking services
aaa. Increase the number of specialty clinic locations
bbb. Conduct quality improvement for projects including rapid cycle and learning collaborative exchanges

Inadequate access to specialty care has contributed to the limited scope and size of safety net health systems. For children with health care needs that exceed the abilities of the primary care provider, access to and coordination with subspecialty care is critical to ensuring the provision of efficient and effective health care and in securing a comprehensive medical home.[155]

Milestones and Metrics
The following milestones and metrics have been chosen for the project based on the core components and the needs of the targeted pediatric population.

- Process milestone and metrics: P-1 (P-1.1); P-8 (P-8.1);
- Improvement milestones and metrics: I-23 (I-23.1)

Unique community need identification number the project addresses:

- CN.2: Inadequate access to specialty care,
- CN.6: Inadequate access to treatment and services designed for children.

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
This project will enhance current services by expanding and maximizing provider accessibility that will result in a greater number of patients served. In addition it will result in prompt service and allow more children access to allergy & immunology subspecialty care.

Related Category 3 Outcome Measure(s):
OD-5 Cost of Care
IT-5.1: Improved cost savings
IT-5.2: Per episode of care cost
IT-5.3: Length of stay

Reasons/rationale for selecting the outcome measures:

[155] Redlener, Irwin, Grant Roy, and Krol David M. "Beyond Primary Care: Ensuring Access to Subspecialists, Special Services, and Health Care Systems for Medically Underserved Children." *Advances in Pediatrics*. 52 (2005): 9-22.

Our project will increase appropriate access to care. Increased access to appropriate subspecialty care leads to better long term outcomes in children and reduction in unnecessary health care costs.[156]

Relationship to other Projects: All of Texas Children's projects are working to expand access to subspecialty care for the pediatric population. Texas continues to have a growing pediatric population and a shortage of specialized pediatric providers.

Children are the future of healthcare and will dictate the treatments needed as well as the cost of healthcare in future years so it is critical that they receive the access needed throughout their pediatric lives. The focus of pediatric specialty care is similar throughout the region with a concentrated focus in the Harris county proper geographic region and allows for the expansion of access to numerous specialties such as cardiology, neurology, ENT, and many more. The outcome measures focus to appropriate length of stay, per episode cost of care, and improved cost savings. The Region 3 Initiative grid allows for a cross reference of similar initiatives in our region. (addendum)

Plan for Learning Collaborative: We plan to participate in a region-wide learning collaborative as offered by the anchor for Region 3, Harris Health System. Our participation in this collaborative with other performing providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our region's health care system.

Project Valuation: This project's value is based on the benefits related to cost avoidance of medical expenses and improved quality of life. For example, increased provider capacity leads to reduction in emergency room visits and reduction in inpatient hospital visits.[157] Our valuation also includes an increase in the patient's quality of life. We are using a conservative Quality Adjusted Life Year ("QALY") per year and a percentage of that QALY for the pediatric population.[158] The QALY is used as a one-time improvement in the quality of life, even though we know the patient's quality of life will be improved for many years. We recognize that this is a government funded waiver and thus we chose to have conservative valuations out of respect for the taxpayer funded program.

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[156] *Reducing Costs Through the Appropriate Use of Specialty Services*. Cambridge: Institute for Healthcare Improvement, 2007.

[157] Smith, John T, Price, Christopher, Stevens Peter M., Masters, Kevin S., and Young, Mark. "Selected Topics - Does Pediatric Orthopedic Subspecialization Affect Hospital Utilization and Charges?" *Journal of Pediatric Orthopedics*. 19.4 (1999): 553-555.

[158] Brannon, Ike. "Risk - What Is a Life Worth? Despite Its Prima Facie Callousness, Determining the Value of a Human Life Is Necessary for Good Public Policy." *Regulation*. 27.4 (2004): 60-63.

139135109.1.11	*1.9.2*	*A-D*	*IMPROVE ACCESS TO SPECIALTY CARE: EXPAND PEDIATRIC ALLERGY/IMMUNOLOGY CARE*
Texas Children's Hospital			139135109
Related Category 3 Outcome Measure(s):	*139135109.3.27* *139135109.3.28* *139135109.3.29*	*IT- 5.1* *IT-5.2* *IT-5.3*	*Improved cost savings* *Per episode of care cost* *Length of stay*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 (P-1): Conduct specialty care gap assessment to determine barriers to accessing subspecialty care <u>Metric 1 (P-1.1):</u> Documentation of gap assessment Data Source: Gap Assessment Milestone 1 Estimated Incentive Payment: $463,265.50 **Milestone 2 (P-8):** Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements. <u>Metric 1 (P-8.1):</u> Participate in semi-annual face-to-face meetings or seminars organized by the RHP.	**Milestone 3 (I-23):** Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services. <u>Metric 1 (I-23.1)</u>: Documentation of increased number of visits. Demonstrate improvement over baseline reporting period (established in FY12). a. Total number of visits for reporting period b. Data Source: Registry, EHR Goal: 10% increase Milestone 3 Estimated Incentive Payment:$505,937.50 **Milestone 4 (P-8):** Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements.	**Milestone 5 (I-23):** Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services. <u>Metric 1 (I-23.1)</u>: Documentation of increased number of visits. Demonstrate improvement over baseline reporting period (baseline established in FY12). a. Total number of visits for reporting period b. Data Source: EPIC medical record Goal: 15% increase Milestone 5 Estimated Incentive Payment:$506,867 **Milestone 6 (P-8):** Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do	**Milestone 7 (I-23):** Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services. <u>Metric 1 (I-23.1)</u>: Documentation of increased number of visits. Demonstrate improvement over baseline reporting period (baseline established in FY12). a. Total number of visits for reporting period b. Data Source: EPIC medical record Goal: 20% increase Milestone 7 Estimated Incentive Payment: $418,716 **Milestone 8 (P-8):** Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to

139135109.1.11	1.9.2	A-D	IMPROVE ACCESS TO SPECIALTY CARE: EXPAND PEDIATRIC ALLERGY/IMMUNOLOGY CARE
Texas Children's Hospital			139135109
Related Category 3 Outcome Measure(s):	*139135109.3.27* *139135109.3.28* *139135109.3.29*	*IT- 5.1* *IT-5.2* *IT-5.3*	*Improved cost savings* *Per episode of care cost* *Length of stay*

Year 2 (10/1/2012 – 9/30/2013)	**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: Participate in all semi-annual face-to-face meetings or seminars. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Milestone 2 Estimated Incentive Payment: $463,265.50	Metric 1 (P-8.1): Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: Participate in all semi-annual face-to-face meetings or seminars. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Milestone 4 Estimated Incentive Payment: $505,937.50	to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements. Metric 1 (P-8.1): Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: Participate in all semi-annual face-to-face meetings or seminars. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Milestone 6 Estimated Incentive Payment: $506,867	implementing these improvements. Metric 1 (P-8.1): Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: Participate in all semi-annual face-to-face meetings or seminars. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Milestone 8 Estimated Incentive Payment: $418,716
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $926,531	Year 3 Estimated Milestone Bundle Amount: $1,010,795	Year 4 Estimated Milestone Bundle Amount: $1,013,734	Year 5 Estimated Milestone Bundle Amount: $837,432
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)**:*** $3,788,492			

Project Option- 1.9.2 Expand Access to Specialty Care: Otolaryngology Pediatric Care

Unique Project ID: 139135109.1.12

Performing Provider Name/TPI: Texas Children's Hospital/ 139135109

Project Summary: Increase outpatient access for Harris County and the surrounding communities to care for pediatric patients with hearing loss to sinus disease and swallowing abnormalities and those patients with disorders of the ear, nose and/or throat.

Provider:
Texas Children's Hospital, located in Houston, is the largest free standing children's hospital in the county specializing in the care of medically fragile children in Houston and across the country as a regional safety net provider. We currently are licensed for 564 beds and in 2011 we had over 2.7 million patient encounters. Our mission is to provide the finest possible pediatric patient care, education, and research. Texas Children's is an integrated delivery system comprising of a health plan for Medicaid and CHIP pregnant women and children, the nation's largest general pediatrician group and two world class hospitals.

Volume Statistics - FY2012	Patient Payor Mix	Patient Demographics
Hospital Admissions- 25,966 Births (babies delivered)- 2,181 Emergency visits-113,586 Outpatient visits- 3,066,765	Medicaid and CHIP- 53.6% Commercial Insurance- 40.6% Self-Pay- 1.8% Medicare- 1.2%	Hispanic- 35.9% African American- 16.6% Caucasian- 31.0% Asian- 3.8% Other- 12.4% American Indian- 0.3%

Intervention(s): The division is establishing a Voice and Swallowing clinic to evaluate, diagnose, and treat complex disorders in swallowing and vocalization.
Need for the project: In 2012, referrals into the TCH Otolaryngology clinic averaged 900 per month. Given the increasing demand for these specialized services for the majority for FY10 and FY11, the average 3rd Available appointment was less than 30 days. Over the last 6 moths of 2012, at our Texas Medical Center site and other community locations (except our West Campus clinic) exceed 30 days.

Target Population: Our target population is pediatric patients seeking the full spectrum of services from general otolaryngology services, patients with hearing loss, swallowing and vocalization disorders, cochlear implants, aerodigestive diseases, and those patients with disorders of the ear, nose and/or throat.

Category 1 or 2 expected patient benefits:
I-23.1: Our goal is to increase the number of visits by 3% in DY3, by 3% in DY4, and by 6% in DY5 compared to baseline established in DY2.

Category 3 outcomes: IT-5 Improving Cost of Care

Project Option- 1.9.2 Expand Access to Specialty Care: Otolaryngology Pediatric Care

Unique Project ID: 139135109.1.12
Performing Provider Name/TPI: Texas Children's Hospital/ 139135109

Project Description:
Texas Children's Hospital proposes to expand access to pediatric Otolaryncology care through the establishment of a Voice and Swallowing clinic to diagnose and treat complex disorders related to swallowing and vocalization.

Texas Children's Hospital, located in Houston, is the largest free standing children's hospital in the county specializing in the care of medically fragile children in Houston and across the country as a regional safety net provider. We currently are licensed for 564 beds at our main campus and West Houston facilities. In 2011 we had over 2.7 million patient encounters. Our mission is to provide the finest possible pediatric patient care, education, and research. Texas Children's is an integrated delivery system comprising of a health plan for Medicaid and CHIP pregnant women and children, the nation's largest general pediatrician group and two world class hospitals. Texas Children's supports a commitment to quality service and cost-effective care to enhance the health and well-being of children locally, nationally and internationally.

Our project proposal will significantly improve access to pediatric subspecialty care. The Texas Children's ("TCH") Pediatric Otolaryngology Division provides diagnoses and treatment for conditions from hearing loss to sinus disease and swallowing abnormalities. The Otolaryngology Division is establishing a Voice and Swallowing Clinic to evaluate diagnose and treat complex disorders in swallowing and vocalization. The Otolaryngology Division established the Aerodigestive Disease
Clinic in 2011 and added the first laryngologist to practice at Texas Children's Hospital, one of only three pediatric fellowship-trained voice specialists in the nation. We also began offering laryngealstroboscopy, an innovative way of looking at vibratory characteristics of the vocal chord. The Aerodigestive clinic is a multidisciplinary clinic with the pulmonary and gastroenterology sources for complex patients in participation in the Down Syndrome Clinic for specialized expertise with this patient population.

To help improve the diagnosis and treatment of children and babies with disorders of the ear, nose or throat, our physicians are involved in research projects concerning hearing, cochlear implantation, sleep apnea, neck masses and vocal fold mobility. In addition, we are participating in a National Institutes of Health (NIH) grant to study cochlear implants in children with multiple disabilities as well as a Texas Children's Hospital-funded study of sleep apnea in children. In 2012, referrals into the TCH Otolaryngology clinic averaged 900 per month. TCH uses the industry standard of 3rd available appointment as a measure of access to care - ideal access would be less than 14 days. However, given the increasing demand for these specialized services for the majority of FY10 and FY11, the average 3rd Available appointment was less than 30 days. Over the last 6 months of 2012, at our Texas Medical Center site and other community locations (except our West Campus clinic), exceeds 30 days.

Goals and Relationship to Regional Goals:

Project Goals: To meet the growing demand for acute pediatric Otolaryngology services, TCH will:

26. Focus on provider productivity to optimize clinical time for all providers and enhance training of subspecialists and fellows,
27. Establish an initiative to review scheduling processes to increase the appointment availability of these targeted providers that aligns with new clinic capacity,
28. Expand provider capacity by hiring additional clinicians and support staff,
29. Enhance service availability by targeting new providers to not only work in the Texas Medical Center but also serve 1-3 additional community locations for specialty care.

This project meets the following Region 3 Goals:

- Increased access to specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their conditions, regardless of where they reside or their ability to pay for care.
- Develop a regional approach to healthcare delivery that leverages and improves on existing programs and infrastructure, is responsive to patients' needs throughout the entire region, and improves health care outcomes and patient satisfaction

Challenges:
In Texas, limited Medicaid reimbursement is an ongoing challenge for children's hospitals and the workforce that provides health care services for the pediatric population enrolled in this program. As advocates for improving and sustaining quality children's health care, our organization informs and educates elected officials and community leaders about the importance of Medicaid and the need to adequately fund the program. We will continue these efforts throughout the duration of waiver to ensure existing programs and services will be maintained and expanded.

Five year expected outcome for provider and patients:
Texas Children's Hospital expects to see improvements in access to subspecialty care for our pediatric patients; this in turn will improve patient satisfaction due to the delivery of the right care at the right place at the right time.

Starting Point/Baseline:
The baseline for patient volumes in FY 12 is 12,150. Our fiscal year runs from October 1st to September 30th. The baseline patient cycle time for FY12 in minutes: CCC – 85; Clear Lake Health Center – 90; CyFair Health Center 124 Sugarland Health Center – 65; West Campus – 85 minutes; The Woodlands Health Center – 69. The average across all locations of care 84 (note this is not a weighted average and includes time that the patient spends alone this is not average of minutes spent with provider)

Rationale:
This project will create increased capacity through more efficient operations and new physician recruitment. Our project significantly enhances TCH's existing pediatric otolaryngology services to improve patient satisfaction by aspiring to provide the right care in the right setting at the right

time. In order to increase access Otolaryngology is working to expand its services with a Voice & Swallowing clinic and multi-disciplinary Aerodigestive clinic. The expansion of this service is necessary as many of our patients have medically complex conditions involving the airway, pulmonary function, upper digestive tract, as well as feeding disorders resulting from prematurity, congenital anomalies, trauma, etc. To improve patient outcomes and overall health status of these patients, access must be enhanced so that conditions can be treated timely and effectively.

Project Components:
Through the expanded access to specialty care, we propose to meet all required project components listed and these selected milestones and metrics do relate to project components.

- ccc. Conduct specialty care gap assessment based on community need for subspecialty.
- ddd. Implement transparent standardized referrals across the system
- eee. Increase specialty care volume of visits and evidence of improved access for patients seeking services
- fff. Increase service availability hours and increase number of specialty clinic locations.
- ggg. Conduct quality improvement for projects including rapid cycle and learning collaborative exchanges. It is our goal to reach the industry standard of less than 14 days for the 3rd available appointment.

Inadequate access to specialty care has contributed to the limited scope and size of safety net health systems. For children with health care needs that exceed the abilities of the primary care provider, access to and coordination with subspecialty care is critical to ensuring the provision of efficient and effective health care and in securing a comprehensive medical home.[159]

Milestones and Metrics
The following milestones and metrics have been chosen for the project based on the core components and the needs of the targeted pediatric population.

- Process milestone and metrics: P-1 (P-1.1); P-8 (P-8.1); P-17 (P-17.1)
- Improvement milestones and metrics: I-23 (I-23.1)

Unique community need identification number the project addresses:

- CN.2: Inadequate access to specialty care.
- CN.6: Inadequate access to treatment and services designed for children.

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
The resources provided by this project will allow us to significantly expand our current program. Increased collaboration and the ability to grow programs are currently things we focusing on. To provide comprehensive multidisciplinary care for our patients the Otolaryngology Division has partnerships with other departments within the hospital including Audiology, Speech Language

[159] Redlener, Irwin, Grant Roy, and Krol David M. "Beyond Primary Care: Ensuring Access to Subspecialists, Special Services, and Health Care Systems for Medically Underserved Children." *Advances in Pediatrics*. 52 (2005): 9-22.

and Learning, Pediatric General Surgery, Texas Children's Cancer Center, Neurology, Pediatric Radiology, GI, Pulmonary, and Plastic Surgery.

Related Category 3 Outcome Measure(s):
OD-5 Cost of Care
IT-5.1: Improved cost savings
IT-5.2: Per episode of care cost
IT-5.3: Length of stay

Reasons/rationale for selecting the outcome measures:
Our project will increase appropriate access to care. Increased access to appropriate subspecialty care leads to better long term outcomes in children and reduction in unnecessary health care costs.[160]

Relationship to other Projects: All of Texas Children's projects are working to expand access to subspecialty care for the pediatric population. Texas continues to have a growing pediatric population and a shortage of specialized pediatric providers.

Relationship to Other Performing Providers' Projects : This project will compliment other projects designed to improve appropriate access to specialty care, improve chronic care management, and those designed to improve the patient experience.

Plan for Learning Collaborative: We plan to participate in a region-wide learning collaborative as offered by the anchor for Region 3, Harris Health System. Our participation in this collaborative with other performing providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our region's health care system.

Project Valuation: This project's value is based on the benefits related to cost avoidance of medical expenses and improved quality of life. For example, increased provider capacity leads to reduction in emergency room visits and reduction in inpatient hospital visits.[161] Our valuation also includes an increase in the patient's quality of life. We are using a conservative Quality Adjusted Life Year ("QALY") per year and a percentage of that QALY for the pediatric population.[162] The QALY is used as a one-time improvement in the quality of life, even though we know the patient's quality of life will be improved for many years. We recognize that this is a government funded waiver and thus we chose to have conservative valuations out of respect for the taxpayer funded program.

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[160] *Reducing Costs Through the Appropriate Use of Specialty Services*. Cambridge: Institute for Healthcare Improvement, 2007.
[161] Smith, John T, Price, Christopher, Stevens Peter M., Masters, Kevin S., and Young, Mark. "Selected Topics - Does Pediatric Orthopedic Subspecialization Affect Hospital Utilization and Charges?" *Journal of Pediatric Orthopedics*. 19.4 (1999): 553-555.
[162] Brannon, Ike. "Risk - What Is a Life Worth? Despite Its Prima Facie Callousness, Determining the Value of a Human Life Is Necessary for Good Public Policy." *Regulation*. 27.4 (2004): 60-63.

139135109.1.12	***1.9.2***	***A-D***	***EXPAND ACCESS TO SPECIALTY CARE: OTOLARYNGOLOGY PEDIATRIC CARE***
Texas Children's Hospital			*139135109*
Related Category 3 Outcome Measure(s):	*139135109.3.32* *139135109.3.33* *139135109.3.34*	*IT- 5.1* *IT-5.2* *IT-5.3*	*Improved cost savings* *Per episode of care cost* *Length of stay*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 (P-1): Conduct specialty care gap assessment to determine barriers to accessing subspecialty care Metric 1 P-1.1 Documentation of gap assessment Data Source: Gap Assessment Milestone 1 Estimated Incentive Payment: $479,375 **Milestone 2 (P-8):** Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements. Metric 1 [P-8.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: Participate in all semi-annual face-to-face meetings or seminars.	**Milestone 3 (P-17):** Implement the re-design of Texas Children's Otolaryngology Clinic to increase operational efficiency, shorten patient cycle time and increase provider productivity. Metric 1 (P-17.1): Number of medical specialty clinics that have completed clinic redesign. Goal: Our goal will be to improve patient cycle time by 3% Data Source: EPIC/ EDW Milestone 3 Estimated Incentive Payment: $522,972.50 **Milestone 4 [P-8]:** Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements. Metric 1 [P-8.1]: Participate in semi-annual face-to-face meetings or	**Milestone 5 (I-23):** Increase clinic volume of visits and evidence of improved access for patients seeking services. Metric 1(I-23.1): Documentation of increased number of visits. Demonstrate improvement over prior reporting period (baseline established in FY12). a. Total number of visits for reporting period b. Data Source: EPIC/EDW Goal: Increase clinic volume 3% across all locations of care Milestone 5 Estimated Incentive Payment: $524,492.50 **Milestone 6 [P-8]:** Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to	**Milestone 7 (I-23):** Increase clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 (I-23.1): Documentation of increased number of visits. Demonstrate improvement over prior reporting period (baseline established in FY12). a. Total number of visits for reporting period b. Data Source: EPIC/EDW Goal: Increase clinic volume 6% across all locations of care Milestone 7 Estimated Incentive Payment: $433,276.50 **Milestone 8 [P-8]:** Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing

139135109.1.12	**1.9.2**	**A-D**	**EXPAND ACCESS TO SPECIALTY CARE: OTOLARYNGOLOGY PEDIATRIC CARE**
Texas Children's Hospital			*139135109*
Related Category 3 Outcome Measure(s):	*139135109.3.32* *139135109.3.33* *139135109.3.34*	*IT- 5.1* *IT-5.2* *IT-5.3*	*Improved cost savings* *Per episode of care cost* *Length of stay*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Milestone 2 Estimated Incentive Payment: $479,375	seminars organized by the RHP. Goal: Participate in all semi-annual face-to-face meetings or seminars. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Milestone 4 Estimated Incentive Payment: $522,972.50	implementing these improvements. <u>Metric 1</u> [P-8.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: Participate in all semi-annual face-to-face meetings or seminars. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Milestone 6 Estimated Incentive Payment: $524,492.50	these improvements. <u>Metric 1</u> [P-8.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: Participate in all semi-annual face-to-face meetings or seminars. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Milestone 8 Estimated Incentive Payment: $433,276.50
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $958,750	Year 3 Estimated Milestone Bundle Amount: $1,045,945	Year 4 Estimated Milestone Bundle Amount:1,048,985	Year 5 Estimated Milestone Bundle Amount:$866,553
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)**:**$3,920,233*			

Project Option: 1.9.2 Expand Access to Specialty Care: Pediatric Plastic Surgery

Unique Project ID: 139135109.1.13

Performing Provider Name/TPI: Texas Children's Hospital/139135109

Project Summary: Increase outpatient access for Harris County and the surrounding communities to care for pediatric patients needing treatment and surgical correction of cleft lip and palate anomalies amongst other diagnosis.

Provider:
Texas Children's Hospital, located in Houston, is the largest free standing children's hospital in the county specializing in the care of medically fragile children in Houston and across the country as a regional safety net provider. We currently are licensed for 564 beds and in 2011 we had over 2.7 million patient encounters. Our mission is to provide the finest possible pediatric patient care, education, and research. Texas Children's is an integrated delivery system comprising of a health plan for Medicaid and CHIP pregnant women and children, the nation's largest general pediatrician group and two world class hospitals.

Volume Statistics - FY2012	Patient Payor Mix	Patient Demographics
Hospital Admissions- 25,966 Births (babies delivered)- 2,181 Emergency visits-113,586 Outpatient visits- 3,066,765	Medicaid and CHIP- 53.6% Commercial Insurance- 40.6% Self-Pay- 1.8% Medicare- 1.2%	Hispanic- 35.9% African American- 16.6% Caucasian- 31.0% Asian- 3.8% Other- 12.4% American Indian- 0.3%

Intervention(s): The Plastic Surgery division has and will continue to add clinic coverage at Texas Children's West Campus and expand its clinical locations. Other programs the division is working to establish are hand and microvascular surgery, Craniosynostosis, Peripheral Nerve, Oral Surgery, and Orthognathic Surgery.
Need for the project: There is no ACGME Pediatric Plastics program, so many of the providers dip into the adult practice as well as pediatric. Plastic Surgery can be invaluable to help children's psychological needs that are associated with deformomities. Given the high demand and provider shortage currently the average 3rd Available for a patient with a cleft lip and palate diagnosis is greater than 30 days.

Target Population: Our target population is pediatric patients needing treatment and surgical correction of cleft lip and palate anomalies amongst other diagnosis.

Category 1 or 2 expected patient benefits:
I-23.1: Our goal is to increase the number of visits by 3% in DY3, by 3% in DY4, and by 6% in DY5 compared to baseline established in DY2.

Category 3 outcomes: IT-5 Improving Cost of Care

Project Option: 1.9.2 Expand Access to Specialty Care: Pediatric Plastic Surgery

Unique Project ID: 139135109.1.13
Performing Provider Name/TPI: Texas Children's Hospital/139135109

Project Description:
Texas Children's Hospital proposes to expand capacity for Pediatric Plastic Surgery.

Texas Children's Hospital, located in Houston, is the largest free standing children's hospital in the county specializing in the care of medically fragile children in Houston and across the country as a regional safety net provider. We currently are licensed for 564 beds at our main campus and West Houston facilities. In 2011 we had over 2.7 million patient encounters. Our mission is to provide the finest possible pediatric patient care, education, and research. Texas Children's is an integrated delivery system comprising of a health plan for Medicaid and CHIP pregnant women and children, the nation's largest general pediatrician group and two world class hospitals. Texas Children's supports a commitment to quality service and cost-effective care to enhance the health and well-being of children locally, nationally and internationally.

Specifically, this project will increase capacity within Pediatric Plastic Surgery. Funding for this project will allow Texas Children's to fulfill our tri-part mission of providing quality pediatric care, training the next generation of pediatric providers and investigating ways to improve care through innovative therapies. The Texas Children's ("TCH") Plastic Surgery Division provides treatment and surgical correction of cleft lip and palate anomalies amongst other diagnosis. The Plastic Surgery Division recently began performing Orthognathic Surgery, a specialized procedure to help correct the misalignment of the upper and lower jaws in certain types of cleft palate disorders. Plastic Surgery has and will continue to add clinic coverage at Texas Children's West Campus, and expand its clinical locations. Other programs the Plastic Surgery Division is working to establish are hand and microvascular surgery, Craniosynostosis, Peripheral Nerve, and Oral Surgery. TCH uses the industry standard of 3rd available appointment as a measure of access to care - ideal access would be less than 14 days. However, given the high demand and provider shortage, currently the average 3rd Available for a patient with a cleft lip and palate diagnosis is greater than 30 days.

Goals and Relationship to Regional Goals:

Project Goals: To meet the growing demand for high impact pediatric plastic surgery services, TCH will:

1) Focus on provider productivity to optimize clinical time for all providers,
2) Establish an initiative to review scheduling processes to increase the availability of these targeted providers,
3) Expand internal capacity by hiring additional clinical providers and
4) Enhance service availability by targeting new providers to not only work in the Texas Medical Center but to also serve 1-3 additional community locations for specialty care,

This project meets the following Region 3 Goals:

- Increased access to specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their conditions, regardless of where they reside or their ability to pay for care.
- Develop a regional approach to healthcare delivery that leverages and improves on existing programs and infrastructure, is responsive to patients' needs throughout the entire region, and improves health care outcomes and patient satisfaction

Challenges: There is no ACGME Pediatric Plastics program, so many of the providers dabble in adult practice as well as pediatric. Plastic Surgery can be invaluable to help children's psychological needs that are associated with deformities.[163] Unfortunately, due to monetary constraints in health care budgets, corrective surgeries are often viewed as 'elective or cosmetic' and not reimbursable or lowly reimbursed. [164]In Texas, limited Medicaid reimbursement is an ongoing challenge for children's hospitals and the workforce that provides health care services for the pediatric population enrolled in this program. As advocates for improving and sustaining quality children's health care, our organization informs and educates elected officials and community leaders about the importance of Medicaid and the need to adequately fund the program. We will continue these efforts throughout the duration of waiver to ensure existing programs and services will be maintained and expanded. While we continue to increase our overall outpatient volumes at all of our locations by 5.7% year over year in our pediatric physician practices, we still have not been able to significantly decrease the patient available appointment wait time. By reconfiguring clinic processes, scheduling and the addition of more providers, we will try to improve this measure.

Five year expected outcome for provider and patients:
Texas Children's Hospital expects to see improvements in access to subspecialty care for our pediatric patients; this in turn will improve patient satisfaction due to the delivery of the right care at the right place at the right time.

Starting Point/Baseline:
The baseline of patient volume in FY 2012 is 2,250. Our fiscal year runs from October 1st to September 30th. The baseline patient cycle time across all locations is 170 minutes (Clinical Care Center – 145 minutes; West Campus – 25 minutes) (Note this includes time that the patient spends alone this is not average of minutes spent with provider)

Rationale:
The significant increase in access to specialty care created by this project attempts to address the growing demands in our community for specialized pediatric providers. This project will create

[163] Andersson, G.-B., Gillberg, C., Fernell, E., Johansson, M., & Nachemson, A. (November 01, 2011). Children with surgically corrected hand deformities and upper limb deficiencies: Self-concept and psychological well-being. *Journal of Hand Surgery: European Volume, 36,* 9, 795-801.

[164] Pierce, T. R., Mehlman, C. T., Tamai, J., & Skaggs, D. L. (January 01, 2012). Access to care for the adolescent anterior cruciate ligament patient with Medicaid versus private insurance. *Journal of Pediatric Orthopedics, 32,* 3.)

increased capacity through more efficient operations and new physician recruitment. Our project significantly enhances TCH's existing pediatric plastic surgery services to improve patient satisfaction by aspiring to provide the right care in the right setting at the right time.

Cleft lip and palate are among the most common genetic defects in the United States. Cleft patients have complex needs that require lifelong care, treatment, and monitoring by an interdisciplinary team. The Texas Children's ("TCH") Plastic Surgery Division provides treatment and surgical correction of cleft lip and palate anomalies amongst other diagnosis. A new service TCH is looking to expand into is Orthognathic surgery which is typically done on patients to correct conditions of the jaw and face or who have bilateral cleft lip and palate. Orthognathic surgery is performed by an oral and maxillofacial surgeon, plastic surgeon or ENT in collaboration with an orthodontist.

Project Components: Through the expanded access to specialty care, we propose to meet all required project components listed and these selected milestones and metrics do relate to project components.

hhh. Conduct specialty care gap assessment based on community need for subspecialty.
iii. Implement transparent standardized referrals across the system
jjj. Increase specialty care volume of visits and evidence of improved access for patients seeking services
kkk. Increase service availability hours and increase number of specialty clinic locations.
lll. Conduct quality improvement for projects including rapid cycle and learning collaborative exchanges. It is our goal to reach the industry standard of less than 14 days for the 3rd available appointment.

Inadequate access to specialty care has contributed to the limited scope and size of safety net health systems. For children with health care needs that exceed the abilities of the primary care provider, access to and coordination with subspecialty care is critical to ensuring the provision of efficient and effective health care and in securing a comprehensive medical home.[165]

Milestones and Metrics

The following milestones and metrics have been chosen for the project based on the core components and the needs of the targeted pediatric population.

- Process milestone and metrics: P-1 (P-1.1); P-8 (P-8.1); P-17 (P-17.1)
- Improvement milestones and metrics: I-23 (I-23.1)

Unique community need identification number the project addresses:

- CN.2: Inadequate access to specialty care,
- CN.6: Inadequate access to treatment and services designed for children.

[165] Redlener, Irwin, Grant Roy, and Krol David M. "Beyond Primary Care: Ensuring Access to Subspecialists, Special Services, and Health Care Systems for Medically Underserved Children." *Advances in Pediatrics*. 52 (2005): 9-22.

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

With the new offerings and increase in collaborations there will be less untreated care and less out of state travel for care for our patients and families.

Related Category 3 Outcome Measure(s):
OD-5 Cost of Care
IT-5.1: Improved Cost Savings
IT-5.2: Per Episode Cost of Care
IT-5.3: Length of Stay

Reasons/rationale for selecting the outcome measures:
Our project will increase appropriate access to care. Increased access to appropriate subspecialty care leads to better long term outcomes in children and reduction in unnecessary health care costs.[166]

Children are the future of healthcare and will dictate the treatments needed as well as the cost of healthcare in future years so it is critical that they receive the access needed throughout their pediatric lives. The focus of pediatric specialty care is similar throughout the region with a concentrated focus in the Harris county proper geographic region and allows for the expansion of access to numerous specialties such as cardiology, neurology, ENT, and many more. The outcome measures focus to appropriate length of stay, per episode cost of care, and improved cost savings. The Region 3 Initiative grid allows for a cross reference of similar initiatives in our region. (addendum)

Relationship to Other Performing Providers' Projects: This project will compliment other projects designed to improve appropriate access to specialty care, improve chronic care management, and those designed to improve the patient experience.

Plan for Learning Collaborative: We plan to participate in a region-wide learning collaborative as offered by the anchor for Region 3, Harris Health System. Our participation in this collaborative with other performing providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our region's health care system.

Project Valuation: This project's value is based on the benefits related to cost avoidance of medical expenses and improved quality of life. For example, increased provider capacity leads to reduction in emergency room visits and reduction in inpatient hospital visits.[167] Our valuation also includes an increase in the patient's quality of life. We are using a conservative Quality Adjusted Life Year ("QALY") per year and a percentage of that QALY for the pediatric

[166] *Reducing Costs Through the Appropriate Use of Specialty Services*. Cambridge: Institute for Healthcare Improvement, 2007.
[167] Smith, John T, Price, Christopher, Stevens Peter M., Masters, Kevin S., and Young, Mark. "Selected Topics - Does Pediatric Orthopedic Subspecialization Affect Hospital Utilization and Charges?" *Journal of Pediatric Orthopedics*. 19.4 (1999): 553-555.

population.[168] The QALY is used as a one-time improvement in the quality of life, even though we know the patient's quality of life will be improved for many years. We recognize that this is a government funded waiver and thus we chose to have conservative valuations out of respect for the taxpayer funded program.

[168] Brannon, Ike. "Risk - What Is a Life Worth? Despite Its Prima Facie Callousness, Determining the Value of a Human Life Is Necessary for Good Public Policy." *Regulation*. 27.4 (2004): 60-63.

139135109.1.13	1.9.2	A-D	EXPAND ACCESS TO SPECIALTY CARE/ PEDIATRIC PLASTIC SURGERY
Texas Children's Hospital			139135109
Related Category 3 Outcome Measure(s):	139135109.3.33 139135109.3.34 139135109.3.35	IT- 5.1 IT-5.2 IT-5.3	Improved Cost Savings Per Episode Cost of Care Length of Stay

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1 (P-1): Conduct specialty care gap assessment to determine barriers to accessing subspecialty care Metric 1 [P-1.1] Documentation of gap assessment Data Source: Gap Assessment Milestone 1 Estimated Incentive Payment:$ 688,135.50 **Milestone 2 (P-8)** Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements. Metric 1 [P-8.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: Participate in all semi-annual face-to-face meetings or seminars.	**Milestone 3 (P-17):** Implement process improvements of Texas Children's Plastic Surgery Clinic to increase operational efficiency, shorten patient cycle time and increase provider productivity. Metric 1 (P-17.1): Number of specialty clinics that have completed clinic redesign. a. Numerator: Average cycle time of appointments in Plastic Surgery clinic that has done process improvements with patient flow and clinic workflow. b. Denominator: Overall average cycle time of appointments in Plastic Surgery c. Data Source: Specialty clinic appointment tracking system. Goal: Improve patient cycle time by 3% Milestone 3 Estimated Incentive Payment:$ 750,719 **Milestone 4 [P-8]:** Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements	**Milestone 5 (I-23):** Increase clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 (I-23.1): Documentation of increased number of visits. Demonstrate improvement over prior reporting period (baseline established in FY12). a. Total number of visits for reporting period b. Data Source: Epic/EDW Goal: Increase clinic volume 3% across all locations of care Milestone 5 Estimated Incentive Payment: $752,901.50 **Milestone 6 [P-8]:** Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to	**Milestone 7 (I-23):** Increase clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 (I-23.1): Documentation of increased number of visits. Demonstrate improvement over prior reporting period (baseline established in FY12). a. Total number of visits for reporting period b. Data Source: Epic/EDW Goal: Increase clinic volume 6% across all locations of care Milestone 7 Estimated Incentive Payment: $621,962 **Milestone 8** [P-8]: Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing

139135109.1.13	*1.9.2*	*A-D*	*EXPAND ACCESS TO SPECIALTY CARE/ PEDIATRIC PLASTIC SURGERY*
Texas Children's Hospital			139135109
Related Category 3 Outcome Measure(s):	*139135109.3.33* *139135109.3.34* *139135109.3.35*	*IT- 5.1* *IT-5.2* *IT-5.3*	*Improved Cost Savings* *Per Episode Cost of Care* *Length of Stay*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Milestone 2 Estimated Incentive Payment: $688,135.50	(simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements. Metric 1 [P-8.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: Participate in all semi-annual face-to-face meetings or seminars. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Milestone 4 Estimated Incentive Payment: $750,719	implementing these improvements. Metric 1 [P-8.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: Participate in all semi-annual face-to-face meetings or seminars. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Milestone 6 Estimated Incentive Payment: $752,901.50	these improvements. **Metric 1** [P-8.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: Participate in all semi-annual face-to-face meetings or seminars. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Milestone 8 Estimated Incentive Payment: $621,962
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone): $1,376,271*	Year 3 Estimated Milestone Bundle Amount:$1,501,438	Year 4 Estimated Milestone Bundle Amount:$1,505,803	Year 5 Estimated Milestone Bundle Amount: $1,243,924
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)**:** $5,627,436*			

Project Option: 1.9.2 Expand Pediatric Neurosurgery CareProject Option: 1.9.2 Expand Pediatric Neurosurgery Care,

Unique Project ID/TPI:139135109.1.14

Performing Provider Name/TPI: Texas Children's Hospital/ 139135109

Project Summary: Increase outpatient access for Harris County and the surrounding communities to care for pediatric patients with conditions affecting the brain and neurological system

Provider:
Texas Children's Hospital, located in Houston, is the largest free standing children's hospital in the county specializing in the care of medically fragile children in Houston and across the country as a regional safety net provider. We currently are licensed for 564 beds and in 2011 we had over 2.7 million patient encounters. Our mission is to provide the finest possible pediatric patient care, education, and research. Texas Children's is an integrated delivery system comprising of a health plan for Medicaid and CHIP pregnant women and children, the nation's largest general pediatrician group and two world class hospitals.

Volume Statistics - FY2012	Patient Payor Mix	Patient Demographics
Hospital Admissions- 25,966 Births (babies delivered)- 2,181 Emergency visits-113,586 Outpatient visits- 3,066,765	Medicaid and CHIP- 53.6% Commercial Insurance- 40.6% Self-Pay- 1.8% Medicare- 1.2%	Hispanic- 35.9% African American- 16.6% Caucasian- 31.0% Asian- 3.8% Other- 12.4% American Indian- 0.3%

Intervention(s): This project will create increased capacity through more efficient operations and new provider recruitment. In order to maintain prompt access to our Neurosurgeons the division is working to expand its services by utilizing Advanced Practice Providers who can see lower acuity patients thereby freeing up our Neurosurgeons to see more complex spine and epilepsy patients, as well as be able to expand services to fetal, craniofacial and trauma cases.
Need for the project: The purpose of this project is to meet the growing demand for high impact pediatric Neurosurgery services. There are few "skilled" surgeons that focus upon Pediatric Neurosurgery. Texas Children's Hospital became the first hospital in the world to use real-time MRI guided thermal imaging and laser technology to destroy lesions in the brain that cause Epilepsy. Currently, 100% of these post operative patients are seizure free.
Target Population:
The target population of patients being served are those patients that are comprehensive and require lifelong care.
Category 1 or 2 expected patient benefits:
I-23.1: Our goal is to increase the number of visits by 3% in DY3, by 3% in DY4, and by 6% in DY5 compared to baseline established in DY2.
Category 3 outcomes: IT-5 Improving Cost of Care

Unique Project ID/TPI:139135109.1.14
Performing Provider Name/TPI: Texas Children's Hospital/ 139135109

Project Description:
Texas Children's Hospital proposes to expand access to pediatric Neurosurgery care, enabling patients to receive care in a more timely manner and reduce wait times for appointments.

Texas Children's Hospital, located in Houston, is the largest free standing children's hospital in the county specializing in the care of medically fragile children in Houston and across the country as a regional safety net provider. We currently are licensed for 564 beds at our main campus and West Houston facilities. In 2011 we had over 2.7 million patient encounters. Our mission is to provide the finest possible pediatric patient care, education, and research. Texas Children's is an integrated delivery system comprising of a health plan for Medicaid and CHIP pregnant women and children, the nation's largest general pediatrician group and two world class hospitals. Texas Children's supports a commitment to quality service and cost-effective care to enhance the health and well-being of children locally, nationally and internationally.

Our project proposal will significantly improve access to pediatric subspecialty care. Specifically, the expansion of capacity funded by this project will allow us to increase appointment capacity in our Neurosurgery Clinic thereby improving patient access to care. While this improved access will benefit all families we expect at least half of the increased access will serve the Mediciad population. Funding for this project will allow Texas Children's to fulfill our tri-part mission of providing quality pediatric care, training the next generation of pediatric providers and investigating ways to improve care through innovative therapies.

Funding for this project will allow Texas Children's to fulfill our tri-part mission of providing quality pediatric care, training the next generation of pediatric providers and investigating ways to improve care through innovative therapies. The Texas Children's ("TCH") Neurosurgery Division is ranked # 5 in the 2012 U.S. News and World Report Best Children's Hospitals. We are one of the largest pediatric neurosurgery units in the United States. We take a collaborative approach to care; working closely with Texas Children's Cancer Center, Texas Children's Fetal Center, the comprehensive Epilepsy Program, neurology, adolescent medicine, developmental pediatrics, interventional neuroradiology, and trauma. In 2011, Texas Children's Hospital became the first hospital in the world to use real-time MRI guided thermal imaging and laser technology to destroy lesions in the brain that cause Epilepsy. Currently, 100% of these post operative patients are seizure free.

Project Goals: To meet the growing demand for high impact pediatric Neurosurgery services, TCH will:

1. Focus on provider productivity to optimize clinical time for all providers,
2. Establish an initiative to review scheduling processes to increase the availability of these targeted providers,
3. Expand internal capacity by hiring additional clinical providers, and
4. Enhance service availability by targeting new providers to not only work in the Texas Medical Center but to also serve 1-3 additional community locations.

This project meets the following Region 3 Goals:

- Increased access to specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their conditions, regardless of where they reside or their ability to pay for care.
- Develop a regional approach to healthcare delivery that leverages and improves on existing programs and infrastructure, is responsive to patients' needs throughout the entire region, and improves health care outcomes and patient satisfaction

Challenges: The challenges we are faced with are that these patients are comprehensive and require lifelong care. There are few "skilled' surgeons that focus upon Pedi Neurosurgery. There is the possibility of taking the Neurosurgery program out to West Campus but that would depend of Neurology focus and the expansion of the epilepsy and Vagas nerve stimulator – which require significant financial and intellectual investment. In Texas, limited Medicaid reimbursement is an ongoing challenge for children's hospitals and the workforce that provides health care services for the pediatric population enrolled in this program. As advocates for improving and sustaining quality children's health care, our organization informs and educates elected officials and community leaders about the importance of Medicaid and the need to adequately fund the program. We will continue these efforts throughout the duration of waiver to ensure existing programs and services will be maintained and expanded. While we continue to increase our overall outpatient volumes at all of our locations by 5.7% year over year in our pediatric physician practices, we still have not been able to significantly decrease the patient available appointment wait time. By reconfiguring clinic processes, scheduling and the addition of more providers, we will try to improve this measure.

Five year expected outcome for provider and patients:
Texas Children's Hospital expects to see improvements in access to subspecialty care for our pediatric patients; this in turn will improve patient satisfaction due to the delivery of the right care at the right place at the right time.

Starting Point/Baseline: Our fiscal year runs from October 1st to September 30th. The average 3rd available appointment at the TCH Neurosurgery Division is less than 14 days. The baseline for patient volumes in FY 12 is 3,450. The baseline for FY12 average patient cycle time is 89.98 minutes. This includes when the patient is 'alone waiting' this is not just an average of 89.98 minutes with the provider.

Rationale:
The significant increase in access to specialty care created by this project attempts to address the growing demands in our community for specialized pediatric providers. This project will create increased capacity through more efficient operations and new physician recruitment. In order to maintain prompt access to our Neurosurgeons the division is working to expand its services by utilizing the use of Advance Care Providers. These providers are able see the division's lower acuity patients thereby freeing up our neurosurgeons to see more complex spine and epilepsy patients, as well as be able to expand services to fetal, craniofacial and trauma cases. The NPPs are also able to see more patients in the Neonatal and Pediatric Intensive Care Units and provide the continuum of care from the inpatient stay through the necessary follow up in the outpatient clinic setting.

Project Components: Through the expanded access to specialty care, we propose to meet all required project components listed and these selected milestones and metrics do relate to project components.

mmm. Conduct specialty care gap assessment based on community need for subspecialty.
nnn. Implement transparent standardized referrals across the system
ooo. Increase specialty care volume of visits and evidence of improved access for patients seeking services
ppp. Increase service availability hours and increase number of specialty clinic locations.
qqq. Conduct quality improvement for projects including rapid cycle and learning collaborative exchanges. It is our goal to reach the industry standard of less than 14 days for the 3rd available appointment.

Inadequate access to specialty care has contributed to the limited scope and size of safety net health systems. For children with health care needs that exceed the abilities of the primary care provider, access to and coordination with subspecialty care is critical to ensuring the provision of efficient and effective health care and in securing a comprehensive medical home.[169]

Milestones and Metrics
The following milestones and metrics have been chosen for the project based on the core components and the needs of the targeted pediatric population.

- Process milestone and metrics: P-1 (P-1.1); P-8 (P-8.1); P-17 (P-17.1)
- Improvement milestones and metrics: I-23 (I-23.1);

Customizable Improvement Milestone and Metric was chosen in order to specifically tailor the intent of project to the targeted pediatric population.

Unique community need identification number the project addresses: CN.2: Inadequate access to specialty care., CN.6: Inadequate access to treatment and services designed for children.

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative: This project will allow Texas Children's to significantly enhance our exisiting Neurosurgery appointment availability. With the shortage of specialists in this area, TCH has had to work within the resources available nationwide to build a program that provides superior care for children with these conditions. This expansion project, through its focus on national recruitment as well as the use of mid-level providers for care, aims to improve access to these services for children in the state of Texas.

Related Category 3 Outcome Measure(s):
OD-5 Cost of Care
Reasons/rationale for selecting the outcome measures:

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[169] Redlener, Irwin, Grant Roy, and Krol David M. "Beyond Primary Care: Ensuring Access to Subspecialists, Special Services, and Health Care Systems for Medically Underserved Children." *Advances in Pediatrics*. 52 (2005): 9-22.

Our project will increase appropriate access to care. Increased access to appropriate subspecialty care leads to better long term outcomes in children and reduction in unnecessary health care costs.[170]

Relationship to other Projects: All of Texas Children's projects are working to expand access to subspecialty care for the pediatric population. Texas continues to have a growing pediatric population and a shortage of specialized pediatric providers.

Children are the future of healthcare and will dictate the treatments needed as well as the cost of healthcare in future years so it is critical that they receive the access needed throughout their pediatric lives. The focus of pediatric specialty care is similar throughout the region with a concentrated focus in the Harris county proper geographic region and allows for the expansion of access to numerous specialties such as cardiology, neurology, ENT, and many more. The outcome measures focus to appropriate length of stay, per episode cost of care, and improved cost savings. The Region 3 Initiative grid allows for a cross reference of similar initiatives in our region. (addendum)

Plan for Learning Collaborative: We plan to participate in a region-wide learning collaborative as offered by the anchor for Region 3, Harris Health System. Our participation in this collaborative with other performing providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our region's health care system.

Project Valuation: This project's value is based on the benefits related to cost avoidance of medical expenses and improved quality of life. For example, increased provider capacity leads to reduction in emergency room visits and reduction in inpatient hospital visits.[171] Our valuation also includes an increase in the patient's quality of life. We are using a conservative Quality Adjusted Life Year ("QALY") per year and a percentage of that QALY for the pediatric population.[172] The QALY is used as a one-time improvement in the quality of life, even though we know the patient's quality of life will be improved for many years. We recognize that this is a government funded waiver and thus we chose to have conservative valuations out of respect for the taxpayer funded program.

[170] *Reducing Costs Through the Appropriate Use of Specialty Services*. Cambridge: Institute for Healthcare Improvement, 2007.
[171] Smith, John T, Price, Christopher, Stevens Peter M., Masters, Kevin S., and Young, Mark. "Selected Topics - Does Pediatric Orthopedic Subspecialization Affect Hospital Utilization and Charges?" *Journal of Pediatric Orthopedics*. 19.4 (1999): 553-555.
[172] Brannon, Ike. "Risk - What Is a Life Worth? Despite Its Prima Facie Callousness, Determining the Value of a Human Life Is Necessary for Good Public Policy." *Regulation*. 27.4 (2004): 60-63.

139135109.1.14	*1.9.2*	*1.9.2 A-D*	*EXPAND SPECIALTY ACCESS TO NEUROSURGERY CARE*
Texas Children's Hospital			139135109
Related Category 3 Outcome Measure(s):	*139135109.3.36* *139135109.3.37* *139135109.3.38*	*IT- 5.1* *IT-5.2* *IT-5.3*	*Cost of Care*

Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Milestone 1 (P-1): Conduct specialty care gap assessment to determine barriers to accessing subspecialty care **Metric P-1.1** Documentation of gap assessment Data Source: Gap Assessment Milestone 1 Estimated Incentive Payment: $327,962 **Milestone 2 (P-8)** Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements. **Metric 1 [P-8.1]:** Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: Participate in all semi-annual face-to-face meetings or seminars. Data Source: Documentation of semiannual meetings including meeting agendas, slides from	**Milestone 3 (P-17):** Implement the re-design of Texas Children's Neurosurgery Clinic to increase operational efficiency, shorten patient cycle time and increase provider productivity. **Metric 3 (P-17.1):** Number of specialty clinics that have completed clinic redesign. a. Numerator: Average cycle time of appointments in Neurosurgery clinic that has undergone re-design. b. Denominator: Overall average cycle time of appointments in the Neurosurgery clinic c. Data Source: EPIC/ EDW Goal: Our goal will be to improve patient cycle time by 3% Milestone 3 Estimated Incentive Payment:$ 357,789 **Milestone 4 [P-8]:** Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance).	**Milestone 5 (I-23):** Increase care clinic volume of visits and evidence of improved access for patients seeking services. **Metric 5 (I-23.1)**: Documentation of increased number of visits. Demonstrate improvement over prior reporting period (baseline established in FY12). a. Total number of visits for reporting period b. Data Source: Epic/EDW Goal: Increase clinic volume 3% across all locations of care Milestone 5 Estimated Incentive Payment: $358,829 **Milestone 6 [P-8]:** Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements.	**Milestone 7 (I-23)**: Increase care clinic volume of visits and evidence of improved access for patients seeking services. **Metric 7 (I-23.1)**: Documentation of increased number of visits. Demonstrate improvement over prior reporting period (baseline established in FY12). a. Total number of visits for reporting period b. Data Source: Epic/EDW Goal: Increase clinic volume 6% across all locations of care Milestone 5 Estimated Incentive Payment: $296,424 **Milestone 8 [P-8]:** Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements.

139135109.1.14	***1.9.2***	***1.9.2 A-D***		***EXPAND SPECIALTY ACCESS TO NEUROSURGERY CARE***
Texas Children's Hospital				139135109
Related Category 3 Outcome Measure(s):	*139135109.3.36* *139135109.3.37* *139135109.3.38*	*IT- 5.1* *IT-5.2* *IT-5.3*	*Cost of Care*	

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
presentations, and/or meeting notes. Milestone 2 Estimated Incentive Payment: $327,962	Each participating provider should publicly commit to implementing these improvements. **Metric 1 [P-8.1]:** Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: Participate in all semi-annual face-to-face meetings or seminars. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Milestone 4 Estimated Incentive Payment: $357,789	**Metric 6 [P-8.1]:** Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: Participate in all semi-annual face-to-face meetings or seminars. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Milestone 6 Estimated Incentive Payment: $358,829	**Metric 8 [P-8.1]:** Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: Participate in all semi-annual face-to-face meetings or seminars. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Milestone 8 Estimated Incentive Payment: $296,424
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $655,924	Year 3 Estimated Milestone Bundle Amount:$715,578	Year 4 Estimated Milestone Bundle Amount:$717,658	Year 5 Estimated Milestone Bundle Amount: $592,848
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)**:** $2,682,008*			

Project Option -1.9.2 Expand Access to Specialty Care: Orthopedic Pediatric Care

Unique Project ID: 139135109.1.15

Performing Provider Name/TPI: Texas Children's Hospital/ 139135109

Project Summary: Increase outpatient access for Harris County and the surrounding communities to care for pediatric patients with simple to high complex acute or chronic orthpedic problems.

Provider:
Texas Children's Hospital, located in Houston, is the largest free standing children's hospital in the county specializing in the care of medically fragile children in Houston and across the country as a regional safety net provider. We currently are licensed for 564 beds and in 2011 we had over 2.7 million patient encounters. Our mission is to provide the finest possible pediatric patient care, education, and research. Texas Children's is an integrated delivery system comprising of a health plan for Medicaid and CHIP pregnant women and children, the nation's largest general pediatrician group and two world class hospitals.

Volume Statistics - FY2012	**Patient Payor Mix**	**Patient Demographics**
Hospital Admissions- 25,966 Births (babies delivered)- 2,181 Emergency visits-113,586 Outpatient visits- 3,066,765	Medicaid and CHIP- 53.6% Commercial Insurance- 40.6% Self-Pay- 1.8% Medicare- 1.2%	Hispanic- 35.9% African American- 16.6% Caucasian- 31.0% Asian- 3.8% Other- 12.4% American Indian- 0.3%

Intervention(s): The division is working to enhance its sub-specialization in the following areas of Sports Medicine, Orthopedic Oncology, Leg and Limb Deformity, and Hand/Upper Extremity. TCH West Campus will expand services to include a new sports medicine program.
Need for the project: The division of Orthopedics provides 24/7 emergency coverage at TCH Medical Center Campus, Outpatient, Operating Room, and emergency services at TCH West Campus. The number of children referred into the TCH Orthopedics clinic averages 230 referrals per month. In FY10 and FY11 the averge 3rd Available appoitnment at the TCH Orthopedics cilnic is greater than 30 days. Due to the demand and the wait times and access into the service our patients do not get the care they need and therefore are faced living with "treatable" defomities.
Target Population: Our target population is pediatric patients with simple to high complex acute or chronic orthpedic problems. One particular area of focus will be the interdiscpliary Sports Medicine program for patients from the physically active to the pediatric or adolsecent athlete.
Category 1 or 2 expected patient benefits:
I-23.1: Our goal is to increase the number of visits by 3% in DY3, by 3% in DY4, and by 6% in DY5 compared to baseline established in DY2.
Category 3 outcomes: IT-5 Improving Cost of Care

Project Option -1.9.2 Expand Access to Specialty Care: Orthopedic Pediatric Care

Unique Project ID: 139135109.1.15
Performing Provider Name/TPI: Texas Children's Hospital/ 139135109

Project Description:
Texas Children's Hospital proposes to expand access to pediatric orthopedic care, enabling patients to receive care in a more timely manner and reduce wait times for appointments.

Texas Children's Hospital, located in Houston, is the largest free standing children's hospital in the county specializing in the care of medically fragile children in Houston and across the country as a regional safety net provider. We currently are licensed for 564 beds at our main campus and West Houston facilities. In 2011 we had over 2.7 million patient encounters. Our mission is to provide the finest possible pediatric patient care, education, and research. Texas Children's is an integrated delivery system comprising of a health plan for Medicaid and CHIP pregnant women and children, the nation's largest general pediatrician group and two world class hospitals. Texas Children's supports a commitment to quality service and cost-effective care to enhance the health and well-being of children locally, nationally and internationally.

Our project proposal will significantly improve access to pediatric subspecialty care. The Texas Children's ("TCH") Orthopedics Division is ranked # 33 in the 2012 U.S. News and World Report Best Children's Hospitals. Orthopedics provides 24/7 emergency coverage at TCH. Outpatient, Operating Room, and emergency services are available at TCH West Campus, and clinics are held at all TCH Health Center locations. From minor fractures to complex disorders the Orthopedic Surgery division at Texas Children's Hospital provides exemplary care for pediatric patients from newborn to skeletal maturity with simple to high complex acute or chronic orthopedic problems. In 2010, the Orthopedic Surgery division established the Adolescent and Young Adult Hip clinic, the only one of its kind in the region and focuses on diagnosis and treatment of hip conditions.

The division is currently working to continue to enhance is sub-specialization in the following areas of Sports Medicine, Orthopedic Oncology, Leg and Limb Deformity, and Hand/Upper Extremity. Texas Children's West Campus will expand patient services to include a new Sports Medicine Program dedicated to treating children for all types of sports-related injuries and disorders. This new program will utilize an interdisciplinary approach for the diagnosis, evaluation and treatment of children and adolescents from the physically active to the pediatric or adolescent athlete. Currently referrals into the TCH pediatric Orthopedics clinic average 230 referrals per month. New programs within the Orthopedic Surgery Department include Sports Medicine, Ortho Oncology, Leg and Limb Deformities, and Hand and Upper Extremity subspecialization. TCH uses the industry standard of 3rd available appointment as a measure of access to care - ideal access would be less than 14 days. However, given the high demand and provider shortage, for the majority of FY10 and FY11, the average 3rd Available appointment at the TCH Orthopedics clinic is greater than 30 days.

Goals and Relationship to Regional Goals:

Project Goals: To meet the growing demand for acute pediatric orthopedic services, TCH will:

- Focus on provider productivity to optimize clinical time for all providers and enhance training of subspecialists and fellows,
- Establish an initiative to review scheduling processes to increase the appointment availability of these targeted providers that aligns with new clinic capacity,
- Expand provider capacity by hiring additional clinicians and support staff,
- Expand service availability through the provision of services with additional providers not only in the Texas Medical Center clinic site, but also in at least 1-3 community care settings.

This project meets the following Region 3 Goals:

- Increased access to specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their conditions, regardless of where they reside or their ability to pay for care.
- Develop a regional approach to healthcare delivery that leverages and improves on existing programs and infrastructure, is responsive to patients' needs throughout the entire region, and improves health care outcomes and patient satisfaction

Challenges:

Some of the challenges we may face while trying to improve access in the Orthopedics area is with providers who have an adult practice as well as pediatric patient panel. Due to demand and the wait times and access into the service our patients do not get the care need, and therefore are faced living with "treatable" deformities. In many cases these deformities can lead to other health issues. In Texas, limited Medicaid reimbursement is an ongoing challenge for children's hospitals and the workforce that provides health care services for the pediatric population enrolled in this program. As advocates for improving and sustaining quality children's health care, our organization informs and educates elected officials and community leaders about the importance of Medicaid and the need to adequately fund the program. We will continue these efforts throughout the duration of waiver to ensure existing programs and services will be maintained and expanded. While we continue to increase our overall outpatient clinic volumes at all of our locations by 5.7% year over year in our pediatric physician practices, we still have not been able to significantly decrease the patient available appointment wait time. By reconfiguring clinic processes, scheduling and the addition of more providers, we will try to improve this measure.

Five year expected outcome for provider and patients:
Texas Children's Hospital expects to see improvements in access to subspecialty care for our pediatric patients; this in turn will improve patient satisfaction due to the delivery of the right care at the right place at the right time.

Starting Point/Baseline:
The average 3rd Available appointment at the TCH Orthopedics clinic is greater than 30 days. The baseline of patient volumes in FY 12 is 6,350. Our fiscal year runs from October 1st to September 30th. The baseline average patient cycle time in FY12 in minutes: Clinical Care Center-90 minutes; Clear Lake Health Center-87 minutes; CyFair – 96 minutes; Sugarland- 98

minutes; The Woodlands-78 minutes; West Campus – 85 minutes. (Note this is not a weighted average and includes time that the patient spends alone this is not average of minutes spent with provider)

<u>Rationale:</u>

Reasons for selecting project option:

Pediatric orthopedic specialists diagnose, treat, and manage children's musculoskeletal problems including Limb and spine deformities (such as club foot, scoliosis), Gait abnormalities (limping), Bone and joint infections and broken bones. Texas Children's Hospital is a level 1 trauma center; therefore, sees an increasing number of children who may require orthopedic services. Likewise, its orthopedics division is nationally recognized for its treatment and diagnosis of rare musculoskeletal diseases/abnormalities. For many families living in the Gulf coast region of the United States, our orthopedics department is the sole point of care for their medically complex child or a child who may suffer from a rare bone/muscular abnormality or joint disorder.

Project Components:

Through the expanded access to specialty care, we propose to meet all required project components listed and these selected milestones and metrics do relate to project components.

- rrr. Conduct specialty care gap assessment based on community need for subspecialty.
- sss. Implement transparent standardized referrals across the system
- ttt. Increase specialty care volume of visits and evidence of improved access for patients seeking services
- uuu. Increase service availability hours and increase number of specialty clinic locations.
- vvv. Conduct quality improvement for projects including rapid cycle and learning collaborative exchanges. It is our goal to reach the industry standard of less than 14 days for the 3rd available appointment.

Inadequate access to specialty care has contributed to the limited scope and size of safety net health systems. For children with health care needs that exceed the abilities of the primary care provider, access to and coordination with subspecialty care is critical to ensuring the provision of efficient and effective health care and in securing a comprehensive medical home.[173]

The following milestones and metrics have been chosen for the project based on the core components and the needs of the targeted pediatric population.

- Process milestone and metrics: P-1 (P-1.1); P-8 (P-8.1); P-17 (P-17.1)
- Improvement milestones and metrics: I-23 (I-23.1); I-X (I-X.1)

Customizable Improvement Milestone and Metric was chosen in order to specifically tailor the intent of project to the targeted pediatric population.

Unique community need identification number the project addresses:

- CN.2: Inadequate access to specialty care. CN.6: Inadequate access to treatment and services designed for children.

[173] Redlener, Irwin, Grant Roy, and Krol David M. "Beyond Primary Care: Ensuring Access to Subspecialists, Special Services, and Health Care Systems for Medically Underserved Children." *Advances in Pediatrics*. 52 (2005): 9-22.

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
This project will significantly enhance current services by providing new care to the patient population. Expanding locations provides increased access and convenience for patients and their families. Also being able to utilize a health system for best outcomes thru a multi-specialty collaboration will enhance the existing delivery system initiative.

Related Category 3 Outcome Measure(s):
OD-5 Cost of Care
IT 5.1: Improved Cost Savings
IT 5.2: Per Episode Cost of Care
IT 5.3: Other Outcome Improvement Target: Reduced Length of Stay

Reasons/rationale for selecting the outcome measures:
Our project will increase appropriate access to care. Increased access to appropriate subspecialty care leads to better long term outcomes in children and reduction in unnecessary health care costs.[174]

Relationship to other Projects: All of Texas Children's projects are working to expand access to subspecialty care for the pediatric population. Texas continues to have a growing pediatric population and a shortage of specialized pediatric providers.

the cost of healthcare in future years so it is critical that they receive the access needed throughout their pediatric lives. The focus of pediatric specialty care is similar throughout the region with a concentrated focus in the Harris county proper geographic region and allows for the expansion of access to numerous specialties such as cardiology, neurology, ENT, and many more. The outcome measures focus to appropriate length of stay, per episode cost of care, and improved cost savings. The Region 3 Initiative grid allows for a cross reference of similar initiatives in our region. (addendum)

Plan for Learning Collaborative: We plan to participate in a region-wide learning collaborative as offered by the anchor for Region 3, Harris Health System. Our participation in this collaborative with other performing providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our region's health care system.

Project Valuation: This project's value is based on the benefits related to cost avoidance of medical expenses and improved quality of life. For example, increased provider capacity leads to reduction in emergency room visits and reduction in inpatient hospital visits.[175] Our valuation

[174] *Reducing Costs Through the Appropriate Use of Specialty Services*. Cambridge: Institute for Healthcare Improvement, 2007.
[175] Smith, John T, Price, Christopher, Stevens Peter M., Masters, Kevin S., and Young, Mark. "Selected Topics - Does Pediatric Orthopedic Subspecialization Affect Hospital Utilization and Charges?" *Journal of Pediatric Orthopedics*. 19.4 (1999): 553-555.

also includes an increase in the patient's quality of life. We are using a conservative Quality Adjusted Life Year ("QALY") per year and a percentage of that QALY for the pediatric population.[176] The QALY is used as a one-time improvement in the quality of life, even though we know the patient's quality of life will be improved for many years. We recognize that this is a government funded waiver and thus we chose to have conservative valuations out of respect for the taxpayer funded program.

[176] Brannon, Ike. "Risk - What Is a Life Worth? Despite Its Prima Facie Callousness, Determining the Value of a Human Life Is Necessary for Good Public Policy." *Regulation*. 27.4 (2004): 60-63.

139135109.1.15	*1.9.2*	*A-D*	*EXPAND SPECIALTY ACCESS TO ORTHOPEDIC SURGERY CARE*
Texas Children's Hospital			*139135109*
Related Category 3 Outcome Measure(s):	*139135109.3.39* *139135109.3.40* *139135109.3.41*	*IT- 5.1* *IT-5.2* *IT-5.3*	*Improved Cost Savings* *Per Episode Cost of Care* *Other Outcome Improvement Target: Reduced Length of Stay*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 (P-1): Conduct specialty care gap assessment to determine barriers to accessing subspecialty care Metric 1[P-1.1]: Documentation of gap assessment Data Source: Gap Assessment Milestone 1 Estimated Incentive Payment: $889,335.50 **Milestone 2 (P-8):** Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements. Metric 1 [P-8.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: Participate in all semi-annual face-to-face meetings or seminars.	**Milestone 3 (P-17):** Implement process improvements of Texas Children's Orthopedic Surgery Clinic to increase operational efficiency, shorten patient cycle time and increase provider productivity. Metric 1 (P-17.1): Number of specialty clinics that have completed clinic redesign. a. Numerator: Average cycle time of appointments in Orthopedic Surgery clinic that has performed process improvements with patient flow and clinic workflow. b. Denominator: Overall average cycle time of appointments in the Orthopedics Clinic c. Data Source: EPIC/ EDW Goal: Our goal will be to improve patient cycle time by 3% Milestone 3 Estimated Incentive Payment: $970,217 **Milestone 4 [P-8]:** Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify	**Milestone 5 (I-23):** Increase clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 (I-23.1): Documentation of increased number of visits. Demonstrate improvement over prior reporting period (baseline established in FY12). a. Total number of visits for reporting period b. Data Source: Epic/EDW Goal: Increase clinic volume 3% across all locations of care Milestone 5 Estimated Incentive Payment: $973,037.50 **Milestone 6 [P-8]:** Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to	**Milestone 7 (I-23):** Increase clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 (I-23.1): Documentation of increased number of visits. Demonstrate improvement over prior reporting period (baseline established in FY12). a. Total number of visits for reporting period b. Data Source: Epic/EDW Goal: Increase clinic volume 6% across all locations of care Milestone 7 Estimated Incentive Payment: $803,813.50 **Milestone 8 [P-8]:** Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing

139135109.1.15	*1.9.2*	*A-D*	*EXPAND SPECIALTY ACCESS TO ORTHOPEDIC SURGERY CARE*
Texas Children's Hospital			*139135109*
Related Category 3 Outcome Measure(s):	*139135109.3.39* *139135109.3.40* *139135109.3.41*	*IT- 5.1* *IT-5.2* *IT-5.3*	*Improved Cost Savings* *Per Episode Cost of Care* *Other Outcome Improvement Target: Reduced Length of Stay*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Milestone 2 Estimated Incentive Payment: $889,335.50	and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements. Metric 1 [P-8.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: Participate in all semi-annual face-to-face meetings or seminars. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Milestone 4 Estimated Incentive Payment: $ 970,217	implementing these improvements. Metric 1 [P-8.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: Participate in all semi-annual face-to-face meetings or seminars. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Milestone 6 Estimated Incentive Payment: $973,037.50	these improvements. Metric 1 [P-8.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: Participate in all semi-annual face-to-face meetings or seminars. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Milestone 8 Estimated Incentive Payment: $803,813.50
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $1,778,671	Year 3 Estimated Milestone Bundle Amount: $1,940,434	Year 4 Estimated Milestone Bundle Amount: $1,946,075	Year 5 Estimated Milestone Bundle Amount: $1,607,627
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:** $7,272,807			

Project Option: 1.9.2 Improve access to specialty care: Expand Women's Mental Health Care

Unique Project ID: 139135109.1.16

Performing Provider Name/TPI: Texas Children's Hospital/ 139135109

Project Summary:
To increase access in providing women's reproductive mental health services to the meet the needs of this population.

Provider:
Texas Children's Hospital, located in Houston, is the largest free standing children's hospital in the county specializing in the care of medically fragile children in Houston and across the country as a regional safety net provider. We currently are licensed for 564 beds and in 2011 we had over 2.7 million patient encounters. Our mission is to provide the finest possible pediatric and women's patient care, education, and research. Texas Children's is an integrated delivery system comprising of a health plan for Medicaid and CHIP pregnant women and children, the nation's largest general pediatrician group and two world class hospitals.

Volume Statistics - FY2012	Patient Payor Mix	Patient Demographics
Hospital Admissions- 25,966 Births (babies delivered)- 2,181 Emergency visits-113,586 Outpatient visits- 3,066,765	Medicaid and CHIP- 53.6% Commercial Insurance- 40.6% Self-Pay- 1.8% Medicare- 1.2%	Hispanic- 35.9% African American- 16.6% Caucasian- 31.0% Asian- 3.8% Other- 12.4% American Indian- 0.3%

Intervention(s):
This project will allow us to create access resources which will allow us to diagnosis women quicker and enhance their quality of life. Educating and training obstetricians and pediatricians to improve screening in post-partum depression, to understand the challenges of psychiatric medications during pregnancy and breastfeeding, and to understand the mental health needs of menopausal women.

Need for the project:
This project will increase access for women with reproductive mental health issues. American women are two times more likely to experience depression than men and depression is considered to be the leading cause of disease-related disability among women today. Approximately 13-15% of new mothers are diagnosed with Postpartum Depression (PPD).

Target Population:
All women within the Houston community who can benefit from this project, specifically with reproductive mental health issues.

Category 1 or 2 expected patient benefits:
Our DY 4 goal is to increase patient visits by 10% from the baseline in fiscal year 2012. DY5 goal is to increase patient visits by 20% from the baseline in fiscal year 2012.

Category 3 outcomes:
IT-2.4 Our goal is to reduce preventable admissions for patients with Behavioral Health/ Post Partum Psychosis

Project Option: 1.9.2 Improve access to specialty care: Expand Women's Mental Health Care

Unique Project ID: 139135109.1.16
Performing Provider Name/TPI: Texas Children's Hospital/ 139135109

Project Description:
Texas Children's Hospital will expand provider capacity, improve processes and increase availability of mental health services for women
Texas Children's Hospital, located in Houston, is the largest free standing children's hospital in the county. Our mission is to provide the finest possible pediatric and women's patient care, education, and research. Texas Children's is an integrated delivery system comprising of a health plan for Medicaid and CHIP pregnant women and children, the nation's largest general pediatrician group and two world class hospitals. Texas Children's supports a commitment to quality service and cost-effective care to enhance the health and well-being of women and children locally, nationally and internationally.
In November 2011, Texas Children's Hospital embarked on a unique opportunity and built a state of the art Pavilion for Women to provide comprehensive inpatient and outpatient services in Obstetrical and Gynecological care. In addition, the Pavilion for Women has recently opened The Women's Place - Center for Reproductive Psychiatry. It is one of only a handful of programs in the United States dedicated to the care and treatment of women's reproductive mental health issues. The services offered will range from premenstrual dysphoric disorder, prenatal evaluation and treatment, care, postpartum mental health care, perimenopausal and menopausal mental health conditions. Our philosophy is to focus on the health of women because it leads to healthy families.
Approximately 13-15% of new mothers are diagnosed with Postpartum Depression (PPD).[9] The *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* (DSM-IV) defines PPD as a nonpsychotic, major depressive disorder with a specifier of postpartum onset within 4 weeks after childbirth.[177] Among younger and socioeconomically disadvantaged mothers, the prevalence is even higher: about 1 in 4 women.[178] Other risk factors for developing PPD include a history of depression, experience of depression or anxiety during the pregnancy, or a family history of psychiatric illness.[179],[180],[181] Also, a woman's relationship with her partner can be a predictive variable for PPD; women that are less satisfied, have higher levels of conflict, and receive less support from their partners are potentially at greater risk for PPD. [9]
Evidence suggests that some mental illnesses are more prevalent in women; that women use mental health services more frequently than men do and that women want a different range of treatment and support options than is currently available. Additionally, women's mental health needs change across their lifespan. Specifically during the postpartum period, about 85% of

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[177] American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*. 4th ed. Washington, DC: American Psychiatric Association, 2000.
[178] Chaudron L, Szilagyi P, Kitzman H, Wadkins H, Conwell Y. Detection of postpartum depressive symptoms by screening at well-child visits. *Pediatrics*. March 2004;113(3 Pt 1):551-558.
[179] Beck C. Predictors of postpartum depression: an update. *Nursing Research*. September 2001;50(5):275-285.

[180] O'Hara MW, Swain AM. Rates and risk of postpartum depression: A meta-analysis. *International Review of Psychiatry*. 1996; 8: 37-54.
[181] Steiner M. Postnatal depression: a few simple questions. *Family Practice*. October 2002;19(5):469-470.

women experience some type of mood disturbance. (Massachusetts General Center for Woman's Mental Health, http://www.womensmentalhealth.org/specialty-clinics/postpartum-psychiatric-disorders/) For most the symptoms are mild and short-lived; however, 10% to 15% of women develop more significant symptoms of depression or anxiety. Postpartum psychiatric illness is typically divided into three categories: (1) postpartum blues (2) postpartum depression and (3) postpartum psychosis. Mental illness can also occur during pregnancy and women require expert help in determining which treatments, including medication are safe during pregnancy. Without expert care women are more likely to not receive treatment or to abruptly discontinue psychiatric medication which can have serious negative consequences for both mother and child. Evidence supports that untreated maternal depression can have negative consequences for her child, including increased risk of school problems, psychiatric illness, and even physical illness such as reactive airway disease. http://www-ncbi-nlm-nihgov.ezproxyhost.library.tmc.edu/pubmed/19850709

Goals and Relationship to Regional Goals:

Project Goals**:**

To meet the growing demand for high impact reproductive psychiatry services, TCH will:

1. Focus on provider productivity to optimize clinical time for all providers and enhance training of subspecialists and trainees.
2. Establish an initiative to review scheduling processes to increase the appointment availability of these targeted providers that aligns with new clinic capacity.
3. Expand provider capacity by hiring additional clinicians and support staff, in order to offer non-medical treatments to pregnant and breastfeeding mothers with depression.
4. Enhance service availability by targeting new providers to not only work in the Texas Medical Center but also serve additional 1-2 community locations.
5. Engage pediatricians in screening mothers for postpartum depression and providing effective systems for referral and treatment.

This project meets the following Region 3 Goals:

- (CN.2, CN.15) Increased access to specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their conditions, regardless of where they reside or their ability to pay for care.
- Develop a regional approach to healthcare delivery that leverages and improves on existing programs and infrastructure, is responsive to patients' needs throughout the entire region, and improves health care outcomes and patient satisfaction.
- (CN.18) Address the insufficient access to integrated care programs for behavioral health and physical health conditions as a need in our community.

Challenges: One of the greatest challenges in mental health is the stigma surrounding the disease. Women who are suffering from psychiatric illness during pregnancy and the postpartum period are especially afraid to seek treatment. And if women reach out for help access to mental health services is a challenge. Finding a provider who understands the unique features of women's care during the reproductive years is particularly challenging. There are very few comprehensive women's mental health programs across the country and we will be one of them. The Pavilion for Women is particularly unique because our women's mental health program is embedded in the hospital where women come to seek care. Access to care is easier and more accepted than going to another facility; there is less stigma to seeking help.Across the nation, there is limited reimbursement for mental health services with private and public payors. In

many instances psychiatrists have chosen a fee for service practice that is prohibitively expensive for most women. Finding a provider who is knowledgeable about the unique needs of women during the reproductive is particularly difficult. Finding expert, reimbursed care is challenging can sometimes be impossible in most communities. Because of the lack of mental health providers to treat this population many women fall through the cracks. Although it is estimated that 10 to 15% of women will suffer from postpartum depression, most hospitals and physicians do not offer screening. If there is no mental health care available then identifying illness creates a problem with limited solutions. Although screening for postpartum depression has been advocated to be the standard of care, many health care facilities and physicians are reluctant to do so due to lack of appropriate referrals. Women are sent home with new babies and either don't receive care or receive inadequate care. Untreated depression has increased morbidity and mortality for both mother and child.

Five year expected outcome for provider and patients:

Texas Children's Hospital expects to see improvements in access to subspecialty care for our obstetric and gynecologic patients; this in turn will improve patient satisfaction and patient health due to the delivery of the right care at the right place at the right time.

Starting Point/Baseline:

The baseline of patient volume in FY 12 is 500. Our fiscal year runs from October 1st to September 30th.

Rationale:

The significant increase in access to specialty care created by this project attempts to address the growing demands in our community for specialized women's mental health providers. This project will create increased capacity through more efficient operations and new licensed provider recruitment. Specifically in our region there are only 3.5 providers who specialize in woman's reproductive mental health, three of those providers provide fee for service care only. Until recently patients who for financial reasons must use insurance have been unable to access appropriate specialized care for serious mental illness during the reproductive years. Region 3 identified (CN.18). Texas Children's Hospital is working to develop The Women's Place - Center for Reproductive Psychiatry at Texas Children's Pavilion for Women. It will be one of only a handful of programs in the United States dedicated to the care and treatment of women's reproductive mental health issues. The services offered will range from premenstrual dysphoric disorder, prenatal evaluation and treatment, postpartum mental health care, perimenopausal and menopausal mental health conditions. Texas Children's identified these services as a foundation for our women's health strategies in our community -- as healthy women lead to healthy families. The program has started with .5 FTE Reproductive Psychiatrist providing clinical services.

According to the Mental Health Report conducted by the World Health Organization, depression affects nearly 121 million people worldwide each year and is the fourth leading contributor to the global burden of disease. Of these cases, 850,000 result in tragic fatalities via means of suicide annually and fewer than 25% of those affected have access to effective treatments.[182] In the United States alone, major depressive disorder affects about 14.8 million adults or 6.7% of the

[182] World Health Organization. Mental health: Depression. http://www.who.int/mental_health/management/depression/definition/en/. 2010. Accessed March 8, 2010.

population age 18 and older within a given year.[183] American women are two times more likely to experience depression than men and depression is considered to be the leading cause of disease-related disability among women today.[184]

While researchers continue to explore the reasons for women's increased risk for depression over men, studies have shown that changes in hormone levels directly affect brain chemistry, a significant factor contributing to depressive disorders. Women during pregnancy and after delivery of their infants are particularly vulnerable to depression due to the rapid decline in estrogen and progesterone[185], as well as
the new responsibility of caring for a newborn.[1] In fact, epidemiologic studies have demonstrated that women are more likely to be admitted to a psychiatric unit after giving birth than at any other time in their lives.[186]

Approximately 13-15% of new mothers are diagnosed with Postpartum Depression (PPD).[9] The *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* (DSM-IV) defines PPD as a nonpsychotic, major depressive disorder with a specifier of postpartum onset within 4 weeks after childbirth.[187] Among younger and socioeconomically disadvantaged mothers, the prevalence is even higher: about 1 in 4 women.[188] Other risk factors for developing PPD include a history of depression, experience of depression or anxiety during the pregnancy, or a family history of psychiatric illness.[189],[190],[191] Also, a woman's relationship with her partner can be a predictive variable for PPD; women that are less satisfied, have higher levels of conflict, and receive less support from their partners are potentially at greater risk for PPD. [9]

To have a diagnosis of PPD, a woman must present with depressed mood or loss of interest or pleasure in daily activities that represents a change in normal behavior and impairs everyday functioning for a minimum time frame of two weeks.[6] Additionally, four of the following symptoms must also be present in order to constitute a diagnosis of PPD: weight change in absence of dieting, insomnia or hypersomnia, psychomotor agitation or retardation, fatigue or loss of energy, feelings of worthlessness or guilt, decreased ability to think or concentrate, and recurrent thoughts of death or suicide.[6]

Once PPD has been identified, immediate treatment is essential. Patients that are not treated promptly are at risk for a longer duration of the illness which can lead to impaired functioning, refusal of treatment, prolonged symptoms, and suicide. Evidence-based treatment options that

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[183] National Institute of Mental Health. The numbers count: Mental disorders in America. http://www.nimh.nih.gov/health/publications/the-numbers-count-mental-disorders-in-america/index.shtml. 2008. Accessed March 8, 2010.

[184] Nolen-Hoeksema S. Gender differences in depression. Current Directions in Psychological Science. October 2001;10(5): 173-176.

185 Bloch M, Schmidt PJ, Danaceau M, Murphy J, Neiman L, Rubinow DR. Effects of gonadal steroids in women with a history of postpartum depression. American Journal of Psychiatry. 2000;157: 924-930.

[186] Munk-Olsen T, Laursen T, Pedersen C, Mors O, Mortensen P. New parents and mental disorders: a population-based register study. *JAMA: The Journal of the American Medical Association*. December 6, 2006;296(21):2582-2589.

[187] American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*. 4th ed. Washington, DC: American Psychiatric Association, 2000.

[188] Chaudron L, Szilagyi P, Kitzman H, Wadkins H, Conwell Y. Detection of postpartum depressive symptoms by screening at well-child visits. *Pediatrics*. March 2004;113(3 Pt 1):551-558.

[189] Beck C. Predictors of postpartum depression: an update. *Nursing Research*. September 2001;50(5):275-285.

[190] O'Hara MW, Swain AM. Rates and risk of postpartum depression: A meta-analysis. *International Review of Psychiatry*. 1996; 8: 37-54.

[191] Steiner M. Postnatal depression: a few simple questions. *Family Practice*. October 2002;19(5):469-470.

have been shown effective include focused psychotherapy, antidepressants, or a combination approach.[192] In 2011, Harris County had 69,896 births alone, at a minimum 6,900 of those women would benefit from treatment just during the postpartum period.

Project Components: Through the expanded access to specialty care, we propose to meet all required project components listed and these selected milestones and metrics do relate to project components.

a. Conduct specialty care gap assessment based on community need for subspecialty.
b. Implement transparent standardized referrals across the system.
c. Increase specialty care volume of visits and evidence of improved access for patients seeking services.
d. Increase service availability hours and increase number of specialty clinic locations.
e. Conduct quality improvement for projects to improve access and learning collaborative exchanges.

Inadequate access to specialty care has contributed to the limited scope and size of safety net health systems. For women with health care needs that exceed the abilities of the primary care provider, access to and coordination with subspecialty care is critical to ensuring the provision of efficient and effective mental health care and in securing a comprehensive medical home.[193]

Milestones and Metrics

The following milestones and metrics have been chosen for the project based on the core components and the needs of the targeted women's mental health population.

- Process milestone and metrics: P-1 (P-1.1); P-8 (P-8.1); P-17 (P-17.1)
- Improvement milestones and metrics: I-23 (I-23.1); I-X (I-X.1)

Customizable Improvement Milestone and Metric was chosen in order to specifically tailor the intent of project to the targeted women's mental health population.

Unique community need identification number the project addresses:

- CN.2: Inadequate access to specialty care,
- CN.6: Inadequate access to treatment and services designed for women.
- CN15: Insufficient access to services for pregnant women, particularly low income women
- CN18: Insufficient access to integrated care programs for behavioral health and physical health conditions

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

This initiative in women's mental health will allow us to provide a comprehensive program that creates resources, for this patient population, that is currently limited in Houston. Increasing access, will allow us to diagnosis women quicker which will enhance their quality of life. Educating and training obstetricians and pediatricians to improve screening in post-partum depression, to understand the challenges of psychiatric medications during pregnancy and breastfeeding, and to understand the mental health needs of menopausal women will significantly enhance the quality of care women receive and allow us to collaboratively identify the most appropriate mental health services a women may need.

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

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[192] Wisner K, Parry B, Piontek C. Clinical practice. Postpartum depression. *The New England Journal of Medicine*. July 18, 2002;347(3):194-199.

[193] Redlener, Irwin, Grant Roy, and Krol David M. "Beyond Primary Care: Ensuring Access to Subspecialists, Special Services, and Health Care Systems for Medically Underserved Children." *Advances in Pediatrics*. 52 (2005): 9-22.

OD-2 Potentially Preventable Psychiatric Admissions
IT-2.4 Behavioral Health/Major Depressive Disorder(BH/MDD)

Reasons/rationale for selecting the outcome measures:
Our project will increase appropriate access to care. Increased access to appropriate subspecialty care leads to better long term outcomes in children and reduction in unnecessary health care costs.[194]

Relationship to other Projects: All of Texas Children's projects are working to expand access to subspecialty care for the women's mental health population. This project focuses on expanding access to women's reproductive mental health. Texas Children's is investing in women's health services as one of the best ways to truly impact children's health by starting before conception and supporting maternal mental health after delivery. These interventions have a major impact on the mental and physical health of the child.

Relationship to Other Performing Providers' Projects and Plan for Learning Collaborative: This project will compliment other projects designed to improve appropriate access to specialty care, improve chronic care management, and those designed to improve the patient experience. We plan to participate in a region-wide learning collaborative as offered by the anchor for Region 3, Harris Health System. Our participation in this collaborative with other performing providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our region's health care system.
The behavioral health crisis in Region 3 is considerable and the proposed initiatives in our RHP plan will only imply a small impression into the overall community need for treatment, but is a good start. The outpatient focus of many RHP Plan initiatives will help numerous facilities focus to treating the patients in an ambulatory setting as well as continued navigation of services with a focus to keeping patients from the inpatient unit. This initiative is similar to many others in the sense of the category of behavioral health. The Region 3 Initiative Grid attached in the addendum will show the relationship to other programs.

Project Valuation: This project's value is based on the benefits related to cost avoidance of medical expenses and improved quality of life. For example, increased provider capacity leads to reduction in emergency room visits and reduction in inpatient hospital visits.[195] Our valuation also includes an increase in the patient's quality of life. We are using a conservative Quality Adjusted Life Year ("QALY") per year and a percentage of that QALY for the pediatric population.[196] The QALY is used as a one-time improvement in the quality of life, even though we know the patient's quality of life will be improved for many years. We recognize that this is a government funded waiver and thus we chose to have conservative valuations out of respect for the taxpayer funded program.

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[194] *Reducing Costs Through the Appropriate Use of Specialty Services*. Cambridge: Institute for Healthcare Improvement, 2007.
[195] Smith, John T, Price, Christopher, Stevens Peter M., Masters, Kevin S., and Young, Mark. "Selected Topics - Does Pediatric Orthopedic Subspecialization Affect Hospital Utilization and Charges?" *Journal of Pediatric Orthopedics*. 19.4 (1999): 553-555.
[196] Brannon, Ike. "Risk - What Is a Life Worth? Despite Its Prima Facie Callousness, Determining the Value of a Human Life Is Necessary for Good Public Policy." *Regulation*. 27.4 (2004): 60-63.

139135109.1.16	*1.9.2*	*A-D*	***Improve access to specialty care: Expand Women's Mental Health Care***
Texas Children's Hospital			*139135109*
Related Category 3 Outcome Measure(s):	*139135109.3.42*	*IT- 2.4*	*Potentially Preventable Admissions*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 (P-1): Conduct specialty care gap assessment to determine barriers to accessing subspecialty care Metric 1 P-1.1 Documentation of gap assessment Data Source: Gap Assessment Milestone 1 Estimated Incentive Payment: 268,593 **Milestone 2 (P-8)** Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements. Metric 1 [P-8.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: Participate in all semi-annual face-to-face meetings or seminars.	**Milestone 3 (I-X):** Create a Menopausal Clinic to have a one stop shop for women who are having issues with depression during menopause. The vision is to have a mental health visit and gynecological visit in the same day. Metric 1 (I-X.1.): Number of patients seen for a mental health and gynecological visit in the same day. a Baseline/goal: This will be a new initiative for us. Our baseline is zero and our goal is 100 patients. b. Data Source: EPIC electronic medical record Milestone 3 Incentive Payment: $293,020.50 **Milestone 4 (P-8)** Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements.	**Milestone 5 (I-23):** Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 (I-23.1): Documentation of increased number of visits. Demonstrate improvement over prior reporting period (baseline established in FY12). a. Total number of visits for reporting period b. Data Source: Registry, EHR Goal: Increased visits by 10% Milestone 5 Estimated Incentive Payment: $293,872.50 **Milestone 6 [P-8]:** Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to	**Milestone 7 (I-23):** Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 (I-23.1): Documentation of increased number of visits. Demonstrate improvement over prior reporting period (baseline established in FY12). a. Total number of visits for reporting period b. Data Source: Registry, EHR Goal: Increased visits by 20% Milestone 7 Estimated Incentive Payment:$ 242,764 **Milestone 8 [P-8]:** Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements.

139135109.1.16	1.9.2	A-D	**IMPROVE ACCESS TO SPECIALTY CARE: EXPAND WOMEN'S MENTAL HEALTH CARE**
Texas Children's Hospital			*139135109*
Related Category 3 Outcome Measure(s):	*139135109.3.42*	*IT- 2.4*	*Potentially Preventable Admissions*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Milestone 2 Estimated Incentive Payment: $268,593	Metric 1 [P-8.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: Participate in all semi-annual face-to-face meetings or seminars. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Milestone 4 Estimated Incentive Payment: $293,020.50	implementing these improvements. Metric 1 [P-8.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: Participate in all semi-annual face-to-face meetings or seminars. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Milestone 6 Estimated Incentive Payment: $293,872.50	Metric 1 [P-8.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: Participate in all semi-annual face-to-face meetings or seminars. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Milestone 8 Estimated Incentive Payment: $ 242,764
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone)*: $537,186	Year 3 Estimated Milestone Bundle Amount: $586,041	Year 4 Estimated Milestone Bundle Amount: $587,745	Year 5 Estimated Milestone Bundle Amount: $485,528
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:** $2,196,500			

The University of Texas Health Science Center - Houston

Pass 1

Project Option 1.1.2 - 1.1 Expand Primary Care Capacity: Expand Existing Primary Care Capacity at UT Physicians Clinics

Unique RHP Project ID: 111810101.1.1
Performing Provider Name/TPI: UTHealth, UTPhysicians / 111810101

Project Summary:

Provider:
UT Physicians is the clinical practice of The University of Texas Medical School at Houston. With more than 900 physicians certified in 80 medical specialties and subspecialties, 906 residents and fellows, and 283,920 patient visits in 2011, it is the fastest growing academic practice in the nation for the last five years. In addition to our flagship location in the Texas Medical Center, UT Physicians has 4 neighborhood locations throughout the Greater Houston area, and also offers specialty clinics at several Memorial Hermann Hospital locations.

Intervention(s):
UT Physicians will expand primary care capacity at each of its 4 outlying clinics. Space will be purchased for additional consulting, exam and procedure rooms. Additional providers and support staff will be added to provide primary care services, and the hours of service will be extended, including evenings and Saturdays. A minimum of 4 FTE providers will be added, which has the potential for 16,800 additional primary care contacts per year (using the HRSA physician productivity target).

Need for the project:
This project addresses the county's inadequate access to primary care and high rates of inappropriate emergency department utilization. For the fiscal year 2010, 10% of all potentially preventable hospitalizations (PPR) were ambulatory care sensitive. In 2009, 41% (390,945) of ED visits in Houston were primary care related (PCR), including non-urgent, primary care treatable, and primary care preventable, and for 26.8% (104,762) of these PCR visits, Medicaid was the payer.

Target Population:
The service areas of our 4 outlying clinics include large populations with economic, cultural, language, and transportation barriers to receiving primary care. Using the Harris County rate (14.5%) of Medicaid clients, there are an estimated 1,423,176 Medicaid clients living within the service areas of the UT Physician Clinics.

Category 1 or 2 expected patient benefits:
Our goal is to increase primary care clinic visits and improve access for patients seeking services. This will trasnlate to better patient satisfaction with primary care services.

Category 3 outcomes:
T-1.1: Our goal is, by DY5, to reduce the average length of time in days between the day a patient makes a request for an appointment with a physician and the third available appointment for a new patient physical, routine exam, or return visit exam to zero (0) days.

Project Option 1.1.2 – Expand Primary Care Capacity: C3 Expand Existing Primary Care Capacity at UT Physicians Clinics

Unique RHP Project Identification Number: 111810101.1.1
Performing Provider Name/TPI: UTHealth, UTPhysicians/111810101

Project Description: 1.1 Expand Primary Care Capacity (Option 1.1.2)

UT Physicians (UTP) will expand primary care capacity at each of its 4 outlying (outside the Texas Medical Center) clinics. UTP has defined the service area for its clinics to include the census tracts within a seven-mile radius of each clinic. The Bayshore Clinic is in the southeast area of Houston and includes parts of Pasadena, South Houston, and areas immediate south of the ship channel. The service area of this clinic has a population of 431,199, with 36.5% living at/below the federal poverty level (FPL). The population is 49.2% Hispanic and of those, 51.1% are not proficient in English. The Bellaire Clinic, with a population of 472,698, is on the west side of Houston and also has a large minority population, with 24.1% Black/African American and 46% Hispanic, and 52.2% live at/below the FPL. Of the Spanish-speaking population in the Bellaire Clinic service area, 62.8% are not proficient in English. The Cinco Ranch (population 287,744) and Sienna Village (population 231,535) clinics serve populations reaching into Ft. Bend County that closely mirror the overall county demographics, with the exception of Sienna Village Clinic, which has a large Black/African American population of 33.5%. There are 20.8% of the Cinco Ranch Clinic population and 26.2% of the Sienna Village Clinic population living at/below the FPL. These two clinics also serve rural populations. The service areas of these 4 clinics include large populations with economic, cultural, language, and transportation barriers to receiving primary care. Using the Harris County rate (14.5%) of Medicaid clients, there are an estimated 1,423,176 Medicaid clients living within the service areas of the UT Physician Clinics. (All population statistics are from the U.S. Census Bureau, 2010 Census. Poverty statistics are from the U.S. Census Bureau, Small Area Estimates Branch. Release date: 11.2011. Table 1: 2010 Poverty and Median Income Estimates - Counties. The Medicaid rate is from the U.S. Census Bureau and the Centers for Disease Control and Prevention, State and County by Demographic and Income Characteristics. SAHIE, 2009.)

Additional space will be purchased to expand UT Physicians' Clinics. This will include additional consulting, exam and procedure rooms. Additional providers will be added to provide primary care services, support staff will be increased to accommodate the additional providers and increased patient load, and the hours of service will also be extended, including additional evening hours and Saturdays. With a minimum of one additional primary care provider and related support staff at each of the 4 clinics, there is the potential for 16,800 additional primary care contacts per year using the HRSA physician productivity target.

Goal and Relationship to Regional Goals:

Project Goals:

Expand primary care capacity to better accommodate the needs of the regional patient population and community, so that patients have enhanced access to the right health care services, at the right time, in the right setting.

This project addresses the following regional goals:

One of the goals of the region is to "Increase access to primary and specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their condition, regardless of where they live or their ability to pay". Expansion of primary care capacity certainly relates to this goal as it will make it easier for UT Physicians to provide care to underserved populations.

Challenges:

Need: 1) Inadequate access to primary care. 2) High rates of inappropriate emergency department utilization.

Implementation: 1) Staff recruitment and retention. 2) Marketing of expansion.

By expanding the capacity of their clinics, UT Physicians will be better able to deliver timely care to more patients when needed thereby diverting patients away from the emergency room. UT Physicians will recruit physicians from the UTHealth residents placed at Memorial Hermann Hospital-TMC and will offer them a competitive salary and other incentives to practice in the outlying clinics. A marketing campaign that addresses the culture(s) and needs of the community will be implemented to inform the community of our expanded capacity to provide quality care that is convenient for them.

5-Year Expected Outcome for Provider and Patients:

There will be shortening of waiting times for primary care appointments and increased uptake of primary care services in our service areas, which will increase the percentage of patients who receive regular screenings for breast cancer and colon cancer. Detecting cancer early can reduce the burden of the disease in terms of both improved health outcomes and lower costs. In addition to benefiting the current Medicaid (23% as of 2011, or 65,302 patient visits) and low-income client base of UTP clinics, the expansion of services will be marketed to the additional 1,423,176 Medicaid and Medicaid-eligible residents living within the service areas of the UT Physician Clinics. The expansion of service hours to nights and Saturdays will be of particular benefit to those unable to see a physician during business hours. The increase in primary care capacity, coupled with our transition to the team-based, proactive healthcare delivery model of medical homes, all conveniently located where there is great need, will help to address many of the barriers that the low-income population typically encounter in getting the appropriate care, facilitating better health outcomes.

Starting Point/Baseline:

To be determined during DY3.

Rationale:

Research has shown that access to primary care is associated with better health outcomes at less cost. Access to primary care ensures better preventive care and better management of chronic disease; on the other hand lack of access often results in more expensive care, received in hospitals and emergency departments (ED). For the fiscal year 2010, 10% of all potentially preventable readmissions (PPR) were ambulatory care sensitive. In 2009, 41% (390,945) of ED visits in Houston were primary care related (PCR), including non-urgent, primary care treatable, and primary care preventable, and for 26.8% (104,762) of these PCR visits, Medicaid was the payor. Getting more patients into primary care will help to reduce the use of this more costly care. Placing more primary care providers out in the communities served by the UT Physcians

will help to address transportation access barriers and the expansion of clinic service hours will provide a greater selection of available appointment times. By increasing primary care capacity and engaging more people in the primary care system, avoiding inappropriate utilization of costly services, the community will experience better health outcomes and greater patient satisfaction. (PPR rate was from the Texas Health and Human Services Commission report on Potentially Preventable Readmissions in the Texas Medicaid Population, Fiscal year 2010, published January, 2012. The statistics for ED use were from the Houston Hospitals Emergency Deaprtment Use Study (January 1, 2009 through December 31, 2009), Final Report, prepared by the UT School of Public Health, May 2011, included in the 2010 Harris County Community Needs Assessment for Memorial Hermann.)

Project Components:

As part of the program to Expand Existing Primary Care Capacity at UT Physicians Clinics, we propose to meet all required project components listed below:

a) UTP will identify and purchase/lease additional primary care clinic space to include additional consulting, exam and procedure rooms.

b) UTP will recruit additional primary care providers and support staff to implement the expansion.

c) The hours of UTP clinics will be expanded to include evening and Saturday hours.

Milestones and Metrics:

For the Expand Existing Primary Care Capacity at UT Physicians Clinics Program, we have chosen the below milestones and metrics based upon the above project components and relationship to project goals and population needs. All baselines and goals will be determined during DY2.

Process Milestones and Metrics:

Milestone 1 [P-1]: Expand existing primary care clinics
Metric 1 [P-1.1]: Amount of additional space aquired to expand clinic services.
Milestone 2 [P-5]: Hire additional primary care providers and staff
Metric 1 [P-5.1]: Documentation of increased number of providers and staff.
Milestone 3 [P-4]: Expand the hours of a primary care clinic, including evening and/or weekend hours
Metric 1 [P-4.1]: Increased number of hours at primary care clinic over baseline

Improvement Milestones and Metrics:

Milestone 4 [I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services.
Metric 1 [I-12.1]: Documentation of increased number of visits. Demonstrate improvement over prior reporting period.
Milestone 5 [I-11]: Patient satisfaction with primary care services.
Metric 1 [I-11.1]: Improved Patient satisfaction scores

Unique community need identification numbers the project addresses:

This project addresses community needs CN.1 (Inadequate access to primary care) and CN.8 (High rates of inappropriate emergency department utilization).

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

system reform initiative:

UT Physicians operates 4 clinics that serve areas that include large populations with economic, cultural, language, and transportation barriers to receiving primary care. This project proposes to add space, providers, support staff, and extend service hours to include evenings and weekends at these locations where the demand for services is high. This project is an expansion of services in order to improve access to care.

Related Category 3 Outcome Measure(s):

OD-1 Primary Care and Chronic Disease Management

- IT-1.1 Third next available appointment (Non- standalone measure)
  Reduce the average length of time in days between the day a patient makes a request for an appointment with a physician and the third available appointment for a new patient physical, routine exam, or return visit exam. The goals will be to decrease number of days to third next available appointment to zero days (same day) for Primary Care.

OD-12 Primary Care and Primary Prevention

- IT-12.1 Breast Cancer Screening (HEDIS 2012) (Non-standalone measure)
  Numerator: Number of women aged 40 to 69 that have received an annual mammogram during the reporting period. Denominator: Number of women aged 40 to 69 in the patient or target population. Women who have had a bilateral mastectomy are excluded.

OD-12 Primary Care and Primary Prevention

- IT-12.3 Colorectal Cancer Screening (HEDIS 2012) (Non-standalone measure)
  Numerator: Number of adults aged 50 to 75 that have received one of the following screenings. Fecal occult blood test yearly, Flexible sigmoidoscopy every five years, Colonoscopy every 10 years
  Denominator: Number of adults aged 50 to 75 in the patient or target population. Adults with colorectal cancer or total colectomy are excluded.

Relationship to other Projects:

1.2 (A2, SPH1) - Increased training of primary care workforce will provide physicians and support staff needed to expand primary care capacity.

1.7 (A1) - Expanded primary care capacity will facilitate and enhance access to specialty care via telemedicine.

1.10 (MS1) - The systems engineering and user dashboards will give providers greater access to information and provide reports facilitating a continuous quality improvement process.

2.1 (C1-2) - As part of the medical home project, all patients will be assigned to a primary care provider within the UT Health medical home. Expanded primary care capacity will be a necessary step to making this possible.

2.2 (CL3, C5-C9) - Expanded capacity in primary care will ensure the availability of staff to implement the expansion of the chronic care management model for the targeted diseases.

2.11 (C10) - The medication management program will be an integral part of the coordinated care provided by the primary care physicians.

2.12 (A3, CL1, CL2, MS4) - For the various care transition projects to be succesful, UT Health needs to ensure it has adequate primary care capacity to handle the increased volume of patients.

Relationship to Other Performing Providers' Projects in the RHP:

Primary Care/Ambulatory Care clinics are a top priority to Region 3 due to the regional patient mix, population concentration, and lack of primary care access points for our patient base. The regional approach of collaboration as well as existing patient referral pattern relationships allowed our team to properly identify the community needs based on the necessity of population, uninsured, and medically underserved patient bases. This program is consistent with our region and similar to numerous initiatives in our RHP plan sharing both concepts as well as outcome measures focused on percent improvement over baseline of patient satisfaction scores, reduction of inappropriate ED utilization, and third next available appointment status. The Region 3 Initiative Grid attached as a RHP Plan addendum reflects a grid of relationship for all initiatives.

Plan for Learning Collaborative:

UTHealth will participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system.

Project Valuation:

The anchor, Harris Health, provided a spreadsheet that contained 6 criteria, which could be used to rate each project on a 10-point scale. The ratings for each criterion were weighted, summed for each project to arrive at a total score (value weight) for each project. The sum of all the project's total scores were then divided by the percent of total DSRIP funds to be secured for that year to arrive at a dollar value multiplier to be applied towards each project's total score (value weight), thereby allocating a greater proportion of the funds towards those projects valued highest based upon the 6 criteria. UTHealth used this approach, with one exception—we did not use two of the criteria. Following are the criteria, the considerations for awarding points for projects using that criterion, and the reasons two of the criteria were not used:

1. Transformational Impact (Weight = 20%): Points were awarded for projects that meet the community benefit criteria, such as: improving access; improving quality; improving costs (long-term cost-savings); transformative (Innovative), collaborative (partners with other organization(s)). This project's score for this criterion: **6**

2. Population Served/Project Size (Weight = 20%): Points were awarded based on the size of the population affected and whether the target population is uninsured or on Medicaid. This project's score for this criterion: **6**

3. Aligned with Community Needs (Weight = 20%): Points were awarded based on judgments in two categories: whether or not the CNA indicates a need in the area of the project and the severity of the health/healthcare need(s) the project addresses. This project's score for this criterion: 111810101.1.1 X 2 = **7**

4. Cost Avoidance (Weight = 15%): Points were awarded based on judgment of project's cost effectiveness relative to similar projects. This project's score for this criterion: **6**

5. Partnership/Collaboration (Weight = 10%): ***This was not rated***, because UTHealth planned to partner with Harris Health to perform many similar projects, so the rating would have been

the same for all projects. This would have diluted the scores, hiding the more significant variations in other value criteria.

6. Sustainability (Weight = 15%): ***This was also not rated***, because UTHealth does not consider any of the projects to be unsustainable, or at the very least do not consider one project less sustainable than another. Giving the projects the same, or very similar ratings on this criterion again would have had a diluting effect, hiding the more significant variations in other value criteria.

Total Valuation Score for this project: **4.7**

111810101.1.1	***OPTION 1.1.2***	***1.1.2 (A-C)***	***C3 EXPAND EXISTING PRIMARY CARE CAPACITY AT UT PHYSICIANS CLINICS***
UTHealth, UTPhysicians			*111810101*
Related Category 3 Outcome Measure(s):	*111810101.3.1* *111810101.3.2* *111810101.3.3*	*IT-1.1* *IT-12.1* *IT-12.3*	*Third next available appointment (Non- standalone measure)* *Breast Cancer Screening (HEDIS 2012) (Non-standalone measure)* *Colorectal Cancer Screening (HEDIS 2012) (Non-standalone measure)*
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-1]: Expand existing primary care clinics <u>Metric 1</u> [P-1.1]: Amount of additional space aquired to expand clinic services. Baseline/Goal: TBD Data Source: New primary care schedule and other UT Physicians' documents. Milestone 1 Estimated incentive payment: $ 2,281,182 **Milestone 2** [P-5]: Hire additional primary care providers and staff <u>Metric 1</u> [P-5.1]: Documentation of increased number of providers and staff. Baseline/Goal: TBD Data Source: UT Physicians' report, policy, contract or other documentation Milestone 2 Estimated incentive payment: $ 2,281,182	**Milestone 3** [P-4]: Expand the hours of a primary care clinic, including evening and/or weekend hours <u>Metric 1</u> [P-4.1]: Increased number of hours at primary care clinic over baseline Baseline/Goal: TBD Data Source: Clinic documentation Milestone 3 Estimated incentive payment: $4,927,491	**Milestone 4** [I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. <u>Metric 1</u> [I-12.1]: Documentation of increased number of visits. Demonstrate improvement over prior reporting period. Goal: TBD Data Source: Registry, EHR, claims or other UT Physicians' source Milestone 4 Estimated incentive payment: $5,549,726	**Milestone 5** [I-11]: Patient satisfaction with primary care services. <u>Metric 1</u> [I-11.1]: Improved Patient satisfaction scores Goal: TBD Data Source: CG-CAHPS3 or other developed evidence based satisfaction assessment tool, available in formats and language to meet patient population. Milestone 5 Estimated incentive payment: $5,141,601
Year 2 Estimated Milestone Bundle Amount: $4,562,364	Year 3 Estimated Milestone Bundle Amount: $4,927,491	Year 4 Estimated Milestone Bundle Amount: $5,549,726	Year 5 Estimated Milestone Bundle Amount: $5,141,601

111810101.1.1	***OPTION 1.1.2***	***1.1.2 (A-C)***	***C3 EXPAND EXISTING PRIMARY CARE CAPACITY AT UT PHYSICIANS CLINICS***	
UTHealth, UTPhysicians				*111810101*
Related Category 3 Outcome Measure(s):	*111810101.3.1* *111810101.3.2* *111810101.3.3*	*IT-1.1* *IT-12.1* *IT-12.3*	*Third next available appointment (Non- standalone measure)* *Breast Cancer Screening (HEDIS 2012) (Non-standalone measure)* *Colorectal Cancer Screening (HEDIS 2012) (Non-standalone measure)*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**	
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*:* $20,181,182				

Project Option 1.2.1- 1.2 Increase Training of Primary Care Workforce: UT Health Regional Academy for Translational Medicine and UT Health Academy for Patient Quality and Safety

Unique RHP Project ID: 111810101.1.2
Performing Provider Name/TPI: UTHealth, UTPhysicians / 111810101

Project Summary:

Provider:
UT Physicians is the clinical practice of The University of Texas Medical School at Houston. With more than 900 physicians certified in 80 medical specialties and subspecialties, 906 residents and fellows, and 283,920 patient visits in 2011, it is the fastest growing academic practice in the nation for the last five years. In addition to our flagship location in the Texas Medical Center, UT Physicians has 4 neighborhood locations throughout the Greater Houston area, and also offers specialty clinics at several Memorial Hermann Hospital locations.

Intervention(s):
This innovative program will train residents in the "new primary care" model that is capable of staffing "enhanced medical homes." The training program for health care providers will be updated to lay emphasis on team-based practice, quality and cost control. Faculty staff at UT Health will be trained to implement the new residency program.

Need for the project:
In addition to the overall shortage of primary care physicians in the region and Texas as a whole, the current curriculum used in residency training needs to be updated by emphasizing the importance of team based care, care coordination and the central role of the patient in achieving desirable health outcomes and controlling costs.

Target Population:
All patients within the greater Houston area and beyond will potentially benefit from this project, since it will produce new cohorts of physicians that will serve as invaluable resource for the transformation of the health care system in Houston and Texas as a whole.

Category 1 or 2 expected patient benefits:
By DY4 the project will increase the number of faculty staff completing educational courses, and by DY5 increase primary care training in Continuity Clinics.

Category 3 outcomes:
IT – 14.6 Percent of trainees who have spent at least 5 years living in a healthprofessional shortage area (HPSA) or medically underserved area (MUA)
IT- 14.7 Percent of trainees who report that they plan to practice in HPSAs or MUAs based on a systematic survey
IT – 14.8 Percent of trainees who report that they plan to serve Medicaid populations based on a systematic survey

Project Option 1.2.1 – Increase Training of Primary Care Workforce: A2 UT Health Regional Academy for Translational Medicine and UT Health Academy for Patient Quality and Safety

Unique RHP Project Identification Number: 111810101.1.2
Performing Provider Name/TPI: UTHealth, UTPhysicians/111810101

Project Description: 1.2 Increase Training of Primary Care Workforce (Option 1.2.1)

In addition to the overall shortage of primary care physicians in the region and Texas as a whole, the current curriculum used in residency training needs to be updated by emphasizing the importance of team based care, care coordination and the central role of the patient in achieving good health outcomes and controlling costs. To transform primary care in the region, there is a need to train a generation of physicans that will embrace the concepts of the patient-centered medical home (PCMH) practice, cost control, and place emphasis on quality improvement in their practice.

An innovative residency program in translational medicine will be developed and implemented by the UT Health Regional Academy for Translational Medicine. This innovative program, linked to new scholarly concentration(s), will train residents in the "new primary care" in Texas and the United States capable of staffing "enhanced medical homes." Also, the UT Health Academy for Patient Quality and Safety will operate a structured educational training for health care providers with emphasis on team-based practice, quality and cost control. These training programs will update the current model of training for primary care physicians by including training on the medical home and chronic care models, disease registry use for population health management, patient panel management, oral health, and quality/performance improvement. Faculty and staff at UT Health (including family medicine, internal medicine, obstetrics and gynecology, geriatrics, and pediatrics) will be trained to implement the new residency training.

Goal and Relationship to Regional Goals:

Project Goal:

To update primary care training programs to include organized care delivery models, with an emphasis on team-based practice, quality and cost control.

This project addresses the following regional goals:

Among the goals of the region is to "transform health care delivery from a disease-focused model of episodic care to a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary or duplicative services, and builds on the accomplishments of our existing health care system". By reorienting the education of physicians, this project will produce a new generation of physcians that better appreciate the importance of team care, patient focus, and role of care coordination in achieving satisfactory outcomes.

Challenges:

Need: 1) Shortage of primary care physicians trained in team-based models of care, such as the medical homes model.

Implementation: 1) Training for the trainers. 2) Attracting physicians to primary care.

This project will ensure that physicians trained in family medicine, internal medicine, obstetrics and gynecology, geriatrics, and pediatrics will be prepared to deliver coordinated care in institutions using the "new primary care model" or medical home model, thereby giving the population access to care teams better suited to attend to their needs. Training for attending physicians will be provided as a part of UTHealth's transition to a medical home model of practice and the necessary support given during and after the transition by putting in place monitoring, quality control, and evaluation systems. Since the study of medical students reaction to their training showed that they valued training that better prepared them for this type of practice experience, we expect that this program will be attractive to future physicians.

5-Year Expected Outcome for Provider and Patients:

Our primary care residency programs will have been reoriented to a new primary care model, with faculty adequately prepared to train new physicians on organized care delivery models that emphasize team-based practice, quality and cost control. The transition to this team-based, proactive healthcare delivery model will help to address many of the barriers that the low-income population typically encounter in getting the appropriate care, facilitating better health outcomes.

Starting Point/Baseline:

To be determined during DY3.

Rationale:

It has been well-documented that our current system of care is fragmented, which leads to suboptimal performance, including unnecessary procedures, safety problems, avoidable complications and costs, and the available care can vary greatly in both quantity and quality (Swensen SJ, et al. Cottage Industry to Postindustrial Care — The Revolution in Health Care Delivery. February 4, 2010. N Engl J Med, 362(5);e12). In order to move closer to a well-functioning health care delivery system, providers must have training that prepares them for the coordinated, outcomes- and evidence-based health care systems they will be entering. A recent nation-wide study conducted with medical students found that students felt their training was appropriate in terms of clinical decision making and clinical care, but felt that their training had not prepared them appropriately for practicing medicine (Patel MS, Davis MM, Lypson ML. Medical Student Perceptions of Education in Health Care Systems. September, 2009. Academic Medicine, 84(9):1301-6).

Project Components:

Through the UT Health Regional Academy for Translational Medicine and UT Health Academy for Patient Quality and Safety Program, we propose to meet all required project components listed below.

1) UT Health will enlist/recruit faculty for the development of the new primary care residency program.
2) Faculty will be trained in the new primary care medical home model.
3) The new primary care training program will provide resident training on:
   a) medical homes,
   b) chronic care models,
   c) disease registry use for population health management,

d) patient panel management,
e) oral health, and
f) quality/performance improvement

4) UT Physicians clinics will serve as the continuity clinics for the new residenty program.

Milestones and Metrics:

For the UT Health Regional Academy for Translational Medicine and UT Health Academy for Patient Quality and Safety Program, we have chosen the below milestones and metrics based upon the above project components and relationship to project goals and population needs. All baselines and goals will be determined during DY3.

Process Milestones and Metrics:

Milestone 1 [P-8]: Establish/expand a faculty development program
Metric 1 [P-8.1]: Enrollment of faculty/staff into primary care education and training program
Milestone 2 [P-9]: Develop/disseminate clinical teaching tools for primary care or interdisciplinary clinics/sites
Metric 2 [P-9.1]: Clinical teaching tools

Improvement Milestones and Metrics:

Milestone 3 [I-14]: Increase the number of faculty staff completing educational courses
Metric 1 [I-14.1]: Number of staff completing courses
Milestone 4 [I-15]: Increase primary care training in Continuity Clinics, which may be in diverse, low-income, community-based settings, (must include at least one of the following metrics):
Metric 1 [I-15.1]: Increase number of Continuity Clinic sessions available for primary care trainees.

Unique community need identification numbers the project addresses:

This project addresses community needs CN.16 (Shortage of primary and specialty care physicians), CN.25 (Graduate medical education, residency training, in health care systems, team-based practice, quality improvement, and cost control), CN.7 (Insufficient access to care coordination practice management and integrated care treatment programs), and CN.24 (Lack of care coordination and unnecessary duplication of services due to insufficient implementation and use of electronic health records)

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

This is a new initiative. The current residency program does not include training for residents on health care systems, patient-centered team-based practice, quality improvement, and cost control.

Related Category 3 Outcome Measure(s):

OD-14 Workforce Development

- IT − 14.6 Percent of trainees who have spent at least 5 years living in a health professional shortage area (HPSA) or medically underserved area (MUA)

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

Relationship to other Projects:

1.1 (C3) - Increased training of workforce competent to staff the 'new primary care' model will facilitate the recruitment of providers for expansion of primary care capacity.

1.3 (C12) - Part of the innovative training of primary care providers will be centered on the role of chronic disease management, for which the registries are essential.

1.7 (A1) - Enhanced training will include education on telemedicine as a cost-effective alternative to the more traditional face-to-face access to specialty medical care consults.

2.1 (C1-2) - Increased training of workforce competent to staff the 'new primary care' model will facilitate the recruitment of providers ready to practice in a medical home setting.

2.2 (C5-9,CL3) - Part of the innovative training of primary care providers will be centered on the chronic care model, with emphasis on team-based practice.

2.11 (C10) - Structured educational training for health care providers on quality and cost control will entail instruction in medication therapy management for minimizing medication errors.

Relationship to Other Performing Providers' Projects in the RHP:

Our region is blessed with multiple academic organizations that are a recruitment ground for areas that are currently medically underserved, but there is a drastic need of additional residency programs due to existing class size and training programs. The residency program proposals will allow the organizations to benefit in workforce need for all other initiatives. There is a unique initiative in our region for the expansion of a residency program.

Plan for Learning Collaborative:

UTHealth will participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system.

Project Valuation:

The anchor, Harris Health, provided a spreadsheet that contained 6 criteria, which could be used to rate each project on a 10-point scale. The ratings for each criterion were weighted, summed for each project to arrive at a total score (value weight) for each project. The sum of all the project's total scores were then divided by the percent of total DSRIP funds to be secured for that year to arrive at a dollar value multiplier to be applied towards each project's total score (value weight), thereby allocating a greater proportion of the funds towards those projects valued highest based upon the 6 criteria. UTHealth used this approach, with one exception—we did not use two of the criteria. Following are the criteria, the considerations for awarding points for projects using that criterion, and the reasons two of the criteria were not used:

1. Transformational Impact (Weight = 20%): Points were awarded for projects that meet the community benefit criteria, such as: improving access; improving quality; improving costs

(long-term cost-savings); transformative (Innovative), collaborative (partners with other organization(s)). This project's score for this criterion: **5**

2. Population Served/Project Size (Weight = 20%): Points were awarded based on the size of the population affected and whether the target population is uninsured or on Medicaid. This project's score for this criterion: **1**

3. Aligned with Community Needs (Weight = 20%): Points were awarded based on judgments in two categories: whether or not the CNA indicates a need in the area of the project and the severity of the health/healthcare need(s) the project addresses. This project's score for this criterion: 111810101.1.2 X 2 = **2**

4. Cost Avoidance (Weight = 15%): Points were awarded based on judgment of project's cost effectiveness relative to similar projects. This project's score for this criterion: **1**

5. Partnership/Collaboration (Weight = 10%): ***This was not rated***, because UTHealth planned to partner with Harris Health to perform many similar projects, so the rating would have been the same for all projects. This would have diluted the scores, hiding the more significant variations in other value criteria.

6. Sustainability (Weight = 15%): ***This was also not rated***, because UTHealth does not consider any of the projects to be unsustainable, or at the very least do not consider one project less sustainable than another. Giving the projects the same, or very similar ratings on this criteria again would have had a diluting effect, hiding the more significant variations in other value criteria.

Total Valuation Score for this project: **1.75**

111810101.1.2	*OPTION 1.2.1*	*1.2.1(A-F)*	*A2 UT HEALTH REGIONAL ACADEMY FOR TRANSLATIONAL MEDICINE AND UT HEALTH ACADEMY FOR PATIENT QUALITY AND SAFETY*
	UTHealth, UTPhysicians		*111810101*
Related Category 3 Outcome Measure(s):	*111810101.3.4* *111810101.3.5* *111810101.3.6*	*IT-14.6* *IT-14.7* *IT-14.8*	*Percent of trainees who have spent at least 5 years living in a health professional shortage area (HPSA) or medically underserved area (MUA)* *Percent of trainees who report that they plan to practice in HPSAs or MUAs based on a systematic survey* *Percent of trainees who report that they plan to serve Medicaid populations based on a systematic survey*
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-8]: Establish/expand a faculty development program Metric 1 [P-8.1]: Enrollment of faculty staff into primary care education and training program Baseline/Goal: TBD Data Source: Program documents Milestone 1 Estimated incentive payment: $ 1,676,230	**Milestone 2** [P-9]: Develop/disseminate clinical teaching tools for primary care or interdisciplinary clinics/sites Metric 1 [P-9.1]: Clinical teaching tools Baseline/Goal: TBD Milestone 2 Estimated incentive payment: $1,740,675	**Milestone 3** [I-14]: Increase the number of faculty staff completing educational courses Metric 1 [I-14.1]: Number of staff completing courses Goal: TBD Data Source: Certificates of completion or course graduate records. Milestone 3 Estimated incentive payment: $ 1,966,104	**Milestone 4** [I-15]: Increase primary care training in Continuity Clinics, which may be in diverse, low-income, community-based settings, (must include at least one of the following metrics): Metric 1 [I-15.1]: Increase number of Continuity Clinic sessions available for primary care trainees. Goal: TBD Data Source: Number of trainee office visits, such as from disease registry, EHR, claims data or other reports Milestone 4 Estimated incentive payment: $1,968,948
Year 2 Estimated Milestone Bundle Amount: $1,676,230	Year 3 Estimated Milestone Bundle Amount: $1,740,675	Year 4 Estimated Milestone Bundle Amount: $1,966,104	Year 5 Estimated Milestone Bundle Amount: $1,968,948
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*:* $7,351,957			

Project Option 1.2.2- 1.2 Increase training of primary care workforce: Training of Community Health Workers (CHWs)

Unique RHP Project ID: 111810101.1.3
Performing Provider Name/TPI: UTHealth, UTPhysicians / 111810101

Project Summary:

Provider:
UT Physicians is the clinical practice of The University of Texas Medical School at Houston. With more than 900 physicians certified in 80 medical specialties and subspecialties, 906 residents and fellows, and 283,920 patient visits in 2011, it is the fastest growing academic practice in the nation for the last five years. In addition to our flagship location in the Texas Medical Center, UT Physicians has 4 neighborhood locations throughout the Greater Houston area, and also offers specialty clinics at several Memorial Hermann Hospital locations.

Intervention(s):
University of Texas School of Public Health will partner with Gateway to Care, Harris Health System, and UT Physicians to increase the number of certified CHWs in the region (currently approximately 500) and respond to specific continuing education needs as identified by providers and CHWs. In addition, providers and clinic staff will be trained on how to integrate CHWs as members of the health care team.

Need for the project:
One of our identified community needs is that there is insufficient access to services that are specifically designed to address racial, ethnic and cultural health care disparities. CHWs are public health professionals who use their unique understanding of the experiences, language and/or culture of the population they serve to promote health, hence they have proven to be an important link between healthcare providers, researchers and disadvantaged communities.

Target Population:
This program targets, primarily, the adult Hispanic population (18 years and above) in our 4 service areas, which number approximately 552,660.

Category 1 or 2 expected patient benefits:
By DY4 the target will be to achieve improvement in trainee knowledge assessment scores of CHWs, and by DY5 to achieve improvement in trainee satisfaction with specific elements of the training program. We expect that CHWs satisfied and confident in their training, will facilitate better care for patients and greater participation in their self care, particularly for minority/underserved patients facing cultural barriers to quality health care.

Category 3 outcomes:
IT-11.5 (IT-2.10): Our goal is to reduce by 3% in DY4 and 5% in DY5, the percentage of all discharges with a principal diagnosis of flu or pneumonia among Hispanics aged 18 years and older who are patients of UT Physicians.

Project Option 1.2.2 – Increase Training of Primary Care Workforce: SPH1 Training of Community Health Workers (CHWs)

Unique RHP Project Identification Number: 111810101.1.3
Performing Provider Name/TPI: UTHealth, UTPhysicians/111810101

Project Description: 1.2 Increase training of primary care workforce (Option 1.2.2)

This project will aid the reshaping of the health care system in Southeast Texas. The University of Texas School of Public Health (UTSPH) has a rich history of community health worker (CHW) training and is a state recognized training center. The UTSPH will partner with Gateway to Care, Harris Health System, and UT Physicians (UTP) to increase the number of certified CHWs in the region (currently approximately 500) and respond to specific continuing education needs as identified by providers and CHWs. Additionally, providers and clinic staff will be trained in how to integrate CHWs as members of the health care team.

Clinics implementing this team-based model will be matched with a clinic operating under the current practice model. Comparisons will be made based on: chronic disease management including diabetes, tobacco control, hypertension, prenatal care, and cancer screening and referral; immunization rates; return on investment; and quality of experience as reported by patients.

In the UTP service areas alone, there are large populations with economic, cultural, and language barriers to receiving health care. UTP has defined the service area for its clinics to include the census tracts within a seven-mile radius of each clinic. The Bayshore Clinic is in the southeast area of Houston and includes parts of Pasadena, South Houston, and areas immediate south of the ship channel. The service area of this clinic has a population of 431,199, with 36.5% living at/below the federal poverty level (FPL). The population is 49.2% Hispanic and of those, 51.1% are not proficient in English. The Bellaire Clinic, with a population of 472,698, is on the west side of Houston and also has a large minority population, with 24.1% Black/African American and 46% Hispanic, and 52.2% live at/below the FPL. Of the Spanish-speaking population in the Bellaire Clinic service area, 62.8% are not proficient in English. The Cinco Ranch (population 287,744) and Sienna Village (population 231,535) clinics serve populations reaching into Ft. Bend County that closely mirror the overall county demographics (23.7% Hispanic), with the exception of Sienna Village Clinic, which has a large Black/African American population of 33.5%. There are 20.8% of the Cinco Ranch Clinic population and 26.2% of the Sienna Village Clinic population living at/below the FPL. These two clinics also serve rural populations. Since the Hispanic population would especially benefit from the involvement of CHWs as a part of their health care team, and the large population of Hispanics living within the UTP service areas (approximately 552,660) and the rest of Harris County, this will be our target population. Furthermore, based upon the demographics of UTPs service areas, we expect that there is a greater rate of Medicaid/Medicaid-eligible clients to be served. However, using the overall Harris County rate (14.5%) of Medicaid clients, there would be at least an estimated 1,423,176 Medicaid clients living within the service areas of the UT Physician Clinics. (All population statistics are from the U.S. Census Bureau, 2010 Census. Poverty statistics are from the U.S. Census Bureau, Small Area Estimates Branch. Release date: 11.2011. Table 1: 2010 Poverty and Median Income Estimates - Counties. The Medicaid rate is from the

U.S. Census Bureau and the Centers for Disease Control and Prevention, State and County by Demographic and Income Characteristics. SAHIE, 2009.)

Goal and Relationship to Regional Goals:

Project Goal:

To increase availability and utilization of certified CHWs trained in organized care delivery models, with an emphasis on team-based practice, quality and cost control, that will serve as members of healthcare delivery teams.

This project addresses the following regional goal:

CHWs will be invaluable in helping the region achieve its goal to "transform health care delivery from a disease-focused model of episodic care to a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary or duplicative services, and builds on the accomplishments of our existing health care system".

Challenges:

Need: 1) Lack of access to culturally appropriate care. 2) Lack of access to programs providing health promotion education, training and support, including screenings, nutrition counseling, patient education programs.

Implementation: 1) Willigness of other providers/clinicians to incorporate CHWs in their care team. 2) Retention of trained CHWs.

CHWs have been proven to be effective in serving as linkages between patients and the health system, helping patients to navigate the daunting challenges posed by the fragmented nature of health care delivery on the US. Most CHWs come from the local population, are in touch with the community, and are better able to attend to the needs of patients by helping the system to deliver culturally sensitive care and by facilitating their access to health education and support, thereby providing an important and cost effective service to health care teams and to patients. Providers/clinicians will be trained onthe value that CHWs bring to the health care team and in how to incorporate them into the practice. The inclusion of CHWs into care teams in their community and competitive compensation will aid in the retention of trained CHWs.

5-Year Expected Outcome for Provider and Patients:

Several CHWs will have been trained for practice in the region, and more practices will have CHWs employed in team-based management models. Since CHWs are able to provide patients with culturally appropriate assistance, we would expect better adherence to a regular schedule of primary care and chronic disease treatment plans, thereby producing better health outcomes and reduced need for acute care services. Since 18.7% of the Harris County population is living in poverty (27.1% of children) and 66% of the population are minorities, with 41% being Hispanic, culturally appropriate assistance in navigating the healthcare system and treatment plans will be very important. The inclusion of CHWs into the community clinics and the safety net hospitals in Harris County has the potential to reach large populations of Medicaid and Medicaid-eligible clients. One of the specific improvements we expect to see is higher rates of vaccinations, so we will be measuring a reduction in admissions for influenza and pneumonia for Hispanic patients.

Starting Point/Baseline:

To be determined during DY3.

Rationale:

CHWs are members of a team of public health professionals who use their unique understanding of the experiences, language and/or culture of the populations they serve to promote health. CHWs have proven to be an important link between healthcare providers, researchers and disadvantaged communities.

As leaders, CHWs bridge the gap between communities and the public health system – they are resource persons who act as liaisons between residents and health and human services. In the United States, CHWs have been a part of the health care delivery system since the 1960s. Their role has evolved over time and varies according to their work setting, which ranges from outreach workers in the community to clinic staff. CHWs have a broad skill set, including communication, leadership, advocacy, and both general and disease or condition-specific health knowledge. Duties performed by CHWs range from counseling and health education to basic clinical tasks (HRSA, 2007). Regardless of their work environment, CHWs are trusted members of the community in which they work and typically reflect the demographic characteristics of the area. Their knowledge of local culture and customs allows them to effectively deliver direct health messages to community members, provide services, connect them to local health and social services, and advocate on their behalf. Nationally and internationally, CHWs are viewed as part of the solution for achieving improved health status in rural and disenfranchised communities.

For many years CHWs have provided an array of health care services in different settings. Recently their role has been elevated, nationally and internationally, as opportunities for integrating CHWs into the health care delivery system are discussed. In 2009, the US Department of Labor recommended the creation of a Standard Occupational Classification for CHWs. This act opened the door for additional integration into the US health system. The 2010 Patient Protection and Affordable Care Act (health reform law) identified community health workers as having major roles in achieving the goals of health care reform. At the International level, the United Nations Millennium Development Goals (MDGs) acknowledge the importance of human capital. In an effort to progress toward meeting health-related MDGs, the World Health Organization recommends CHWs as a part of the health service workforce (Achieving the health-related MDGs. It takes a workforce! 2010).

This project aims to demonstrate improved health outcomes, return-on-investment, and increased patient satisfaction when CHWs are integrated into the health care team in clinics southeast Texas.

Project Components:

Through the Training of Community Health Workers (CHWs) Program, we propose to meet all required project components listed below.

a) Recruit and train more community health workers/promotoras,
b) Train providers and clinic staff on how to integrate CHWs as members of the health care team, and
c) Place CHWs with UT Physician healthcare teams, and other healthcare provider teams throughout the region.

Milestones and Metrics:

For the Training of Community Health Workers (CHWs) Program, we have chosen the below milestones and metrics based upon the above project components and relationship to project goals and population needs. All baselines and goals will be determined during DY2.

Process Milestones and Metrics:

Milestone 1 [P-2]: Expand primary care training for community health workers
Metric 1 [P-2.1]: Expand other primary care staff (community health workers) training programs
Milestone 2 [P-3]: Expand positive primary care exposure for residents/trainees
Metric 1 [P-3.3]: Include trainees/rotations in quality improvement projects

Improvement Milestones and Metrics:

Milestone 3 [I-11]: Increase primary care training and/or rotations
Metric 1 [I-11.6]: Improvement in trainee knowledge assessment scores
Milestone 4 [I-11]: Increase primary care training and/or rotations
Metric 1 [I-11.5]: Improvement in trainee satisfaction with specific elements of the training program

Unique community need identification numbers the project addresses:

This project addresses community needs CN.20 (Lack of access to programs providing health promotion education, training and support, including screenings, nutrition counseling, patient education programs) and CN.22 (Insufficient access to services that are specifically designed to address racial, ethnic and cultural health care disparities).

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

This initiative is an expansion of an existing training program. This initiative proposes increasing the number of CHWs trained and placing more CHWs within health care teams in the area. However, there is a new element being added, which is the training of providers in how to integrate CHWs as members of the health care team.

Related Category 3 Outcome Measure(s):

OD-11 Addressing Health Disparities in Minority Populations

- IT-11.5 (IT-2.10) Select any other Category 3 outcome (PPAs, PPRs, or ED utilization) or a combination of non-standalone measures and target a specific minority population with a demonstrated disparity in the particular measure (Standalone measure) (IT-2.10 Flu and pneumonia Admission Rate)
  For the Hispanic population:
  Numerator: All discharges of age 18 years and older with a principal diagnosis code of flu or pneumonia.
  Denominator: Population in Metro Area or county, age 18 years and older.

Relationship to other Projects:

1.1 (C3) - The training of CHWs will increase the availability of support staff for the expansion of primary care capacity.

1.3 (C12) - The disease management registry will help identify patients that need active follow-up, for which CHWs will be uniquely qualified for outreach to non-compliant patients, facilitating their return to appropriate care.

1.7 (A1) - The telemedine technology will also be available for CHWs in their outreach activities and in facilitating patients' interaction with their healthcare team, particularly for those patients with distance/ transportation barriers.
2.1 (C1-2) - The increased training of CHWs competent to work with the 'new primary care' team-based model of care will be an important component of transitioning patients into medical homes.
2.2 (C5-9,CL3) - Part of the initiatives in the redesigning of chronic care delivery systems is to make better use of non-physician members of the team, such as the CHWs able to facilitate culturally-appropriate communication, education, and navigation, which are important components of the chronic care model.
2.11 (C10) - Trained CHWs able to facilitate culturally-appropriate communication, education, and navigation will be essential to the care team's medication therapy management for minimizing medication errors.

Relationship to Other Performing Providers' Projects in the RHP:

As the regional healthcare platform aggressively grows, so will the need of workforce expansion to accommodate the needs in order to achieve outcome measures. Workforce expansions range from physician to extender workforce needs and are reflected in the Region 3 Initiative grid in the addendum.

Plan for Learning Collaborative:

UTHealth will participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system.

Project Valuation:

The anchor, Harris Health, provided a spreadsheet which contained 6 criteria, which could be used to rate each project on a 10-point scale. The ratings for each criterion were weighted, summed for each project to arrive at a total score (value weight) for each project. The sum of all the project's total scores were then divided by the percent of total DSRIP funds to be secured for that year to arrive at a dollar value multiplier to be applied towards each project's total score (value weight), thereby allocating a greater proportion of the funds towards those projects valued highest based upon the 6 criteria. UTHealth used this approach, with one exception—we did not use two of the criteria. Following are the criteria, the considerations for awarding points for projects using that criterion, and the reasons two of the criteria were not used:

1. Transformational Impact (Weight = 20%): Points were awarded for projects that meet the community benefit criteria, such as: improving access; improving quality; improving costs (long-term cost-savings); transformative (Innovative), collaborative (partners with other organization(s)). This project's score for this criterion: **4**

2. Population Served/Project Size (Weight = 20%): Points were awarded based on the size of the population affected and whether the target population is uninsured or on Medicaid. This project's score for this criterion: **4**

3. Aligned with Community Needs (Weight = 20%): Points were awarded based on judgments in two categories: whether or not the CNA indicates a need in the area of the

project and the severity of the health/healthcare need(s) the project addresses. This project's score for this criterion: 111810101.1.3 X 2 = **4**

4. Cost Avoidance (Weight = 15%): Points were awarded based on judgment of project's cost effectiveness relative to similar projects. This project's score for this criterion: **2**

5. Partnership/Collaboration (Weight = 10%): ***This was not rated***, because UTHealth planned to partner with Harris Health to perform many similar projects, so the rating would have been the same for all projects. This would have diluted the scores, hiding the more significant variations in other value criteria.

6. Sustainability (Weight = 15%): ***This was also not rated***, because UTHealth does not consider any of the projects to be unsustainable, or at the very least do not consider one project less sustainable than another. Giving the projects the same, or very similar ratings on this criteria again would have had a diluting effect, hiding the more significant variations in other value criteria.

Total Valuation Score for this project: **2.7**

111810101.1.3	***1.2.2***	***A-B***	***SPH1 Training of Community Health Workers (CHWs)***
UTHealth, UTPhysicians			*111810101*
Related Category 3 Outcome Measure(s):	*111810101.3.7*	*IT-11.5 (IT-2.10)*	*Select any other Category 3 outcome (PPAs, PPRs, or ED utilization) or a combination of non-standalone measures and target a specific minority population with a demonstrated disparity in the particular measure (Standalone measure) (IT-2.10 Flu and pneumonia Admission Rate)*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-2]: Expand primary care training for community health workers Metric 1 [P-2.1]: Expand other primary care staff (community health workers) training programs Baseline/Goal: TBD Data Source: Training program documentation Milestone 1 Estimated incentive payment: $ 2,586,183	**Milestone 2** [P-3]: Expand positive primary care exposure for residents/trainees Metric 1 [P-3.3]: Include trainees/rotations in quality improvement projects Baseline/Goal: TBD Data Source: Curriculum and/or quality improvement project documentation/data Milestone 2 Estimated incentive payment: $2,766,938	**Milestone 3** [I-11]: Increase primary care training and/or rotations Metric 1 [I-11.6]: Improvement in trainee knowledge assessment scores Goal: TBD Data Source: Knowledge assessment tool Milestone 3 Estimated incentive payment: $ 3,033,417	**Milestone 4** [I-11]: Increase primary care training and/or rotations Metric 1 [I-11.5]: Improvement in trainee satisfaction with specific elements of the training program Goal: TBD Data Source: Trainee satisfaction assessment tool Milestone 4 Estimated incentive payment: $2,990,650
Year 2 Estimated Milestone Bundle Amount: $2,586,183	Year 3 Estimated Milestone Bundle Amount: $2,766,938	Year 4 Estimated Milestone Bundle Amount: $3,033,417	Year 5 Estimated Milestone Bundle Amount: $2,990,650
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*:* $11,377,188			

Project Option 1.3.1- 1.3 Implement a Chronic Disease: UT Physicians Chronic Disease Registry

Unique RHP Project ID: 111810101.1.4
Performing Provider Name/TPI: UTHealth, UTPhysicians / 111810101

Project Summary:

Provider:
UT Physicians is the clinical practice of The University of Texas Medical School at Houston. With more than 900 physicians certified in 80 medical specialties and subspecialties, 906 residents and fellows, and 283,920 patient visits in 2011, it is the fastest growing academic practice in the nation for the last five years. In addition to our flagship location in the Texas Medical Center, UT Physicians has 4 neighborhood locations throughout the Greater Houston area, and also offers specialty clinics at several Memorial Hermann Hospital locations.

Intervention(s):
Data entered into a unique chronic disease registry will be used to pro-actively contact, educate, and track patients by disease status, risk status, self management status, community and family need. Reports drawn from the registry will be used to develop and implement targeted quality improvement plans for diabetes, hypertension, asthma, COPD, and CHF.

Need for the project:
Our service population has high rates of chronic disease, and there is lack of care coordination due to insufficient implementation and use of electronic health records. Utilization of registry functionalities will help our care teams to actively manage patients with targeted chronic conditions because the registry will include clinician prompts and reminders, which would aid in the delivery of proactive care.

Target Population:
This project targets patients in our service area with diabetes, hypertension, asthma, COPD, or CHF. Patients of lower socioeconmic status (which number approximately 448,583 for the UTP clinics service areas) are known to have worse disease control due to the inability to maintain compliance in the long run, hence this project will be beneficial to the Medicaid population in the UTP clinics service areas.

Category 1 or 2 expected patient benefits:
The milestone target for DY4 is to increase the percentage of patients enrolled in the registry. And by DY5 to increase the number of patient contacts recorded in the registry relative to baseline rate.

Category 3 outcomes:
IT-1.7: Our goal is to improve by 3% in DY4 and 5% In DY5, the percentage of UT Physician's patients (ages 18 to 85 years) with a diagnosis of hypertension, whose most recent blood pressure (BP) is adequately controlled (BP less than 140/90 mm Hg) during the measurement year.

Project Option 1.3.1 – Implement a Chronic Disease Management Registry: C12 UT Physicians Chronic Disease Registry

Unique RHP Project Identification Number: 111810101.1.4
Performing Provider Name/TPI: UTHealth, UTPhysicians/111810101

Project Description: 1.3 Implement a Chronic Disease Management Registry (Option 1.3.1)

UT Physicians will implement and use chronic disease management registry functionalities. Data entered into a unique chronic disease registry will be used to pro-actively contact, educate, and track patients by disease status, risk status, self management status, community, and family need. Reports drawn from the registry will be used to develop and implement targeted QI plans for diabetes, hypertension, asthma, COPD, and CHF. Utilization of registry functionalities helps care teams to proactively manage patients with targeted chronic conditions because the disease management registry will include clinician prompts and reminders, which would aid in the delivery of proactive care to patients with chronic diseases. With the high rates of chronic diseases in RHP3 (CN.11), the use of a chronic disease registry will be an important tool in our ability to provide the best quality of care for patients with diabetes, hypertension, asthma, COPD, and CHF. UTP provided 321,716 patient visits during FY 2012. It is unknown at this time how many of these patients have a chronic disease, or which disease(s) they might have, since we do not currently have chronic disease registry. Whatever the number, we are expecting growth in patient visits by about 42,000 for primary care and 38,000 for specialty care due to expansion in these areas, which means that we will be providing over 400,000 patient visits by the end of DY5 (most of this growth is expected to be among Medicaid/Medicaid-eligible clients). With a patient base this large, a chronic disease registry will be not only key to providing proactive high-quality care, but will also allow us to identify trends to be addressed through interventions and quality improvement processes.

Through project MS1 (UT Health Regional Systems Engineering Center and UT Health Quality Improvement Dashboard Development Center), the systems engineering and QI teams at UT Health will identify QI targets and methods needed to achieve continuous quality improvement for this project, especially as it relates to identifying challenges for expansion, and building on lessons learned.

Goal and Relationship to Regional Goals:

Project Goal:

To track key patient information, thereby enabling physicians and other members of a patient's care team to identify and reach out to patients who may have gaps in their care in order to prevent complications, which often lead to more costly care interventions.

This project addresses the following regional goal:

By establishing disease specific registries, providers will have the benefit of a rich information source on the dynamics/progress of patients under their care. This taps into the regional goal that aims to "transform health care delivery from a disease-focused model of episodic care to a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary or duplicative services, and builds on the accomplishments of our existing health care system."

Challenges:

Need: 1) Lack of care coordination and unnecessary duplication of services due to insufficient implementation and use of electronic health records. 2) High rates of chronic disease and inadequate access to treatment programs and services for illnesses associated with chronic disease. Implementation: 1) Recruitment and training of case managers to run the registries. 2) Capacity to act on data output from registry.

In addition to the high rates of chronic diseases in the population, the failure to make maximum use of the support of clinical information technology has hampered the effective management of such diseases. Information technology, which is part of Wagner's chronic care model, has been shown to contribute positively to the delivery of a proactive care that keeps patients healthy as much as possible and achieve stable states in disease conditions by yielding timely actionable information.

5-Year Expected Outcome for Provider and Patients:

Chronic disease registries will have been created and incorporated into the care models for the targeted diseases for the delivery of proactive and coordinated care for patients with chronic diseases, such as cardiovascular disease/hypertension. We expect that improved care for these patients will result in better outcomes and less need for acute episodic care, thereby lowering ED utilization for patients with cardiovascular disease/hypertension. In addition to benefiting the current Medicaid (23% as of 2011, or 65,302 patient visits) and low-income client base of UTP clinics, the expansion of primary care and specialty care services will be marketed to the additional 1,423,176 Medicaid and Medicaid-eligible residents living within the service areas of the UT Physician Clinics with cardiovascular disease/hypertension. Since we are expecting growth in our clinics by at least 42,000 patient visits by the end of DY5, and we expect the growth to be primarily in the Medicaid/Medicaid eligible patients (raising our percentage of Medicaid patient visits) the use of the disease registry will potentially benefit a rather large number of people.

Starting Point/Baseline:

To be determined during DY3.

Rationale:

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 would aid in the delivery of proactive care to patients with chronic diseases. The following statistics on select chronic diseases demonstrate the need for tools and processes that assist in the management of these diseases, such as the chronic disease registry.

Asthma is increasing every year in the US; the proportion of people with asthma in the United States grew by nearly 15% in the last decade. There is significant disparities in asthma prevalence in the US. Adults with an annual household income of $75,000 or less are more likely to have asthma than adults with higher incomes. (Asthma's Impact on the Nation: Data from the CDC National Asthma Control Program. Available at: http://www.cdc.gov/asthma/ impacts_nation/ AsthmaFactSheet.pdf. Accessed 10/15/12). Hence the Medicaid population has a higher prevalence of asthma. Asthma costs the US about $3,300 per person with asthma each year from 2002 to 2007 in medical expenses. Medical expenses associated with asthma increased

from $48.6 billion in 2002 to $50.1 billion in 2007. About 2 in 5 (40%) uninsured people with asthma could not afford their prescription medicines and about 1 in 9 (11%) insured people with asthma could not afford their prescription medicines. People with asthma can prevent asthma attacks if they are taught to use inhaled corticosteroids and other prescribed daily long-term control medicines correctly and to avoid asthma triggers. In 2008 less than half of people with asthma reported being taught how to avoid triggers. (CDC 2011: Asthma in the US. Available at: http://www.cdc.gov/vitalsigns/Asthma/#. Accessed 10/15/12).

Hispanics have a 66% higher risk of being diagnosed with diabetes than non-Hispanic whites and non-Hispanic blacks have a 77% higher risk. (2011 National Diabetes Fact Sheet, National Center for Chronic Disease Prevention and Health Promotion, Division of Diabetes Translation, Centers for Disease Control and Prevention. http://www.cdc.gov/diabetes/pubs/estimates11.htm#8 Last reviewed and updated May 23, 2011. Accessed 10-11-12.). About 40% of Harris County residents are of Hispanic origin (U.S. Census Bureau, 2010 Census Summary File 1), compared to 16.3% of the US population. Uncontrolled diabetes can result in complications with dire consequences for the patient. For example, the risk of stroke is 2 - 4 times higher among people with diabetes; diabetes is the leading cause of new onset blindness among adults aged 20 - 74 years in the US; nearly half of all cases of kindey failure can be attributed to diabetes; and more than half of all caes of nontraumatic lower limb amputations are because of poorly controlled diabetes. Diabetes also predisposes patients to dental diseases, pregnancy complications, among other problems. Overall, the risk for death among people with diabetes is about twice that of people of similar age but without diabetes. Studies in the United States have shown that improved glycemic control benefits people with either type 1 or type 2 diabetes. In general, every percentage point drop in A1c blood test results (e.g., from 8.0% to 7.0%) can reduce the risk of microvascular complications (eye, kidney, and nerve diseases) by 40%. After adjusting for population age and sex differences, average medical expenditures among people with diagnosed diabetes were 2.3 times higher than what expenditures would be in the absence of diabetes. Hence achieving good glycemic control among our diabetic patients will save the health system a lot of resources.

Around 5.8 million people in the United States have heart failure and about 670,000 people are diagnosed with it each year. About one in five people who have heart failure die within one year from diagnosis but early diagnosis and treatment can improve quality of life and life expectancy for people who have heart failure. Heart failure results in significant costs to the system; it cost the US nearly $40 billion in 2010 (CDC 2010: healrt failure facts. Available at: http://www.cdc.gov/dhdsp/data_statistics/fact_sheets/docs/fs_heart_failure.pdf. Accessed on 10/15/12).

Chronic lower respiratory diseases, primarily COPD, are the third leading cause of death in the United States, and 5.1% of U.S. adults report a diagnosis of emphysema or chronic bronchitis (Morbidity and Mortality Weekly Report (MMWR) March 2, 2012 / 61(08);143-146. Available at: http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6108a3.htm?s_cid=mm6108a3_w. Accessed 10/15/12). Excess health-care expenditures are estimated at nearly $6,000 annually for every COPD patient in the United States (Deaths from Chronic Obstructive Pulmonary Disease - United States, 2000--2005. November 14, 2008 / 57(45);1229-1232. Available at: http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5745a4.htm. Accsessed 10/15/12), Uncontrolled COPD leads to deterioration in lung function and eventually death.)

In 2009-2010, the age-adjusted percentage of US adults with hypertension whose blood pressure was contolled was 53.3%. So nearly half of all hypertensive patients have poor blood

pressure control.Yet hypertension is a leading cause of stroke, coronary artery disease, heart attack, and heart and kidney failure in the United States, all of which contribute to the rising costs of health care. Aggressive treatment of hypertension, significantly decreases the risk of coronary artery disease, congestive heart failure, stroke, and resulting disability. For example, a 12-point to 13-point reduction in blood pressure can lower the risk of heart attack by 21%, stroke by 37%, and total cardiovascular deaths by 25% (Rein DB, Constantine RT, Orenstein D, Chen H, Jones P, Brownstein JN, et al. A cost evaluation of the Georgia Stroke and Heart Attack Prevention Program. Prev Chronic Dis [serial online] 2006 Jan [date cited]. Available from: URL: http://www.cdc.gov/pcd/issues/2006/jan/05_0143.htm. Accessed on 10/15/12). Low-income individuals without prescription drug coverage are significantly more likely to skip doses to save money or make their hypertension medication prescriptions last longer. (Rein DB, Constantine RT, Orenstein D, Chen H, Jones P, Brownstein JN, et al. A cost evaluation of the Georgia Stroke and Heart Attack Prevention Program. Prev Chronic Dis [serial online] 2006 Jan [date cited]. Available from: URL: http://www.cdc.gov/pcd/issues/2006/jan/05_0143.htm. Accessed on 10/15/12).

Project Components:

Through the UT Physicians Chronic Disease Registry Program, we propose to meet all required project components listed below.

a) UTP will develop a chronic disease registry to track and monitor patients with diabetes, hypertension, asthma, COPD, and CHF,
b) Test and validate the accuracy of the registry, and
c) Train UTP faculty & staff on how to use the registry to proactively contact, educate, and track patients by disease status, risk status, self-management status, community and family need.
d) UTP's quality improvement office will use registry reports to develop and implement a targeted QI plan, and
e) Conduct quality improvement for the project using methods such as rapid cycle improvement.

Milestones and Metrics:

For the UT Physicians Chronic Disease Registry Program, we have chosen the below milestones and metrics based upon the above project components and relationship to project goals and population needs. All baselines and goals will be determined during DY2.

Process Milestones and Metrics:

Milestone 1 [P-1]: Identify one or more target patient populations diagnosed with diabetes, hypertension, asthma, COPD, or CHF.

Metric 1 [P-1.1]: Proportion of patients with diabetes, hypertension, asthma, COPD, and CHF targeted and entered into the registry

Milestone 2 [P-3]: Develop cross-functional team to evaluate registry program.

Metric 1 [P-3.1]: Documentation of personnel (clinical, IT, administrative) assigned to evaluate registry program

Improvement Milestones and Metrics:

Milestone 3 [I-15]: Increase the percentage of patients enrolled in the registry.

Metric 1 [I-15.1]: Percentage of patients in the registry

Milestone 4 [I-16]: Increase the number of patient contacts recorded in the registry relative to baseline rate.

Metric 1 [I-16.1]: Total number of in-person and virtual (including email, phone and web-based) visits, either absolute or divided by denominator.

Unique community need identification numbers the project addresses:

This project addresses community needs CN.11 (High rates of chronic disease and inadequate access to treatment programs and services for illnesses associated with chronic disease) and CN.24 (Lack of care coordination and unnecessary duplication of services due to insufficient implementation and use of electronic health records).

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

The Chronic Disease Management Registry project respresents a new initiative, since this does not currently exist. This initiative will improve our ability to provide pro-active patient-centered care for those with chronic diseases, track these patients, and ensure adherance to treatment plans.

Related Category 3 Outcome Measure(s):

OD-1 Primary Care and Chronic Disease Management

- IT-1.7 Controlling high blood pressure (NCQA-HEDIS 2012, NQF 0018)12 (Stand-alone measure)

Improve the number of patients 18 to 85 years of age with a diagnosis of hypertension,whose most recent blood pressure (BP) is adequately controlled (BP less than 140/90 mm Hg) during the measurement year.

<u>Relationship to other Projects:</u>

1.1 (C3) - Expanded primary care capacity will enable the effective use of the outputs of the disease management registries to bridge gaps for at-risk patients.

1.7 (A1) - Reports from the disease management registry can be transmitted to a specialist at a distant site using telemedicine facilitating quality care.

1.9 (C4) - The disease management registry will serve as a useful resource to every specialty provider involved in managing the enrolled patients.

1.10 (MS1) - The chronic disease registries will make available useful QI data that will be used to populate the QI dashboards under project MS1.

2.1 (C1-2) - The disease management registry will serve as a useful resource to every member of the medical home care team involved in managing the enrolled patients.

2.2 (C5-9,CL3) - The disease management registry (Information Technology support) is a very improtant component of Wagner's Chronic Care Model being implmented in these projects.

2.11 (C10) - The disease management registries and the medication management project will complement each other to ensure patients with chronic diseases, especially those with multiple chronic conditions, get optimal care with minimal errors and sustained active follow up.

2.12 (A3, CL1, CL2, MS4) - The disease management registry will provide important technological support to the care transitions projects with the aim of tracking patients to ensure adequate, sustained follow up.

<u>Relationship to Other Performing Providers' Projects in the RHP:</u>

The sheer volume of population as well as the complexity of patient conditions dictates the need of numerous disease registries in our region to properly identify and manage chronic conditions. The concept is utilized consistently throughout our region in order to help achieve milestones and outcomes specific to patient conditions. All disease registries presented have a

similarity in concept but are unique in the sense of condition or patient population focus. The Region 3 initiative grid in the addendum reflects direct relations between all projects.

Plan for Learning Collaborative:

UTHealth will participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system.

Project Valuation:

The anchor, Harris Health, provided a spreadsheet which contained 6 criteria, which could be used to rate each project on a 10-point scale. The ratings for each criterion were weighted, summed for each project to arrive at a total score (value weight) for each project. The sum of all the project's total scores were then divided by the percent of total DSRIP funds to be secured for that year to arrive at a dollar value multiplier to be applied towards each project's total score (value weight), thereby allocating a greater proportion of the funds towards those projects valued highest based upon the 6 criteria. UTHealth used this approach, with one exception—we did not use two of the criteria. Following are the criteria, the considerations for awarding points for projects using that criteria, and the reasons two of the criteria were not used:

1. Transformational Impact (Weight = 20%): Points were awarded for projects that meet the community benefit criteria, such as: improving access; improving quality; improving costs (long-term cost-savings); transformative (Innovative), collaborative (partners with other organization(s)). This project's score for this criteria: **4**

2. Population Served/Project Size (Weight = 20%): Points were awarded based on the size of the population affected and whether the target population is uninsured or on Medicaid. This project's score for this criteria: **2**

3. Aligned with Community Needs (Weight = 20%): Points were awarded based on judgments in two categories: whether or not the CNA indicates a need in the area of the project and the severity of the health/healthcare need(s) the project addresses. This project's score for this criteria: 111810101.1.4 X 2 = **2**

4. Cost Avoidance (Weight = 15%): Points were awarded based on judgment of project's cost effectiveness relative to similar projects. This project's score for this criteria: **2**

5. Partnership/Collaboration (Weight = 10%): ***This was not rated***, because UTHealth planned to partner with Harris Health to perform many similar projects, so the rating would have been the same for all projects. This would have diluted the scores, hiding the more significant variations in other value criteria.

6. Sustainability (Weight = 15%): ***This was also not rated***, because UTHealth does not consider any of the projects to be unsustainable, or at the very least do not consider one project less sustainable than another. Giving the projects the same, or very similar, ratings on this criteria again would have had a diluting effect, hiding the more significant variations in other value criteria.

Total Valuation Score for this project: **1.9**

<table>
<tr><td>111810101.1.4</td><td>1.3.1</td><td>A-D</td><td colspan="2">C12 UT PHYSICIANS CHRONIC DISEASE REGISTRY</td></tr>
<tr><td colspan="4">UTHealth, UTPhysicians</td><td>111810101</td></tr>
<tr><td>Related Category 3 Outcome Measure(s):</td><td>111810101.3.8</td><td>IT-1.7</td><td colspan="2">Controlling high blood pressure (NCQA-HEDIS 2012, NQF 0018)12 (Stand-alone measure)</td></tr>
<tr><th>Year 2
(10/1/2012 – 9/30/2013)</th><th colspan="2">Year 3
(10/1/2013 – 9/30/2014)</th><th>Year 4
(10/1/2014 – 9/30/2015)</th><th>Year 5
(10/1/2015 – 9/30/2016)</th></tr>
<tr><td>Milestone 1 [P-1]: Identify one or more target patient populations diagnosed with diabetes, hypertension, asthma, COPD, or CHF.

<u>Metric 1</u> [P-1.1]: Proportion of patients with diabetes, hypertension, asthma, COPD, and CHF targeted and entered into the registry
Baseline/Goal: TBD
Data source: UT Physicians' records/documentation and registry

Milestone 1 Estimated incentive payment: $ 1,819,906</td><td colspan="2">Milestone 2 [P-3]: Develop cross-functional team to evaluate registry program.

<u>Metric 1</u> [P-3.1]: Documentation of personnel (clinical, IT, administrative) assigned to evaluate registry program
Baseline/Goal: TBD
Data source: Team roster and minutes from team meetings

Milestone 2 Estimated incentive payment: $1,902,716</td><td>Milestone 3 [I-15]: Increase the percentage of patients enrolled in the registry.

<u>Metric 1</u> [I-15.1]: Percentage of patients in the registry
Goal: TBD
Data Source: Registry and HER

Milestone 3 Estimated incentive payment: $ 2,134,627</td><td>Milestone 4 [I-16]: Increase the number of patient contacts recorded in the registry relative to baseline rate.

<u>Metric 1</u> [I-16.1]: Total number of in-person and virtual (including email, phone and web-based) visits, either absolute or divided by denominator.
Goal: TBD
Data source: Internal clinic records/documentation

Milestone 4 Estimated incentive payment: $2,130,270</td></tr>
<tr><td>Year 2 Estimated Milestone Bundle Amount: $1,819,906</td><td colspan="2">Year 3 Estimated Milestone Bundle Amount: $1,902,716</td><td>Year 4 Estimated Milestone Bundle Amount: $2,134,627</td><td>Year 5 Estimated Milestone Bundle Amount: $2,130,270</td></tr>
<tr><td colspan="5">TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $7,987,519</td></tr>
</table>

Project Option 1.6.2- 1.6 Enhance Urgent Medical Advice: UT Health Nurse-line Medical Triage Call Center

Unique RHP Project ID: 111810101.1.5
Performing Provider Name/TPI: UTHealth, UTPhysicians / 111810101

Project Summary:

Provider:
UT Physicians is the clinical practice of The University of Texas Medical School at Houston. With more than 900 physicians certified in 80 medical specialties and subspecialties, 906 residents and fellows, and 283,920 patient visits in 2011, it is the fastest growing academic practice in the nation for the last five years. In addition to our flagship location in the Texas Medical Center, UT Physicians has 4 neighborhood locations throughout the Greater Houston area, and also offers specialty clinics at several Memorial Hermann Hospital locations.

Intervention(s):
This project will expand access to medical advice and guidance to the appropriate level of care in order to reduce emergency department use for non-emergent conditions, and it will also increase patient access to health care by implementing a nurse-line medical triage call center that will be staffed 24/7/365.

Need for the project:
Our existing nurse line is partial (only exists in two clinics), not-centralized, not available all day and all week round, and does not have full Spanish options. There is need to make the service more culturally sensitive and accessible by expanding the service in Spanish, having a centralized line, and making it available round-the-clock. This will address the need to provide the right care in the right setting at the right time, and hence reduce primary care related emergency department visits.

Target Population:
All current and prospective clients of UTP. However, patients with chronic diseases, such as chronic obstructive pulmonary diseases, asthma, heart failure, pulmonary edema, Hypertension, Angina, or Diabetes are likely to benefit the most. In FY 2012, UTP provided 321,716 patient visits. With UTPs planned expansion of primary care and specialty care capacity, we expect to provide over 400,000 patients visits by DY5.

Category 1 or 2 expected patient benefits:
By DY4 we will increase the number of patients that access the nurse advice line, and by DY5 the target will be to increase patients in the defined population who utilized the nurse advice line and were given an urgent medical appointment via the line when needed.

Category 3 outcomes:
IT-2.11: Our goal is to reduce by 3% in DY4 and 5% in DY5, the percentage of acute care hospitalizations for ambulatory care sensitive conditions for persons under the age 75 years.

Project Option 1.6.2 – Enhance Urgent Medical Advice: C11 UT Health Nurse-line Medical Triage Call Center

Unique RHP Project Identification Number: 111810101.1.5
Performing Provider Name/TPI: UTHealth, UTPhysicians/111810101

Project Description: 1.6 Enhance Urgent Medical Advice (Option 1.6.2)

UT Physicians (UTP) will expand access to medical advice and direction to the appropriate level of care to reduce Emergency Department use for non-emergent conditions and increase patient access to health care by implementing a nurse-line medical triage call center that will be staffed 24/7/365. The nurses receiving the calls will have access to the UT Physicians Schedule Now system to find an appropriate physician to see the patient in a primary care setting for non-emergent conditions. Furthermore, for patients needing urgent medical guidance who are already patients of UT Physicians, the nurses will have access to their EMR through Allscripts. Also, UT Health will be participating in the local public hospital HIE with Memorial Hermann to provide patients with the ability to participate in an HIE for enhanced patient care and provider communication as well as enhanced PI and QI initiatives. This will further enhance the triage nurse's ability to access pertinent information when advising callers.

The UT Physicians practice includes over 900 physicians located in the Texas Medical Center and in 4 out-lying clinics, which provides patients with greater access to care. In FY 2012, UTP provided 321,716 patient visits. With UTPs planned expansion of primary care and specialty care capacity, we expect to provide over 400,000 patients visits by DY5. The nurse triage line will be an important tool in the provision of appropriate care to clients and in avoiding unnecessary Emergency Department use.

Finally, through project MS1 (UT Health Regional Systems Engineering Center and UT Health Quality Improvement Dashboard Development Center), the systems engineering and QI teams at UT Health will identify QI targets and methods needed to achieve continuous quality improvement for this project, especially as it relates to identifying challenges for expansion, and building on lessons learned.

Goal and Relationship to Regional Goals:

Project Goal:

To provide urgent medical advice so that patients who need it can access it telephonically, and an appropriate appointment can be scheduled so that access to urgent medical care is increased and avoidable utilization of urgent care and the ED can be reduced.

This project addresses the following regional goal:

This project relates to the regional goal that aims to "develop a regional approach to health care delivery that leverages and improves on existing programs and infrastructure, is

responsive to patient needs throughout the entire region, and improves health care outcomes and patient satisfaction", since it is going to expand the existing nurse line to better meet the needs of patients.

Challenges:

Need: 1) High rates of inappropriate emergency department utilization. 2) High rates of preventable hospital admissions.

Implementation: 1) Low health literacy levels and low economic resources of the population can influence the ability to effectively utilize the nurse line. 2) Marketing.

By providing readily available triage services patients can conveniently get guidance and advice on non-urgent medical issues and be able to get an appointment set up with a primary care physician when necessary. This will keep people away from the ED. This program will be aggresively advertised to the target population thereby getting them informed about the availability of this free service and increasing its uptake.

5-Year Expected Outcome for Provider and Patients:

We would have a fully functional nurse line and there will be marketing and education of patients (in English and in Spanish) on the availability of the service and how to use it. We expect to record increased uptake of the triage services which would decrease admissions for ambulatory care sensitive admissions. In addition to benefiting the current Medicaid (23% as of 2011, or 65,302 patient visits) and low-income client base of UTP clinics, the expansion of services will be marketed to the additional 1,423,176 Medicaid and Medicaid-eligible residents living within the service areas of the UT Physician Clinics. Since 18.7% of the Harris County population is living in poverty (27.1% of children) and 66% of the population are minorities, with 41% being Hispanic, culturally appropriate assistance in accessing appropriate care will be important in avoiding hospitalizations for ambulatory care sensistive conditions.

Starting Point/Baseline:

To be determined during DY3.

Rationale:

This project will expand the existing nurse line to become available all day and all week round, in order to be there when needed by patients. It will also be made more culturally sensitive by expanding to offer the service in Spanish and it will be marketed widely to inform the target poulation of its availability. With the provision of the triage service from nurses who have access to their records at the time of call, patients will be able to recieve the right care at the right time, thereby preventing inappropriate use of the ED and quickening the process of getting appointment for urgent primary care needs. This project will address the need to provide the

right care in the right setting at the right time, and the need to reduce primary care related emergency department visits.

Project Components:

Through the UT Health Nurse-line Medical Triage Call Center Program, we propose to meet all required project components listed below.

a) UTP will develop a 24/7/365 call center staffed by registered nurses that provide timely triage for patients seeking urgent healthcare guidance. Those than can be addressed through primary care services will be either given appointments with an appropriate provider in a timely manner (even same day appointments), or be directed to an alternate primary care site.
b) The UTP nurse triage line will be available in both English and Spanish.
c) Marketing and educational material on use of the nurse triage line will also be in both English and Spanish.
d) UTP Nurses on the triage line will have access to the appointment scheduling system and to patient records.
e) Communication processes will be developed between UTP Nurses and other primary care providers, urgent care providers, and Emergency Departments to improve care transitions for patients.
f) UTP will conduct surveys of patients using the nurse advice line to ensure patient satisfaction with the services received.
g) The UTP quality improvement office will conduct QI for the project using methods such as rapid cycle improvement.

Milestones and Metrics:

For the UT Health Nurse-line Medical Triage Call Center Program, we have chosen the below milestones and metrics based upon the above project components and relationship to project goals and population needs. All baselines and goals will be determined during DY2.

Process Milestones and Metrics:

Milestone 1 [P-4.]: Expand nurse advice line by XX% based on baseline data to increase access to patients based on need within the RHP.
Metric 1 [P-4.1.]: Number of nurses staffing advice line per shift and number of patient calls per shift
Milestone 2 [P-5.]: Establish a multilingual nurse advice line
Metric 1 [P-5.1.]: Number of bi-lingual nurses staffing advice line per shift
Milestone 3 [P-6.]: Inform and educate patients on the nurse advice line
Metric 1 [P-6.1.]: Number of targeted patients informed/educated
Milestone 4 [P-7.]: Develop/distribute a bilingual (English and Spanish) patient-focused educational newsletter with proactive health information and reminders based on nurse

advice line data/generated report identifying common areas addressed by the nurse advice line.
Metric 1 [P-7.1.]: Newsletter distribution

Improvement Milestones and Metrics:

Milestone 5 [I-13.]: Increase in the number of patients that accessed the nurse advice line
Metric 1 [I-13.1.]: Utilization of nurse advice line
Milestone 6 [I-14.]: Increase patients in defined population who utilized the nurse advice line and were given an urgent medical appointment via the nurse advice and appointment line when needed
Metric 1 [I-14.1.]: Number of urgent medical appointments scheduled via the nurse advice line

Unique community need identification numbers the project addresses:

This project addresses community needs CN.8 (High rates of inappropriate emergency department utilization) and CN.10 (High rates of preventable hospital admissions).

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

The Nurse-line Medical Triage Call Center project is an expansion of what is mainly an appointment line at this time. UT Physicians currently has a line that patients, or would-be patients can call to be matched with a physician, but it does not operate except during business hours and it does not routinely provide consultation with a nurse for urgent needs. This project proposes to operate a medical triage call center, staffed 24/7/365 by nurses who will have access to patient records and provide guidance to patients regarding next steps that include arranging for same-day appointments in a primary care setting where the need is more urgent.

Related Category 3 Outcome Measure(s):

OD-2 Potentially Preventable Admissions

- IT-2.11 Ambulatory Care Sensitive Conditions Admissions Rate: (Standalone measure)

Numerator: Total number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years (including any one most responsible diagnosis code of: Grand mal status and other epileptic convulsions, Chronic obstructive pulmonary diseases, Asthma, Heart failure and pulmonary edema, Hypertension, Angina, and Diabetes). Exclusions: Individuals 75 years of age and older, or death before discharge.

Denominator: Total mid-year population under age 75

Relationship to other Projects:

1.10 (MS1) - The systems engineering and dashboard project will provide a system for continuous quality improvement in the service provided by the nurse triage line.
2.1 (C1-2) - The medical home project and the nurse line will complement each other to ensure that patients get the right care at the right time.

2.9 (A4) - The nurse line will complement the care navigation program, as a 24/7 point of contact, further reducing the risk of avoidable utilization of the ED.
2.11 (C10) - The medication management program with its technological support will provide the nurses with useful information on patients to inform more efficient triaging.
2.12 (A3, CL1, CL2, MS4) - The nurse triage line will complement the care transition projects, as a 24/7 point of contact to ensure that patients get the right care at the right time.

Relationship to Other Performing Providers' Projects in the RHP:

The triage and intake process of patient encounters is the front door to healthcare and an important factor of the success of healthcare transformation. The nurse triage/call center concept is unique in the regional sense of the RHP plan and focuses to outcome measures of ambulatory care sensitive condition readmission rates. The initiative grid attached in the addendum will show similarities with other projects suggested for this region.

Plan for Learning Collaborative:

UTHealth will participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system.

Project Valuation:

The anchor, Harris Health, provided a spreadsheet which contained 6 criteria, which could be used to rate each project on a 10-point scale. The ratings for each criterion were weighted, summed for each project to arrive at a total score (value weight) for each project. The sum of all the project's total scores were then divided by the percent of total DSRIP funds to be secured for that year to arrive at a dollar value multiplier to be applied towards each project's total score (value weight), thereby allocating a greater proportion of the funds towards those projects valued highest based upon the 6 criteria. UTHealth used this approach, with one exception—we did not use two of the criteria. Following are the criteria, the considerations for awarding points for projects using that criteria, and the reasons two of the criteria were not used:

1. Transformational Impact (Weight = 20%): Points were awarded for projects that meet the community benefit criteria, such as: improving access; improving quality; improving costs (long-term cost-savings); transformative (Innovative), collaborative (partners with other organization(s)). This project's score for this criterion: **6**

2. Population Served/Project Size (Weight = 20%): Points were awarded based on the size of the population affected and whether the target population is uninsured or on Medicaid. This project's score for this criterion: **5**

3. Aligned with Community Needs (Weight = 20%): Points were awarded based on judgments in two categories: whether or not the CNA indicates a need in the area of the

project and the severity of the health/healthcare need(s) the project addresses. This project's score for this criterion: 111810101.1.5 X 2 = **5**

4. Cost Avoidance (Weight = 15%): Points were awarded based on judgment of project's cost effectiveness relative to similar projects. This project's score for this criterion: **7**

5. Partnership/Collaboration (Weight = 10%): ***This was not rated***, because UTHealth planned to partner with Harris Health to perform many similar projects, so the rating would have been the same for all projects. This would have diluted the scores, hiding the more significant variations in other value criteria.

6. Sustainability (Weight = 15%): ***This was also not rated***, because UTHealth does not consider any of the projects to be unsustainable, or at the very least do not consider one project less sustainable than another. Giving the projects the same, or very similar ratings on this criteria again would have had a diluting effect, hiding the more significant variations in other value criteria.

Total Valuation Score for this project: **4.25**

111810101.1.5	*Option 1.6.2*	*1.6.2 (A-C)*	*C11 UT Health Nurse-line Medical Triage Call Center*
UTHealth, UTPhysicians			*111810101*
Related Category 3 Outcome Measure(s):	*111810101.3.9*	*IT-2.11*	*Ambulatory Care Sensitive Conditions Admissions Rate: (Standalone measure)*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-4.]: Expand nurse advice line by XX% based on baseline data to increase access to patients based on need within the RHP. Metric 1 [P-4.1.]: Number of nurses staffing advice line per shift and number of patient calls per shift Baseline/Goal: TBD Data Source: Documentation of nurse advice line staffing levels. Milestone 1 Estimated incentive payment: $ 2,035,421 **Milestone 2** [P-5.]: Establish a multilingual nurse advice line Metric 1 [P-5.1.]: Number of bi-lingual nurses staffing advice line per shift Baseline/Goal: TBD Data Source: HR documents or other documentation demonstrating employed and/or contracted nurses to staff a nurse advice line. Milestone 2 Estimated incentive payment: $2,035,422	**Milestone 3** [P-6.]: Inform and educate patients on the nurse advice line Metric 1 [P-6.1.]: Number of targeted patients informed/educated Baseline/Goal: TBD Data Source: Documentation in patient's paper or electronic medical record that patient was contacted and received information about accessing the nurse advice line and education about how to use the nurse advice line. Milestone 3 Estimated incentive payment: $2,220,684 **Milestone 4** [P-7.]: Develop/distribute a bilingual (English and Spanish) patient-focused educational newsletter with proactive health information and reminders based on nurse advice line data/generated report identifying common areas addressed by the nurse advice line. Metric 1 [P-7.1.]: Newsletter distribution Baseline/Goal: TBD Data Source: Mailer vendor invoice	**Milestone 5** [I-13.]: Increase in the number of patients that accessed the nurse advice line Metric 1 [I-13.1.]: Utilization of nurse advice line Goal: TBD Data Source: Call Center phone and encounter records and appointment scheduling software records Milestone 5 Estimated incentive payment: $ 4,774,824	**Milestone 6** [I-14.]: Increase patients in defined population who utilized the nurse advice line and were given an urgent medical appointment via the nurse advice and appointment line when needed Metric 1 [I-14.1.]: Number of urgent medical appointments scheduled via the nurse advice line Goal: TBD Data Source: Call Center phone and encounter records and appointment scheduling software records Milestone 6 Estimated incentive payment: $4,657,637

111810101.1.5	***Option 1.6.2***	***1.6.2 (A-C)***	***C11 UT Health Nurse-line Medical Triage Call Center***
UTHealth, UTPhysicians			*111810101*
Related Category 3 Outcome Measure(s):	*111810101.3.9*	*IT-2.11*	*Ambulatory Care Sensitive Conditions Admissions Rate: (Standalone measure)*
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	Milestone 4 Estimated incentive payment: $2,220,683		
Year 2 Estimated Milestone Bundle Amount: $4,070,843	Year 3 Estimated Milestone Bundle Amount: $4,441,367	Year 4 Estimated Milestone Bundle Amount: $4,774,824	Year 5 Estimated Milestone Bundle Amount: $4,657,637
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*:* $17,944,671			

Project Option 1.7.1- 1.7 Introduce, Expand, or Enhance Telemedicine/Telehealth: UT Health Telemedicine

<u>Unique RHP Project ID:</u> 111810101.1.6
<u>Performing Provider Name/TPI:</u> UTHealth, UTPhysicians / 111810101

<u>Project Summary:</u>

<u>Provider:</u>
UT Physicians is the clinical practice of The University of Texas Medical School at Houston. With more than 900 physicians certified in 80 medical specialties and subspecialties, 906 residents and fellows, and 283,920 patient visits in 2011, it is the fastest growing academic practice in the nation for the last five years. In addition to our flagship location in the Texas Medical Center, UT Physicians has 4 neighborhood locations throughout the Greater Houston area, and also offers specialty clinics at several Memorial Hermann Hospital locations.

<u>Intervention(s):</u>
A telemedicine program will be established to provide access to the UT Health Regional Multispecialty Physician Group, by means of a rapid e-mail and/or internet based and technologically driven consultation process that will manage complicated diabetic cases and other patients who would otherwise require a referral and visit to specialists. We will recruit dedicated specialists, physician assistants and nurse practitioners to manage the process. A dedicated website will be set up for formal consultations.

<u>Need for the project:</u>
Our region has a shortage of primary and specialty care physicians, inadequate transportation options for patients in distant locations and for indigent/low income populations, and inadequate access to specialty care. The use of technology to deliver health care from a distance, has been demonstrated as an effective way of overcoming certain barriers to care.

<u>Target Population:</u>
All people and primary care physicians outside the Houston metropolitan area and rural areas of Region 3, where there is not access to specialty care.

<u>Category 1 or 2 expected patient benefits:</u>
The goal is to increase number of telemedicine visits for each specialty identified as high need.

<u>Category 3 outcomes:</u>
IT-6.1 (3): Our goal is to increase by 3% in DY4 and 5% in DY5, the improvement over baseline (for patients of non-UT Physician primary care practices that accessed the specialty care services via the Telemedicine program) of patient satisfaction scores for patient's rating of doctor access to specialist using the adult CG-CAHPS survey module.

Project Option 1.7.1 – Introduce, Expand, or Enhance Telemedicine/Telehealth: A1 UT Health Telemedicine

Unique RHP Project Identification Number: 111810101.1.6
Performing Provider Name/TPI: UTHealth, UTPhysicians/111810101

Project Description: 1.7 Introduce, Expand, or Enhance Telemedicine/Telehealth (Option 1.7.1)

A telemedicine program will be established that provides access to the UT Health Regional Multispecialty Physician Group. Due to the high demand for services from specialists at clinics in the area, patients wait a long time (as much as 4-6 months) to receive consultation, and it is inconvenient and expensive to travel to specialty clinics. We propose to develop a rapid e-mail and/or internet based/technologically driven consultation process to manage complicated diabetes and other patients who would otherwise require a referral and visit to specialists. We will recruit dedicated specialists, physician assistants and nurse practitioners to manage the process. A dedicated website will be set up for formal consultations. After completion of a patient-specific survey, the E-consult team will provide specific management recommendations to the primary care physician within 72 hours. The E-consult team will also maintain a database of all consults and track outcomes through e-mail communications with PCP's. Finally, through project MS1 (UT Health Regional Systems Engineering Center and UT Health Quality Improvement Dashboard Development Center), the systems engineering and QI teams at UT Health will identify QI targets and methods needed to achieve continuous quality improvement for this project, especially as it relates to identifying challenges for expansion, and building on lessons learned.

Goal and Relationship to Regional Goals:
Project Goal:
To reduce disparities in access, outcome, cost and satisfaction that are created by geographic barriers by means of electronic health care services
This project addresses the following regional goal:
One of the goals of the region is to "Increase access to primary and specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their condition, regardless of where they live or their ability to pay." The telemedicine project will help the attainment of this goal by making it possible for the pool of specialists at UT Health to become reachable to diverse groups of patients even in remote parts of the region.

Challenges:
Need: 1) Shortage of primary and specialty care physicians. 2) Inadequate transportation options for individuals in distant locations and for indigent/low income populations. 3) Inadequate access to specialty care.
Implementation: 1) Technological challenges. 2) Reimbursement issues.
Telemedicine is in an innovative way to address the inadequate supply and distribution of physicians in the region, especially with regards to remote populations. It will also minimize

challenges posed by transportation barriers. The DSRIP funds will make it possible to offset the costs of this project to the benefit of the target population.

5-Year Expected Outcome for Provider and Patients:

Telemedicine will have become part of the health system, scaling-up the delivery of specialty health services to underserved areas, and resulting in increased access to specialty care in our region. Texas has large rural areas and Region 3 is no exception. For the 9-county area of Region 3, there is an estimated 1.2 million people uninsured and another 1+ million with some type of public covereage, including Medicaid. Only Harris county has a large urban population. The remaining 8 counties are primarily rural. The ability to extend specialty consultation services, accepting the Medicaid and Medicaid-eligible clients, to the primary care physicians and their clients in these areas is expected to have a positive impact on the health of these patients who might otherwise not get the needed care and end up in need of acute care services. Improved access to specialty care services is expected to result in improved patient satisfaction as well.

Starting Point/Baseline:

To be determined during DY3.

Rationale:

One of the greatest challenges facing the U.S. healthcare system is to provide quality care to the large segment of the population, which does not have access to specialty physicians because of factors such as geographic limitations or socioeconomic conditions. The use of technology to deliver health care from a distance, has been demonstrated as an effective way of overcoming certain barriers to care. For instance, telemedicine can ease the gaps in providing crucial care for those who are underserved, principally because of a shortage of sub-specialty providers. Our region has problems of access to both primary an specialty care as reflected in the regional community needs assessment.

The development and installation of high-speed wireless telecommunications networks coupled with large-scale search engines and mobile devices will change healthcare delivery as well as the scope of healthcare services. It will allow for real-time monitoring and interactions with patients without bringing them into a hospital or a specialty care center. This real/near-time monitoring and interacting could enable a healthcare team to address patient problems before they require major interventions, creating a potentially patient-centered approach that could undoubtedly translate to magnificient improvement in outcomes.

Project Components:

Through the UT Health Telemedicine Program, we propose to meet all required project components listed below.

a) UTP will conduct an assessment of both the locations where telemedicine would fill a gap in specialty care and determine the specialties that can be provided via telemedicine.
b) UTP will work with primary care providers to complete any needed legal agreements and establish the technology and processes needed to provide consultations services.

c) UTP will recruit providers and support staff to manage the telemedicine program and processes.
d) UTP providers in the specialties determined through the needs assessment and other related health professionals will provide patient consultations using telecommunications.
e) UTPs quality improvement office will conduct QI for the project using methods such as rapid cycle improvement.

Milestones and Metrics:

For the UT Health Telemedicine Program, we have chosen the below milestones and metrics based upon the above project components and relationship to project goals and population needs. All baselines and goals will be determined during DY3.

Process Milestones and Metrics:

Milestone 1 [P-1.]: Conduct needs assessment to identify needed specialties that can be provided via telemedicine

Metric 1 [P-1.1.]: Needs assessment to identify the types of personnel needed to implement the program and hiring of the respective personnel.

Milestone 2 [P-3.]: Implement or expand telemedicine program for selected medical specialties, based upon regional and community need.

Metric 1 [P-3.1.]: Documentation of program materials including implementation plan, vendor agreements/ contracts, staff training and HR documents.

Milestone 3 [P-3.]: Implement or expand telemedicine program for selected medical specialties, based upon regional and community need.

Metric 1 [P-3.2]: Documentation of the number of consults delivered by each specialty

Improvement Milestones and Metrics:

Milestone 4 [I-12.]: Increase number of telemedicine visits for each specialty identified as high need

Metric 1 [I-12.1]: Number of telemedicine visits

Milestone 5 [I-12.]: Increase number of telemedicine visits for each specialty identified as high need

Metric 1 [I-12.2.]: RHPs and providers should provide analysis demonstrating how the telemedicine services provided align with their needs assessment.

Unique community need identification numbers the project addresses:

This project addresses community needs CN.2 (Inadequate access to specialty care), CN.16 (Shortage of primary and specialty care physicians) and CN.21 (Inadequate transportation options for individuals in rural areas and for indigent/low income populations).

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

This project is an expansion of a service that is currently only offered sparingly. We propose to expand our telemedicine program to provide primary care physicians and their patients, who are in more distant locations, access to specialty consultations.

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

- IT-6.1 (3) Percent improvement over baseline of patient satisfaction scores: (3) patient's rating of doctor access to specialist; (Stand-alone measure)

Percent improvement over baseline of patient satisfaction scores for one or more of the patient satisfaction domains that the provider targets for improvement in a specific tool. Certain supplemental modules for the adult CG-CAHPS survey may be used to establish if patients: (3) patient's rating of doctor access to specialist; (patients of other primary care practices that accessed the specialty care services via Telemedicine program)

Relationship to other Projects:

1.1 (C3) - The expansion of primary care capacity and access to health care services will also result in an increased demand for specialty care. Specialty care consults provide via telemedicine will be an important resource in the primary care setting.

1.2 (A2, SPH1) - Enhanced training will include education on telemedicine as a cost-effective alternative to the more traditional face-to-face way of providing medical care.

1.6 (C11) - For patients in distant locations, the nurse triage line will be able to arrange consults via telemedicine were appropriate.

2.1 (C1-2) - Via telemedicine, the UT Health Multispecialty Physician Group will serve as a Virtual Acountable Care Organization (ACO) that will provide an extensive network of specialty support centers for primary care providers, built on the concept of "advanced medical home".

2.2 (C5-9,CL3) - Telemedicine will ensure that chronic care patients will get specialist input into their care when needed, without the current delays being experienced.

2.11 (C10) - The medication management project will ensure that patient medications are managed in a coordinated manner even with inputs and prescriptions from specialists at different sites.

2.12 (A3, CL1, CL2, MS4) - Telemedicine will provide a valuable resource during the care transition processes, further ensuring that patients get the right care at the right time.

Relationship to Other Performing Providers' Projects in the RHP:

An innovative approach to increasing access to primary care and specialty care has been created by the miracles of the internet and computer systems. Telemedicine is leading edge for those communities who cannot easily access behavioral health or specialty care due to remote locations, lack of physicians, or urgency of encounter needs. Numerous telemedicine projects have been proposed, as seen in the Region 3 Initiative grid in the addendum, and all focus to outcomes such as appropriate emergency department utilization, 30-day readmission rates, and patient satisfaction scores.

Plan for Learning Collaborative:

UTHealth will participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system.

Project Valuation:

The anchor, Harris Health, provided a spreadsheet which contained 6 criteria, which could be used to rate each project on a 10-point scale. The ratings for each criterion were weighted, summed for each project to arrive at a total score (value weight) for each project. The sum of all the project's total scores were then divided by the percent of total DSRIP funds to be secured for that year to arrive at a dollar value multiplier to be applied towards each project's total score (value weight), thereby allocating a greater proportion of the funds towards those projects valued highest based upon the 6 criteria. UTHealth used this approach, with one exception—we did not use two of the criteria. Following are the criteria, the considerations for awarding points for projects using that criteria, and the reasons two of the criteria were not used:

1. Transformational Impact (Weight = 20%): Points were awarded for projects that meet the community benefit criteria, such as: improving access; improving quality; improving costs (long-term cost-savings); transformative (Innovative), collaborative (partners with other organization(s)). This project's score for this criterion: **7**

2. Population Served/Project Size (Weight = 20%): Points were awarded based on the size of the population affected and whether the target population is uninsured or on Medicaid. This project's score for this criterion: **4**

3. Aligned with Community Needs (Weight = 20%): Points were awarded based on judgments in two categories: whether or not the CNA indicates a need in the area of the project and the severity of the health/healthcare need(s) the project addresses. This project's score for this criterion: 111810101.1.6 X 2 = **6**

4. Cost Avoidance (Weight = 15%): Points were awarded based on judgment of project's cost effectiveness relative to similar projects. This project's score for this criterion: **6**

5. Partnership/Collaboration (Weight = 10%): ***This was not rated***, because UTHealth planned to partner with Harris Health to perform many similar projects, so the rating would have been the same for all projects. This would have diluted the scores, hiding the more significant variations in other value criteria.

6. Sustainability (Weight = 15%): ***This was also not rated***, because UTHealth does not consider any of the projects to be unsustainable, or at the very least do not consider one project less sustainable than another. Giving the projects the same, or very similar ratings on this criteria again would have had a diluting effect, hiding the more significant variations in other value criteria.

Total Valuation Score for this project: **4.3**

111810101.1.6	***Option 1.7.1***	***1.7.1 (E-F)***	***A1 UT Health Telemedicine***
UTHealth, UTPhysicians			*111810101*
Related Category 3 Outcome Measure(s):	*111810101.3.10*	*IT-6.1 (3)*	*Percent improvement over baseline of patient satisfaction scores: (3) patient's rating of doctor access to specialist; (Stand-alone measure)*
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-1.]: Conduct needs assessment to identify needed specialties that can be provided via telemedicine Metric 1 [P-1.1.]: Needs assessment to identify the types of personnel needed to implement the program and hiring of the respective personnel. Baseline/Goal: TBD Data Source: Needs assessment Milestone 1 Estimated incentive payment: $ 4,118,736	**Milestone 2** [P-3.]: Implement or expand telemedicine program for selected medical specialties, based upon regional and community need. Metric 1 [P-3.1.]: Documentation of program materials including implementation plan, vendor agreements/ contracts, staff training and HR documents. Baseline/Goal: TBD Data Source: Milestone 2 Estimated incentive payment: $2,247,692 **Milestone 3** [P-3.]: Implement or expand telemedicine program for selected medical specialties, based upon regional and community need. Metric 1 [P-3.2]: Documentation of the number of consults delivered by each specialty Baseline/Goal: TBD Data Source: Program records Milestone 3 Estimated incentive payment: $2,247,691	**Milestone 4** [I-12.]: Increase number of telemedicine visits for each specialty identified as high need Metric 1 [I-12.1]: Number of telemedicine visits Goal: TBD Data Source: EMR or electronic referral processing system; encounter records from telemedicine program Milestone 4 Estimated incentive payment: $ 4,830,998	**Milestone 5** [I-12.]: Increase number of telemedicine visits for each specialty identified as high need Metric 1 [I-12.2.]: RHPs and providers should provide analysis demonstrating how the telemedicine services provided align with their needs assessment. Goal: TBD Data source: Needs Assessment prioritized, telemedicine records Milestone 5 Estimated incentive payment: $4,711,411
Year 2 Estimated Milestone Bundle Amount: $4,118,736	Year 3 Estimated Milestone Bundle Amount: $4,495,381	Year 4 Estimated Milestone Bundle Amount: $4,830,998	Year 5 Estimated Milestone Bundle Amount: $4,711,411

111810101.1.6	***Option 1.7.1***	***1.7.1 (E-F)***	***A1 UT Health Telemedicine***	
UTHealth, UTPhysicians				*111810101*
Related Category 3 Outcome Measure(s):	*111810101.3.10*	*IT-6.1 (3)*	*Percent improvement over baseline of patient satisfaction scores: (3) patient's rating of doctor access to specialist; (Stand-alone measure)*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*:* $18,156,526				

Project Option 1.9.2- 1.9 Expand Specialty Care Capacity: Expand UT Physician Specialty Services to Outlying Clinics

Unique RHP Project ID: 111810101.1.7
Performing Provider Name/TPI: UTHealth, UTPhysicians / 111810101

Project Summary:

Provider:
UT Physicians is the clinical practice of The University of Texas Medical School at Houston. With more than 900 physicians certified in 80 medical specialties and subspecialties, 906 residents and fellows, and 283,920 patient visits in 2011, it is the fastest growing academic practice in the nation for the last five years. In addition to our flagship location in the Texas Medical Center, UT Physicians has 4 neighborhood locations throughout the Greater Houston area, and also offers specialty clinics at several Memorial Hermann Hospital locations.

Intervention(s):
UT Physicians will recruit specialists for each of its outlying clinics. Clinic service hours will be extended to provide evening and weekend appointment options. Standardized referral systems will be put in place to ensure access to these specialists.

Need for the project:
Inadequate access to specialty care has contributed to the limited scope and size of safety net health systems, and our region has problems of access to specialty care as reflected in the regional community needs assessment.

Target Population:
The service areas of our 4 outlying clinics include large populations with economic, cultural, language, and transportation barriers to receiving primary care. Using the Harris County rate (14.5%) of Medicaid clients, there are an estimated 1,423,176 Medicaid clients living within the tightly-defined service areas of the UT Physician Clinics. With a minimum of 4 FTE specialty providers, we expect to reach approximately 38,000 specialty patient visits by DY5.

Category 1 or 2 expected patient benefits:
The DY4 goal is to increase the number of specialist providers, clinic hours and/or procedure hours available for the high impact/most impacted medical specialties, and by DY5 to increase the number of referrals of targeted patients to the specialty care clinic.

Category 3 outcomes:
IT-1.1: Our target is to reduce by 1 day over baseline in DY4, and by 2 days in DY5, the average length of time in days between the day a patient makes a request for an appointment with a physician and the third next available appointment for a new patient, or return visit/exam. The ultimate goal is to decrease number of days to third next available appointment to two days for Specialty Care.

Project Option 1.9.2 – Expand Specialty Care Capacity: C4 Expand UT Physician Specialty Services to Outlying Clinics

Unique RHP Project Identification Number: 111810101.1.7
Performing Provider Name/TPI: UTHealth, UTPhysicians/111810101

Project Description: 1.9 Expand Specialty Care Capacity (Option 1.9.2)

UT Physicians (UTP) will recruit specialists for each of its outlying clinics, based upon the specialty care gap assessment to be conducted for each of these service areas. We intend to place at least 1 FTE specialist at each of the 4 UTP clinics described below, but expect that the gap assessment will identify a need for more than 1 specialty at some of the clinics (particularly the two clinics providing service in the Ft. Bend County area, where there is a dearth of specialty providers). We expect to see a need for endocrinologists, pulmonologists, and cardiologists, but will accommodate other specialties, depending upon the outcome of the gap assessment. This will enable expansion of UT Health specialties in areas outside the Texas Medical Center and into other areas where economic and transportation barriers exist and where there is a great need for ambulatory care (see below description of UTP service areas targeted by this project). At a minimum of 4 FTE specialists, this expansion would enable approximately 15,200 patient visits per year (based on 3,800/yr/specialist FTE), with a potential to reach over 38,000 patient visits by the end of DY5. Clinic service hours will be extended including evening and weekend appointment options in order to further increase access to these services. Standardized referral systems will be put in place to ensure access to these specialists. Also, through project MS1 (UT Health Regional Systems Engineering Center and UT Health Quality Improvement Dashboard Development Center), the systems engineering and QI teams at UT Health will identify QI targets and methods needed to achieve continuous quality improvement for this project to ensure that we are delivering the right care to those in need, where it is needed. We will also use these QI processes to identify challenges for further expansion and to build on lessons learned.

UT will market the availability of specialty services to the UTP clinic service areas, which has been defined as the Census Tracts within a seven-mile radius of the clinic, which includes large numbers of medically underserved, low income, and Medicaid/Medicaid-eligible populations. The Bayshore Clinic is in the southeast area of Houston and includes parts of Pasadena, South Houston, and areas immediately south of the ship channel. The service area of this clinic has a population of 431,199, with 36.5% living at/below the federal poverty level (FPL). The population is 49.2% Hispanic and of those, 51.1% are not proficient in English. The Bellaire Clinic, with a population of 472,698, is on the west side of Houston and also has a large minority population, with 24.1% Black/African American and 46% Hispanic, and 52.2% live at/below the FPL. Of the Spanish-speaking population in the Bellaire Clinic service area, 62.8% are not proficient in English. The Cinco Ranch (population 287,744) and Sienna Village (population 231,535) clinics serve populations reaching into Ft. Bend County that closely mirror the overall county demographics, with the exception of Sienna Village Clinic, which has a large

Black/African American population of 33.5%. There are 20.8% of the Cinco Ranch Clinic population and 26.2% of the Sienna Village Clinic population living at/below the FPL. These two clinics also serve rural populations. Furthermore, according to a 2011 report of the Texas Medical Board, Ft. Bend County has a dearth of specialty providers compared to Harris County (76.5 fewer per 100,000 population) and the Texas average (44.1 fewer per 100,000 population). The service areas of these 4 clinics include large populations with economic, cultural, language, and transportation barriers to receiving primary care. Using the Harris County rate (14.5%) of Medicaid clients, there are an estimated 1,423,176 Medicaid clients living within the service areas of the UT Physician Clinics. (All population statistics are from the U.S. Census Bureau, 2010 Census. Poverty statistics are from the U.S. Census Bureau, Small Area Estimates Branch. Release date: 11.2011. Table 1: 2010 Poverty and Median Income Estimates - Counties. The Medicaid rate is from the U.S. Census Bureau and the Centers for Disease Control and Prevention, State and County by Demographic and Income Characteristics. SAHIE, 2009.)

Goal and Relationship to Regional Goals:

Project Goal:

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

This project addresses the following regional goal:

The region aims to "Increase access to primary and specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their condition, regardless of where they live or their ability to pay." By expanding specialty care services, patients will have greater access to specialty care when needed.

Challenges:

Need: 1) Inadequate access to specialty care. 2) Insufficient access to care coordination and integrated care treatment programs.

Implementation: 1) Staff recruitment and retention. 2) Coordination of specialty care and primary care appointments.

As the physician practice arm of the world-class academic and research institution, University of Texas Health Science Center-Houston, UTP is uniquely positioned to attract and retain new physicians. Also, since the UTP primary care clinics are already established, the integration of specialty care services will be a smoother transition than establishing completely new clinics. All providers and staff will be trained and a quality improvement process will be put in place to ensure that we achieve optimum coordination of services.

5-Year Expected Outcome for Provider and Patients:

There will be shortening of waiting times for specialty care appointments, such as for cardiology care, and better disease management for those with targeted chronic diseases. In addition to benefiting UTP's current Medicaid population (23% as of 2011, or 65,302 patient visits), these expanded services will be available to the low-income client base of UTP clinics, particularly the additional Medicaid and Medicaid-eligible residents (1,423,176) living within the service areas of the UT Physician Clinics. The expansion of service hours to nights and

Saturdays will be of particular benefit to those unable to see a physician during business hours. The increase in specialty care capacity, coupled with our transition to the team-based, proactive healthcare delivery model of medical homes, all conveniently located where there is great need, will help to address many of the barriers that the low-income population typically encounter in getting the appropriate care, facilitating better health outcomes. While positive outcomes are expected for each area of specialty care offered, we will specifically be monitoring the increased access to cardiology care for patients at risk of, or with heart disease. It is expected that increased access to cardiology care for these patients will result in increased cholesterol screening, better management of heart disease, and lower LDL-C rates.

Starting Point/Baseline:
To be determined during DY3.

Rationale:
Inadequate access to specialty care has contributed to the limited scope and size of safety net health systems, and our region has problems of access to specialty care as reflected in the regional community needs assessment. To achieve success as an integrated network, this gap must be thoroughly addressed by expanding specialty care services to underserved populations. The availability of specialists to provide care in this area will allow patients to access care where and when needed, thereby potentially reducing the need for emergency care, complications, and hence improve the overall health and wellbeing of the community.

Project Components:
Through the Expand UT Physician Specialty Services to Outlying Clinics Program, we propose to meet all required project components listed below.

a) UTP will conduct a specialty care gap assessment for the service areas of our primary care clinics.
b) UTP will recruit specialists of the type identified in the gap assessment to provider specialty services in the UTP primary care clinics.
c) Space will be identified and secured at the primary care clinics and additional support staff recruited to support the provision of specialty care in each of the clinics.
d) UTP will provide specialty services in the primary care clinics, which will include extended evening and Saturday hours.
e) UTP will implement transparent, standardized referrals across the system.
f) UTP's quality improvement office will conduct QI for each of the clinics providing specialty care using methods such as rapid cycle improvement.

Milestones and Metrics:
For the Expand UT Physician Specialty Services to Outlying Clinics Program, we have chosen the below milestones and metrics based upon the above project components and relationship to project goals and population needs. All baselines and goals will be determined during DY2.

Process Milestones and Metrics:

Milestone 1 [P-1.]: Conduct specialty care gap assessment based on community need

Metric 1 [P-1.1.]: Documentation of gap assessment. Demonstrate improvement over prior reporting period (baseline for DY2).

Milestone 2 [P-3.]: Collect baseline data for wait times, backlog, and/or return appointments in specialties

Metric 1 [P-3.1.]: Establish baseline for performance indicators

Milestone 3 [P-6.]: Develop and implement standardized referral and work-up guidelines

Metric 1 [P-6.1.]: Referral and work-up guidelines

Milestone 4 [P-11]: Launch/expand a specialty care clinic

Metric 1 [P-11.1]: Establish/expand specialty care clinics

Improvement Milestones and Metrics:

Milestone 5 [I-22]: Increase the number of specialist providers, clinic hours and/or procedure hours available for the high impact/most impacted medical specialties

Metric 1 [I-22.1.]: Increase number of specialist providers, clinic hours and/or procedure hours in targeted specialties

Milestone 6 [I-29.]: Increase the number of referrals of targeted patients to the specialty care clinic

Metric 1 [I-29.1.]: Targeted referral rate

Unique community need identification numbers the project addresses:

This project addresses community needs CN.2 (Inadequate access to specialty care) and CN.7 (Insufficient access to care coordination practice management and integrated care treatment programs).

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

Currently, only 2 out of our 4 outlying clinics provide specialty care to patients, and even in these clinics the specialist services provided are limited. Thus this project will enhance our capacity to deliver specialty care, and represents a signifcant expansion of an existing program.. This expansion is needed in the service areas of these clinics, which serve areas that include large populations with economic, cultural, language, and transportation barriers to receiving care.

Related Category 3 Outcome Measure(s):

OD-1 Primary Care and Chronic Disease Management

- IT-1.1 Third next available appointment (Non- standalone measure)
  Reduce the average length of time in days between the day a patient makes a request for an appointment with a physician and the third available appointment for a new patient, or return visit/exam. The goals will be to decrease number of days to third next available appointment to two days for Specialty Care.

OD-1 Primary Care and Chronic Disease Management

- IT-1.6 Cholesterol management for patients with cardiovascular conditions (NCQA-HEDIS 2012) (Standalone measure)
  Increase the number of patients who had each of the following during the reporting period:
  Low-density Lipoprotein Cholesterol (LDL-C) Screening: An LDL-C test performed during the measurement year.
  LDL-C Level Less Than 100 mg/dL: The most recent LDL-C level during the measurement year is less than 100 mg/dL.

Relationship to other Projects:

2.2 (C5-9,CL3) - This project will ensure that chronic care patients get specialist input into their care when needed, without the current delays being experienced.

2.11 (C10) - The medication management project will serve as a useful resource to every provider involved in managing the enrolled patients, to ensure optimum outcomes.

2.12 (A3, CL1, CL2, MS4) - The exansion of specialty care into the primary care settings will complement the care transition projects to ensure that patients get the right care at the right time.

Relationship to Other Performing Providers' Projects in the RHP:

The increased access to primary care visits will naturally generate additional need of specialty care visits based on the condition and acuity of the patients served. Understanding that the patient base targeted through this initiative will generate significant specialty care visits due to chronic conditions and lack of previous treatments, this initiative and similar initiatives will focus to 30-day readmission rate reductions, improvement for patient satisfaction scores, and admission rates specific to chronic conditions. Numerous initiatives have been included in the RHP plan and the addendum of the Initiative Grid can directly tie all specialty care projects together by category.

Plan for Learning Collaborative:

UTHealth will participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system.

Project Valuation:

The anchor, Harris Health, provided a spreadsheet which contained 6 criteria, which could be used to rate each project on a 10-point scale. The ratings for each criterion were weighted, summed for each project to arrive at a total score (value weight) for each project. The sum of all the project's total scores were then divided by the percent of total DSRIP funds to be secured for that year to arrive at a dollar value multiplier to be applied towards each project's total score (value weight), thereby allocating a greater proportion of the funds towards those projects valued highest based upon the 6 criteria. UTHealth used this approach, with one exception—we did not use two of the criteria. Following are the criteria, the considerations for awarding points for projects using that criteria, and the reasons two of the criteria were not used:

1. Transformational Impact (Weight = 20%): Points were awarded for projects that meet the community benefit criteria, such as: improving access; improving quality; improving costs (long-term cost-savings); transformative (Innovative), collaborative (partners with other organization(s)). This project's score for this criterion: **7**

2. Population Served/Project Size (Weight = 20%): Points were awarded based on the size of the population affected and whether the target population is uninsured or on Medicaid. This project's score for this criterion: **5**

3. Aligned with Community Needs (Weight = 20%): Points were awarded based on judgments in two categories: whether or not the CNA indicates a need in the area of the

project and the severity of the health/healthcare need(s) the project addresses. This project's score for this criterion: 111810101.1.7 X 2 = **7**

4. Cost Avoidance (Weight = 15%): Points were awarded based on judgment of project's cost effectiveness relative to similar projects. This project's score for this criterion: **5**

5. Partnership/Collaboration (Weight = 10%): ***This was not rated***, because UTHealth planned to partner with Harris Health to perform many similar projects, so the rating would have been the same for all projects. This would have diluted the scores, hiding the more significant variations in other value criteria.

6. Sustainability (Weight = 15%): ***This was also not rated***, because UTHealth does not consider any of the projects to be unsustainable, or at the very least do not consider one project less sustainable than another. Giving the projects the same, or very similar ratings on this criteria again would have had a diluting effect, hiding the more significant variations in other value criteria.

Total Valuation Score for this project: **4.55**

111810101.1.7	*1.9.2*	*A-D*	*C4 EXPAND UT PHYSICIAN SPECIALTY SERVICES TO OUTLYING CLINICS*
UTHealth, UTPhysicians			*111810101*
Related Category 3 Outcome Measure(s):	*111810101.3.11* *111810101.3.12*	*IT-1.1* *IT-1.6*	*Third next available appointment (Non-standalone measure)* *Cholesterol management for patients with cardiovascular conditions (NCQA-HEDIS 2012) (Standalone measure)*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-1.]: Conduct specialty care gap assessment based on community need Metric 1 [P-1.1.]: Documentation of gap assessment. Demonstrate improvement over prior reporting period (baseline for DY2). Baseline/Goal: TBD Data Source: Needs Assessment Milestone 1 Estimated incentive payment: $ 2,179,098 **Milestone 2** [P-3.]: Collect baseline data for wait times, backlog, and/or return appointments in specialties Metric 1 [P-3.1.]: Establish baseline for performance indicators Baseline/Goals: TBD Data Source: TBD by the Performing Provider Milestone 2 Estimated incentive payment: $ 2,179,099	**Milestone 3** [P-6.]: Develop and implement standardized referral and work-up guidelines Metric 1 [P-6.1.]: Referral and work-up guidelines Baseline/Goal: TBD Data Source: Referral and work-up policies and procedures documents Milestone 3 Estimated incentive payment: $ 2,382,725 **Milestone 4** [P-11]: Launch/expand a specialty care clinic Metric 1 [P-11.1]: Establish/expand specialty care clinics Baseline/Goal: TBD Data Source: Documentation of new/expanded specialty care clinic Milestone 4 Estimated incentive payment: $ 2,382,725	**Milestone 5** [I-22]: Increase the number of specialist providers, clinic hours and/or procedure hours available for the high impact/most impacted medical specialties Metric 1 [I-22.1.]: Increase number of specialist providers, clinic hours and/or procedure hours in targeted specialties Baseline/Goal: TBD Data Source: HR documents or other documentation demonstrating employed/contracted specialists Milestone 5 Estimated incentive payment: $ 5,111,870	**Milestone 6** [I-29.]: Increase the number of referrals of targeted patients to the specialty care clinic Metric 1 [I-29.1.]: Targeted referral rate Goal: TBD Data Source: Registry and/or paper documentation as designated by Performing Provider Milestone 6 Estimated incentive payment: $4,980,280
Year 2 Estimated Milestone Bundle Amount: $4,358,197	Year 3 Estimated Milestone Bundle Amount: $4,765,450	Year 4 Estimated Milestone Bundle Amount: $5,111,870	Year 5 Estimated Milestone Bundle Amount: $4,980,280
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $19,215,797			

Project Option 1.10.2- 1.10 Enhance Performance Improvement and Reporting Capacity: UT Health Regional Systems Engineering Center and UT Health Quality Improvement (QI) Dashboard Development Center

Unique RHP Project ID: 111810101.1.8
Performing Provider Name/TPI: UTHealth, UTPhysicians / 111810101

Project Summary:

Provider:
UT Physicians is the clinical practice of The University of Texas Medical School at Houston. With more than 900 physicians certified in 80 medical specialties and subspecialties, 906 residents and fellows, and 283,920 patient visits in 2011, it is the fastest growing academic practice in the nation for the last five years. In addition to our flagship location in the Texas Medical Center, UT Physicians has 4 neighborhood locations throughout the Greater Houston area, and also offers specialty clinics at several Memorial Hermann Hospital locations.

Intervention(s):
The project will develop a regional systems engineering center, that will recruit systems engineers to integrate with healthcare QI teams to cross train in applying systems engineering science to healthcare processes, and develop interdisciplinary courses for healthcare professionals, students, engineers and administrative healthcare leadership. The project will also develop QI capacity at UT Health by developing specialty-specific QI dashboards that will integrate QI data from various institutions, measure, report monthly specialty specific data, and serve as the engine to drive, conduct and rapidly diffuse quality and patient safety improvements.

Need for the project:
Performance improvement and reporting is a large component of success of all of the project areas across the DSRIP project categories. The majority of medical errors result from faulty systems and processes, not individuals; because of this reason it is important to adopt process improvement techniques to identify inefficiencies, ineffective care, and preventable errors.

Target Population:
The service areas of our 4 outlying clinics. With the expansion of primary and specialty care access to a potential population of another 1,423,176 Medicaid and Medicaid-eligible clients, we expect to provide access to an additional 80,000 patient visits, most of which are expected to be Medicaid/Medicaid-eligible clients (based on the demographics of the UTP clinics service areas).

Category 1 or 2 expected patient benefits:
By DY4 the goal will be to increase the number of reports generated through the QI data systems, and by DY5 to have put in place the quality dashboard.

Category 3 outcomes:
IT-4.8: Our goal is to reduce by 3% in DY4 and 5% in DY5, the percentage of patients expiring during current month hospitalization with sepsis, severe sepsis, or septic shock and/or an infection and organ dysfunction.

Project Option 1.10.2 – Enhance Performance Improvement and Reporting Capacity: MS1 UT Health Regional Systems Engineering Center and UT Health Quality Improvement Dashboard Development Center

Unique RHP Project Identification Number: 111810101.1.8
Performing Provider Name/TPI: UTHealth, UTPhysicians/111810101

Project Description: 1.10 Enhance Performance Improvement and Reporting Capacity (Option 1.10.2)

Development of a UT Health regional systems engineering center that will embed proven evidence-based industrial and systems engineering improvement methods such as Lean, Six Sigma, and Care Logistics into local healthcare organizations to significantly improve care, reduce errors, reduce cost, improve safety and overall quality of healthcare delivered to our patients. The center will recruit systems engineers that will integrate with healthcare quality improvement teams to cross train in applying systems engineering improvement science to major healthcare processes., and 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. The center will also develop interdisciplinary courses for healthcare professionals, students, engineers and administrative healthcare leadership. The center will review major quality improvement projects and partner with quality improvement teams to embed industrial and systems engineering methodology into the design.

In addition, the project will develop quality improvement capacity at UT Health by developing specialty specific quality improvement dashboards through a central center that will integrate quality improvement (QI) data from various institutions and national reporting agencies, measure, report monthly specialty specific data, and serve as the engine to drive, conduct and rapidly diffuse quality and patient safety improvements. The center will interface with various sites (Harris County Hospital District, Memorial Hospital System, UT Health outpatient centers) to obtain clinical data to populate the Quality Dashboards that will be developed for each clinical specialty based on specialty specific key quality metrics (CMS, AHRQ, etc). Through the Quality Dashboards, UT Health will measure, report, support quality improvement projects and drive change with rapid diffusion of key successful process between departments and between organizations.

Goal and Relationship to Regional Goals:
Project Goal:

To expand quality improvement capacity throughout the organization so that the resources are in place to conduct, report, drive and measure quality improvement, and to implement process improvement methodologies to improve safety, quality, and efficiency.

This project addresses the following regional goal:

This project is anchored on the rgional goal that aims to "develop a culture of ongoing transformation and innovation that maximizes the use of technology and best-practices, facilitates regional collaboration and sharing, and engages patients, providers, and other stakeholders in the planning, implementation, and evaluation processes." This will be achieved

partly by establishing learning processes and putting in place mechanisms for effective application and sharing of QI lessons learned.

Challenges:

Need: 1) High rates of preventable hospital admissions. 2) High rates of preventable hospital readmissions.

Implementation: 1) Recruitment and retention of systems engineers. 2) Training of systems users. 3) Willingness of regional health institutions to collaborate on QI partnerships

This project will put quality at the forefront of the health care transformation agenda in the region. Potentially preventable hospital admissions and readmissions are few of the manifestations of failure the system to provide quality care. Such issues are what the quality improvement processes that will be ushered in by this project will address. The project will also create the avenue for different health care organizations in the region to collaborate on quality improvement.

5-Year Expected Outcome for Provider and Patients:

By adopting various process improvement techniques to identify inefficiencies, ineffective care, and preventable errors, patients of UT Physicians, including the current Medicaid (23% as of 2011, or 65,302 patient visits) and low-income client base, will be safer and experience better health outcomes including fewer potentially preventable readmissions and mortality due to sepsis. With the other projects of UTP in expanding primary and specialty care access to a potential population of another 1,423,176 Medicaid and Medicaid-eligible clients, we expect to provide access to an additional 80,000 patient visits, most of which are expected to be Medicaid/Medicaid-eligible clients (based on the demographics of the UTP clinics service areas). The outcome of our quality improvement efforts to ensure the best evidence-based care will surely impact the health of many people.

Starting Point/Baseline:

To be determined during DY3.

Rationale:

Performance improvement and reporting is a very large component of success of all of the project areas across the DSRIP project categories. The health industry is in need of quality and safety improvement initiatives (Martin LA, Nelson EC, Lloyd RC, Nolan TW. Whole System Measures. IHI Innovation Series white paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2007. (Available at: http://www.ihi.org/knowledge/Pages/IHIWhitePapers/WholeSystemMeasuresWhitePaper.aspx, accessed 10/11/12) Quality health care is defined as "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge"(AHRQ: Measures Sought for National Quality Measures Clearinghouse. Available at: http://www.ahrq.gov/qual/nqmcmeas.htm, accessed 10/11/12). According to the Institute of Medicine (IOM), the majority of medical errors result from faulty systems and processes, not individuals. Because errors are caused by system or process failures, it is important to adopt various process improvement techniques to identify inefficiencies, ineffective care, and preventable errors to then influence changes associated with systems. This is what this project aims to achieve for the UTHealth system and other health institutions in the

region. Each of the various techniques involves assessing performance and using the findings to inform change. Strategies and tools for quality improvement include failure modes and effects analysis, Plan-Do-Study-Act, Six Sigma, Lean, and root-cause analysis, and these have been used succesfully to improve the quality and safety of health care.(The Denver Health LEAN Academy: Lean Results. Available at: http://www.denverhealth.org/LEANAcademy/AboutLEANAcademy/CaseStudies.aspx)

Project Components:

Through the UT Health Regional Systems Engineering Center and UT Health Quality Improvement Dashboard Development Center Program, we propose to meet all required project components listed below.

a) UTP will establish a performance improvement office to collect, analyze, and manage real-time data and to monitor the improvement trajectory and improvement activities across the UT Physicians's delivery system.
b) UTP will recruit and/or train quality improvement staff in well-proven quality and efficiency improvement principles, tools and processes, such as rapid cycle improvement, and/or data and analytics staff for reporting purposes.
c) UTP will 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.
d) UTP will design data collection systems and processes to collect real-time data, which will be used to drive continuous quality improvement.

Milestones and Metrics:

For the UT Health Regional Systems Engineering Center and UT Health Quality Improvement Dashboard Development Center Program, we have chosen the below milestones and metrics based upon the above project components and relationship to project goals and population needs. All baselines and goals will be determined during DY2.

Process Milestones and Metrics:

Milestone 1 [P-1]: Establish a performance improvement office to collect, analyze, and manage real-time data and to monitor the improvement trajectory and improvement activities across the UT Physicians's delivery system

Metric 1 [P-1.1]: Documentation of the establishment of performance improvement office

Milestone 2 [P-6]: Hire/train quality improvement staff in well-proven quality and efficiency improvement principles, tools and processes, such as rapid cycle improvement and/or data and analytics staff for reporting purposes (e.g., to measure improvement and trends)

Metric 1 [P-6.1]: Increase number of staff trained in quality and efficiency improvement principles

Improvement Milestones and Metrics:

Milestone 3 [I-7]: Implement quality improvement data systems, collection, and reporting capabilities

Metric 1 [I-7.1]: Increase the number of reports generated through these quality improvement data systems

Milestone 4 [I-8]: Create a quality dashboard or scoreboard to be shared with organizational leadership and at all levels of the organization on a regular basis that includes outcome measures and patient satisfaction measures

Metric 1 [I-8.1]: Submission of quality dashboard or scorecard

Unique community need identification numbers the project addresses:

This project addresses community needs CN.9 (High rates of preventable hospital readmissions) and CN.10 (High rates of preventable hospital admissions).

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

This project represents a new initiative. UT Physicians have not previously had access to these types of tools and processes for quality improvement.

Related Category 3 Outcome Measure(s):

OD-4 Potentially Preventable Complications and Healthcare Acquired Conditions

- IT-4.8 Sepsis mortality (Standalone measure)

Reduce the percentage of patients expiring during current month hospitalization with sepsis, severe sepsis or septic shock and/or an infection and organ dysfunction.

Relationship to other Projects:

1.3 (C12) - The chronic disease registries created under project C12 will make available useful QI data that will be used to populate the QI dashboards this project (MS1) seeks to create.

2.1 (C1-2) -This project will enhance quality improvement processes that will aid in identifying opportunities for continuous improvement in the functioning of the medical homes.

2.2 (C5-9,CL3) - This project will aid in the adoption of a 'whole systems' approach to chronic disease management, enabling the implementation of a comprehensive and proactive approach to chronic care, in which the patient is kept in continuos contact with the care team.

2.11 (C10) - The QI initiatives that will result from the implementation of this project will interact with the medication management program for the reduction of medication errors and noncompliance, providing a system for continuous quality improvement.

2.12 (A3, CL1, CL2, MS4) -Transitions in setting of care—for example from hospital to home or nursing home, or from facility to home and community-based services—have been shown to be prone to errors. This project (MS1) relates with these 4 care transitions projects by putting in place the right processes and systems to ensure that potential errors associated with care transitioning are avoided.

Relationship to Other Performing Providers' Projects in the RHP:

Innovation is key to the transformation of healthcare in our community. The consistency of innovation in our region allows for increased improvements based on research trends, patient need, and provider availability. The waiver funding allows for innovation in specific areas and all innovative projects included in the plan are similar in the fact of program redesigns for historic treatments, and focus to chronic condition outcome measures such as central line infections. The Region 3 initiative grid in the addendum can provide a side by side comparison of all projects that directly relate to innovation.

Plan for Learning Collaborative:

UTHealth will participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system.

Project Valuation:

The anchor, Harris Health, provided a spreadsheet which contained 6 criteria, which could be used to rate each project on a 10-point scale. The ratings for each criterion were weighted, summed for each project to arrive at a total score (value weight) for each project. The sum of all the project's total scores were then divided by the percent of total DSRIP funds to be secured for that year to arrive at a dollar value multiplier to be applied towards each project's total score (value weight), thereby allocating a greater proportion of the funds towards those projects valued highest based upon the 6 criteria. UTHealth used this approach, with one exception—we did not use two of the criteria. Following are the criteria, the considerations for awarding points for projects using that criteria, and the reasons two of the criteria were not used:

1. Transformational Impact (Weight = 20%): Points were awarded for projects that meet the community benefit criteria, such as: improving access; improving quality; improving costs (long-term cost-savings); transformative (Innovative), collaborative (partners with other organization(s)). This project's score for this criterion: **4**

2. Population Served/Project Size (Weight = 20%): Points were awarded based on the size of the population affected and whether the target population is uninsured or on Medicaid. This project's score for this criterion: **2**

3. Aligned with Community Needs (Weight = 20%): Points were awarded based on judgments in two categories: whether or not the CNA indicates a need in the area of the project and the severity of the health/healthcare need(s) the project addresses. This project's score for this criterion: 111810101.1.8 X 2 = **2**

4. Cost Avoidance (Weight = 15%): Points were awarded based on judgment of project's cost effectiveness relative to similar projects. This project's score for this criterion: **2**

5. Partnership/Collaboration (Weight = 10%): ***This was not rated***, because UTHealth planned to partner with Harris Health to perform many similar projects, so the rating would have been the same for all projects. This would have diluted the scores, hiding the more significant variations in other value criteria.

6. Sustainability (Weight = 15%): ***This was also not rated***, because UTHealth does not consider any of the projects to be unsustainable, or at the very least do not consider one project less sustainable than another. Giving the projects the same, or very similar ratings on this criteria again would have had a diluting effect, hiding the more significant variations in other value criteria.

Total Valuation Score for this project: **1.9**

111810101.1.8	***1.10.2***	***A-C***	***MS1 UT HEALTH REGIONAL SYSTEMS ENGINEERING CENTER AND UT HEALTH QUALITY IMPROVEMENT DASHBOARD DEVELOPMENT CENTER***
UTHealth, UTPhysicians			*111810101*
Related Category 3 Outcome Measure(s):	*111810101.3.13*	*IT-4.8*	*Sepsis mortality (Standalone measure)*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-1]: Establish a performance improvement office to collect, analyze, and manage real-time data and to monitor the improvement trajectory and improvement activities across the UT Physicians's delivery system Metric 1 [P-1.1]: Documentation of the establishment of performance improvement office Baseline/Goal: TBD Data source: HR documents, office policies and procedures Milestone 1 Estimated incentive payment: $ 1,819,906	**Milestone 2** [P-6]: Hire/train quality improvement staff in well-proven quality and efficiency improvement principles, tools and processes, such as rapid cycle improvement and/or data and analytics staff for reporting purposes (e.g., to measure improvement and trends) Metric 1 [P-6.1]: Increase number of staff trained in quality and efficiency improvement principles Baseline/Goal: TBD Data Source: Training records Milestone 2 Estimated incentive payment: $1,902,716	**Milestone 3** [I-7]: Implement quality improvement data systems, collection, and reporting capabilities Metric 1 [I-7.1]: Increase the number of reports generated through these quality improvement data systems Goal: TBD Data Source: Quality improvement data systems documentation/reports Milestone 3 Estimated incentive payment: $ 2,134,627	**Milestone 4** [I-8]: Create a quality dashboard or scoreboard to be shared with organizational leadership and at all levels of the organization on a regular basis that includes outcome measures and patient satisfaction measures Metric 1 [I-8.1]: Submission of quality dashboard or scorecard Goal: TBD Data Source: Quality improvement data systems documentation/reports Milestone 4 Estimated incentive payment: $2,130,270
Year 2 Estimated Milestone Bundle Amount: $1,819,906	Year 3 Estimated Milestone Bundle Amount: $1,902,716	Year 4 Estimated Milestone Bundle Amount: $2,134,627	Year 5 Estimated Milestone Bundle Amount: $2,130,270

The University of Texas Health Science Center - Houston

Pass 2

Project Option 1.1.1 – Establish more primary care clinics: New North Harris County Healthcare Clinic

Unique RHP Project ID: 111810101.1.9
Performing Provider Name/TPI: UTHealth, UTPhysicians / 111810101

Project Summary:

Provider:
UT Physicians is the clinical practice of The University of Texas Medical School at Houston. With more than 900 physicians certified in 80 medical specialties and subspecialties, 906 residents and fellows, and 283,920 patient visits in 2011, it is the fastest growing academic practice in the nation for the last five years. In addition to our flagship location in the Texas Medical Center, UT Physicians (UTP) has 4 neighborhood locations throughout the Greater Houston area, and also offers specialty clinics at several Memorial Hermann Hospital locations.

Intervention(s):
UT Physicians will establish the North Harris County Primary Care Clinic. Space will be leased to open the clinic, which will include consulting, exam and procedure rooms. The clinic will offer expanded evening and weekend hours to improve access to care. Primary care providers and support staff will be recruited to operationalize the project.

Need for the project:
UTP has defined the service area for this clinic as a priority for primary care services, because of its high rate of poverty. Although the need in the defined service area for this project is so great that it could support many primary care clinics, there is currently only one community health clinic that serves the indigent population.

Target Population:
The target population are those living in an area of Harris County that is between FM 1960 to the north, Cypress Creek Pkwy to the Northwest, Veteran's Memorial Drive to the west, Aldine Mail Route to the south, and Highway 59N to the east. The population in this area is estimated to be 196,900, out of which 48,244 persons are living below the federal poverty level.

Category 1 or 2 expected patient benefits:
Our DY4 goal is to increase primary care clinic volume of visits over prior reporting period. For DY5, the goal is to increase primary care clinic volume of visits for unique patients.

Category 3 outcomes: (by DY 5)
IT-1.1 Reduce the time to third next available appointment for a new patient physical, routine exam, or return visit exam to zero (0) days, for primary care.
IT-12.1 Increase by 5% the percentage of women patients of UT Physicians aged 40 to 69 that have received an annual mammogram during the reporting period.
IT-12.3 Increase by 5% the percentage of adult patients of UT Physicians aged 50 to 75 that have received one of the following screenings: Fecal occult blood test yearly, Flexible sigmoidoscopy every five years, or Colonoscopy every 10 years.

Project Option 1.1.1 – Establish more primary care clinics: New North Harris County Healthcare Clinic

Unique RHP Project Identification Number: 111810101.1.9 / Pass 2
Performing Provider Name/TPI: UTHealth, UTPhysicians/111810101

Project Description: 1.1 Expand Primary Care Capacity (Option 1.1.1)

UT Physicians (UTP) intends to address the shortage of primary and specialty care in Region 3. In this project, UTP will establish the North Harris County Primary Care Clinic, which will provide primary care for the population in an area of Harris County that is between FM 1960 to the north, Cypress Creek Pkwy to the Northwest, Veteran's Memorial Drive to the west, Aldine Mail Route to the south, and Highway 59N to the east. UTP has defined the service area for this clinic as a priority area for primary care services, because it is an area with a high rate of poverty. The population in this area is estimated to be 196,900 and is made up of 34 census tracts (CTs): 20 of the 34 fall within the top 25% of all census tracts in Harris County with the greatest number of people living below the federal poverty level (FPL), with 9 of those falling within the top 10%. (The CTs in the above defined service area that fall within the top 25% of Harris County CTs with the highest number of people living below the poverty line are: 5511, 5503.01, 5501, 2415, 2405.02, 2227, 2226, 2225.03, 2225.01, 5506.03, 5504.02, 5504.01, 5503.02, 5502, 5337.01, 5336, 2407.01, 2404, 2401, and 2230.02.) A total of 48,244 people in our defined service area are living below the FPL and a total of 99,482 are living below 185% of FPL. Furthermore, this area has a high rate of Hispanics (53.7%), for whom language, as well as poverty, may pose a barrier to obtaining primary care for their children. Black/African Americans, another segment of the population that tend to be medically underserved, also make up a significant proportion of the population (32.6%). Using the Harris County rate (14.5%) of Medicaid clients, there would be an estimated 28,551 Medicaid clients living within this service area. However, since this area has an exceptionally high rate of poverty, the number of Medicaid, or Medicaid-eligible clients, is expected to be much higher than this. (All population statistics are from the U.S. Census Bureau, 2010 Census. Poverty statistics are from the U.S. Census Bureau, Small Area Estimates Branch. Release date: 11.2011. Table 1: 2010 Poverty and Median Income Estimates - Counties. The Medicaid rate is from the U.S. Census Bureau and the Centers for Disease Control and Prevention, State and County by Demographic and Income Characteristics. SAHIE, 2009.) The service area for this clinic includes large populations with economic, cultural, language, and transportation barriers to receiving primary care. In order to address the unique needs of this community in the north Harris County area, UTP has chosen to establish a primary care clinic in this area as an independent DSRIP project.

In order to implement this project, UTP will lease additional space to open the North Harris County Healthcare clinic. This space will include additional consulting, exam and procedure rooms. The clinic will offer expanded evening and weekend hours to improve access to low-wage workers, who often work in jobs that do not grant paid time off for illness, or healthcare related needs. UTP will recruit additional primary care providers and support staff to operationalize the project. UTP is uniquely positioned to attract and retain new physicians, because it is a part of the world-class academic and research institution, The University of Texas Health Science Center-Houston. Although the need in the defined service area for this project is so great that it could support many primary care clinics, there is currently only one community

health clinic that serves the indigent population (Harris Health's Aldine Health Center) and it is on the southern-most border of our defined service area. Harris Health has not proposed any further clinics in this area, but UTP will collaborate with them to ensure that our clinic is placed optimally to provide the greatest convenience to the population without risking duplication of services provided by Harris Health. Furthermore, since this primary care clinic will provide services to the adult population, it will not duplicate services to be provided through Memorial Hermann Hospital's proposed North Harris County Pediatric Clinic, but rather complement these services.

Goal and Relationship to Regional Goals:

Project Goals:

Expand primary care capacity to better accommodate the needs of the regional patient population and community, so that patients have enhanced access to the right health care services, at the right time, in the right setting.

This project addresses the following regional goals:

One of the goals of the region is to "Increase access to primary and specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their condition, regardless of where they live or their ability to pay". Expansion of primary care capacity certainly relates to this goal as it will make it easier for UT Physicians to provide care to underserved populations.

Challenges:

Need: 1) Inadequate access to primary care. 2) High rates of inappropriate emergency department utilization.

Implementation: 1) Staff recruitment and retention. 2) Marketing of expansion.

By expanding the capacity of their clinics, UT Physicians will be better able to deliver timely care to more patients when needed thereby diverting patients away from the emergency room. UT Physicians will recruit physicians from the UTHealth residents placed at Memorial Hermann Hospital-TMC and will offer them a competitive salary and other incentives to practice in the outlying clinics. A marketing campaign that addresses the culture(s) and needs of the community will be implemented to inform the community of our expanded capacity to provide quality care that is convenient for them.

5-Year Expected Outcome for Provider and Patients:

There will be shortening of waiting times for primary care appointments and increased uptake of primary care services in our service areas, which will increase the percentage of patients who receive appropriate primary health care, including preventative services, regular screenings, and monitoring for those patients with chronic illnesses. UT Physicians expects to see an uptake of regular screenings particularly for breast cancer and colon cancer. Detecting cancer early can reduce the burden of the disease in terms of both improved health outcomes and lower costs.

Starting Point/Baseline:

UTHSC-H has identified the targeted service area needing increased access to primary care. Since this will be a new clinic, the baseline will have to be established during DY3.

Rationale:

Research has shown that access to primary care is associated with better health outcomes at less cost. Access to primary care ensures better preventive care and better management of chronic disease, with lack of access often resulting in more expensive care, received in hospitals and emergency departments (ED). For the fiscal year 2010, 10% of all potentially preventable hospitalizations (PPR) were ambulatory care sensitive. In 2009, 41% (390,945) of ED visits in Houston were primary care related (PCR), including non-urgent, primary care treatable, and primary care preventable, and for 26.8% (104,762) of these PCR visits, Medicaid was the payor. Getting more patients into primary care will help to reduce the use of this more costly care. Placing more primary care providers out in the communities served by the UT Physcians will help to address transportation access barriers and the expansion of clinic service hours will provide a greater selection of available appointment times. By increasing primary care capacity and engaging more people in the primary care system, avoiding inappropriate utilization of costly services, the community will experience better health outcomes and greater patient satisfaction. (PPR rate was from the Texas Health and Human Services Commission report on Potentially Preventable Readmissions in the Texas Medicaid Population, Fiscal year 2010, published January, 2012. The statistics for ED use were from the Houston Hospitals Emergency Deaprtment Use Study (January 1, 2009 through December 31, 2009), Final Report, prepared by the UT School of Public Health, May 2011, included in the 2010 Harris County Community Needs Assessment for Memorial Hermann.)

Project Components:

Through the New North Harris County Healthcare Clinic, we propose to:

a) Identify and lease appropriate space within the defined service area to establish a new clinic.
b) Once leased, we will recruit primary care physicians and support staff.
c) The clinic will operate with expanded evening and Saturday hours to increase access.

Milestones and Metrics:

For the Expand Existing Primary Care Capacity at UT Physicians Clinics Program, we have chosen the below milestones and metrics based upon the above project components and relationship to project goals and population needs. All baselines and goals will be determined during DY2.

Process Milestones and Metrics:

Milestone 1 [P-1]: Establish an additional primary care clinic
Metric 1 [P-1.1]: Number of additional clinics.
Milestone 2 [P-5]: Hire additional primary care providers and staff
Metric 1 [P-5.1]: Documentation of increased number of providers and staff.
Milestone 3 [P-4]: Expand the hours of a primary care clinic, including evening and/or weekend hours
Metric 1 [P-4.1]: Increased number of hours at primary care clinic over baseline

Improvement Milestones and Metrics:

Milestone 4 [I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services.
Metric 1 [I-12.1]: Documentation of increased number of visits. Demonstrate improvement over prior reporting period.

Milestone 5 [I-12]: Documentation of increased number of visits. Demonstrate improvement over prior reporting period.
Metric 1 [I-12.2]: Documentation of increased number of unique patients.

Unique community need identification numbers the project addresses:
This project addresses community needs CN.1 (Inadequate access to primary care) and CN.8 (High rates of inappropriate emergency department utilization).

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
UT Physicians operates 4 clinics that serve areas that include large populations with economic, cultural, language, and transportation barriers to receiving primary care. This project proposes to add a new clinic in a different location where there is also a large population with economic, cultural, language, and transportation barriers to receiving primary care and where the demand for services is high. While this project is an expansion of UTP services in order to improve access to care, it is a new clinic in an area of great need.

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

- IT-1.1 Third next available appointment (Non- standalone measure)
  Reduce the average length of time in days between the day a patient makes a request for an appointment with a physician and the third available appointment for a new patient physical, routine exam, or return visit exam. The goals will be to decrease number of days to third next available appointment to zero days (same day) for Primary Care.

OD-12 Primary Care and Primary Prevention

- IT-12.1 Breast Cancer Screening (HEDIS 2012) (Non-standalone measure)
  Numerator: Number of women aged 40 to 69 that have received an annual mammogram during the reporting period. Denominator: Number of women aged 40 to 69 in the patient or target population. Women who have had a bilateral mastectomy are excluded.

OD-12 Primary Care and Primary Prevention

- IT-12.3 Colorectal Cancer Screening (HEDIS 2012) (Non-standalone measure)
  Numerator: Number of adults aged 50 to 75 that have received one of the following screenings. Fecal occult blood test yearly, Flexible sigmoidoscopy every five years, Colonoscopy every 10 years
  Denominator: Number of adults aged 50 to 75 in the patient or target population. Adults with colorectal cancer or total colectomy are excluded.

Relationship to other Projects:
In addition to the UTP Pass-2 project for adding specialty services to this new primary care clinic in the North Harris County defined service area, in order to provide greater access to integrated care, this project is related to the below Pass 1 projects proposed by UT Physicians.
1.2 (A2, SPH1) - Increased training of primary care workforce will provide physicians and support staff needed to expand primary care capacity.
1.7 (A1) - Expanded primary care capacity will facilitate and enhance access to specialty care via telemedicine.

1.10 (MS1) - The systems engineering and user dashboards will give providers greater access to information and provide reports facilitating a continuous quality improvement process.
2.1 (C1-2) - As part of the medical home project, all patients will be assigned to a primary care provider within the UT Health medical home. Expanded primary care capacity will be a necessary step to making this possible.
2.2 (CL3, C5-C9) - Expanded capacity in primary care will ensure the availability of staff to implement the expansion of the chronic care management model for the targeted diseases.
2.11 (C10) - The medication management program will be an integral part of the coordinated care provided by the primary care physicians.
2.12 (A3, CL1, CL2, MS4) - For the various care transition projects to be succesful, UT Health needs to ensure it has adequate primary care capacity to handle the increased volume of patients.

Relationship to Other Performing Providers' Projects in the RHP:

Primary Care/Ambulatory Care clinics are a top priority to Region 3 due to the acuity of the regional patient mix, population concentration, and lack of primary care access points for our patient base. The regional approach of collaboration as well as existing patient referral pattern relationships allowed our team to properly identify the community needs based on the necessity of population, uninsured, and medically underserved patient bases. This program is consistent with our region and similar to numerous initiatives in our RHP plan sharing both concepts as well as outcome measures focused to percent improvement over baseline of patient satisfaction scores, reduction of inappropriate ED utilization, and third next available appointment status. The Region 3 Initiative Grid attached as a RHP Plan addendum reflects a grid of relationship for all initiatives.

Plan for Learning Collaborative:

UTP will participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system.

Project Valuation:

The anchor, Harris Health, provided a spreadsheet which contained 6 criteria, which could be used to rate each project on a 10-point scale. The ratings for each criteria were weighted, summed for each project to arrive at a total score (value weight) for each project. The sum of all the project's total scores were then divided by the percent of total DSRIP funds to be secured for that year to arrive at a dollar value multiplier to be applied towards each project's total score (value weight), thereby allocating a greater proportion of the funds towards those projects valued highest based upon the 6 criteria. UTP used this approach, with one exception—we did not use two of the criteria. Following are the criteria, the considerations for awarding points for projects using that criteria, and the reasons two of the criteria were not used:

1. Transformational Impact (Weight = 20%): Points were awarded for projects that meet the community benefit criteria, such as: improving access; improving quality; improving costs (long-term cost-savings); transformative (Innovative), collaborative (partners with other organization(s)). This project's score for this criteria: **8**

2. Population Served/Project Size (Weight = 20%): Points were awarded based on the size of the population affected and whether the target population is uninsured or on Medicaid. This project's score for this criteria: **8**

3. Aligned with Community Needs (Weight = 20%): Points were awarded based on judgments in two categories: whether or not the CNA indicates a need in the area of the project and the severity of the health/healthcare need(s) the project addresses. This project's score for this criteria: **10**

4. Cost Avoidance (Weight = 15%): Points were awarded based on judgment of project's cost effectiveness relative to similar projects. This project's score for this criteria: **6**

5. Partnership/Collaboration (Weight = 10%): ***This was not rated***, because UTHealth planned to partner with Harris Health to perform many similar projects, so the rating would have been the same for all projects. This would have diluted the scores, hiding the more significant variations in other value criteria.

6. Sustainability (Weight = 15%): ***This was also not rated***, because UTHealth does not consider any of the projects to be unsustainable, or at the very least do not consider one project less sustainable than another. Giving the projects the same, or very similar ratings on this criteria again would have had a diluting effect, hiding the more significant variations in other value criteria.

Total Valuation Score for this project: **6.1**

111810101.1.9	***OPTION 1.1.1***	*N/A*	***NEW NORTH HARRIS COUNTY HEALTHCARE CLINIC***
UTHealth, UTPhysicians			*111810101*
Related Category 3 Outcome Measure(s):	*111810101.3.24* *111810101.3.25* *111810101.3.26*	*IT-1.1* *IT-12.1* *IT-12.3*	*Third next available appointment (Non- standalone measure)* *Breast Cancer Screening (HEDIS 2012) (Non-standalone measure)* *Colorectal Cancer Screening (HEDIS 2012) (Non-standalone measure)*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-1]: Establish an additional primary care clinic Metric 1 [P-1.1]: Number of additional clinics. Baseline/Goal: TBD Data Source: New primary care schedule and other UT Physicians' documents. Milestone 1 Estimated incentive payment: $ 2,026,985 **Milestone 2** [P-5]: Hire additional primary care providers and staff Metric 1 [P-5.1]: Documentation of increased number of providers and staff. Baseline/Goal: TBD Data Source: UT Physicians' report, policy, contract or other documentation Milestone 2 Estimated incentive payment: $ 2,026,985	**Milestone 3** [P-4]: Expand the hours of a primary care clinic, including evening and/or weekend hours Metric 1 [P-4.1]: Increased number of hours at primary care clinic over baseline Baseline/Goal: TBD Data Source: Clinic documentation Milestone 3 Estimated incentive payment: $4,549,814	**Milestone 4** [I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services. Metric 1 [I-12.1]: Documentation of increased number of visits. Demonstrate improvement over prior reporting period. Goal: TBD Data Source: Registry, EHR, claims or other UT Physicians' source Milestone 4 Estimated incentive payment: $4,923,537	**Milestone 5** [I-12]: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services Metric 1 [I-12.2]: Documentation of increased number of unique patients. Demonstrate improvement over prior reporting period. Goal: TBD Data Source: Registry, EHR, claims or other UT Physicians' source. Milestone 5 Estimated incentive payment: $4,470,201
Year 2 Estimated Milestone Bundle Amount: $4,053,969	Year 3 Estimated Milestone Bundle Amount: $4,549,814	Year 4 Estimated Milestone Bundle Amount: $4,923,537	Year 5 Estimated Milestone Bundle Amount: $4,470,201
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*:* $18,267,521			

Project Option 1.9.2 – Expand Specialty Care Capacity: Expand UT Physician Specialty Services to North Harris County

Unique RHP Project Identification Number: 111810101.1.10
Performing Provider Name/TPI: UTHealth, UTPhysicians / 111810101

Project Summary:
Provider:
UT Physicians (UTP) is the clinical practice of The University of Texas Medical School at Houston. With more than 900 physicians certified in 80 medical specialties and subspecialties, 906 residents and fellows, and 283,920 patient visits in 2011, it is the fastest growing academic practice in the nation for the last five years. In addition to our flagship location in the Texas Medical Center, UT Physicians has 4 neighborhood locations throughout the Greater Houston area, and also offers specialty clinics at several Memorial Hermann Hospital locations.
Intervention(s):
UT Physicians will recruit specialists for the new primary care clinic in North Harris County. This will further enable expansion of UT Health specialty services to another area outside the Texas Medical Center. The new primary care clinic's service hours will be extended to provide evening and weekend appointment options, which will be covered by the UTP specialty services as well. Standardized referral systems will be put in place to ensure access to these specialists.
Need for the project:
This project addresses the county's inadequate access specialty care, especially for the service area for this clinic which includes large populations with economic, cultural, language, and transportation barriers to receiving healthcare. In order to address the unique needs of this community in Harris County, there is need to extend specialty care services to this area.Target Population:

The target population are those living in an area of Harris County that is between FM 1960 to the north, Cypress Creek Pkwy to the Northwest, Veteran's Memorial Drive to the west, Aldine Mail Route to the south, and Highway 59N to the east. The population in this area is estimated to be 196,900, out of which 48,244 persons are living below the federal poverty level.
Category 1 or 2 expected patient benefits:
Our DY4 goal is to increase the number of specialist providers, clinic hours and/or procedure hours available for the high impact/most impacted medical specialties, and by DY5 to increase the number of referrals of targeted patients to the specialty care clinic.
Category 3 outcomes: (by DY5)
IT-1.1 The goal will be to decrease number of days to third next available appointment to two days for Specialty Care.
Also, other category 3 outcome goals will be to increase by 5% the percentage of patients who had each of the following during the reporting period: Low-density Lipoprotein Cholesterol (LDL-C) Screening (performed during the measurement year), and LDL-C Level <100 mg/dL.

Tomball Regional Hospital

Pass 1

Project Option 1.1.2- Expand existing primary care capacity: Expand primary care access for uninsured populations within and around Tomball

Unique RHP Project ID: 131044305.1.1
Performing Provider Name/TPI: Tomball Regional Medical Center / 288523801

Project Summary:

Provider:
Tomball Regional Medical Center is a 358 bed acute care hospital located in Northwest Harris County. The hospital is a private for-profit facility that has provided $39.3m in uncompensated care for 2012 and $1.8m charity care.

Volume Statistics - FY2012	Patient Payor Mix	Patient Demographics
Hospital admissions- 10,004 Births (babies delivered)- 709 Emergency visits- 32,935 Outpatient clinic visits- 78,088	Self-Pay- 9% Medicaid and CHIP- 15% Medicare- 34% Other Funding- 1% Commercial Insurance- 41%	Hispanic- 13% African American- 30% Caucasian- 50% Asian- 4% Other- 1% American Indian- 2%

Intervention(s):
This project will expand access to primary care for the uninsured by the hospital providing nurse practioner and office resources to the local indigent care clinic. This resource will allow the clinic to expand hours of coverage into the evenings.

Need for the project:
The purpose of this project is to provide treatment to the working uninsured for medical conditions that if managed timely will prevent the conditions from escalating to the point of needing treatment in a hospital setting. In 2012, the hospital treated 8,340 uninsured patients in the emergency setting

Target Population:
The target population will be the 8,340 uninsured emergency room patient and the estimated 10,000 citizens in the local market without medical coverage.

Category 1 or 2 expected patient benefits:
Our DY4 goal is to improve upon DY2 baseline of patient primary care visits by 5 patients per work day. Our DY5 goal is for 7 patient visits per day.

Category 3 outcomes:
IT-3.2: Our goal is to reduce COPD 30 day readmission rates by 3% of baseline in DY4 and 5% of baseline in DY5. IT -2.10 Our goal is to reduce uninsured hospital admissions for flu and pneumonia by 5%.

Project Option 1.1.2 – Expand existing primary care capacity: Expand primary care access for uninsured populations within and around Tomball.

Unique RHP Project Identification Number: 131044305.1.1
Performing Provider Name/TPI: Tomball Regional Medical Center / 288523801

Project Description:
Tomball Regional Medical Center (TRMC), the area's full service hospital, is proposing a Category 1 DSRIP project to expand primary care access for the uninsured population within and around The City of Tomball.

This project will allow patients to receive the right care at the right time in the right setting. The project will be a partnership of Tomball Hospital Authority (IGT partner), TOMAGWA Healthcare Ministries, a comprehensive family practice clinic, and Tomball Regional Hospital.

TRMC is proposing to provide the professional services of a mid-level provider and office staff to TOMAGWA, so that they may expand their services by providing expanded hours of clinic operations in their current location. TOMAGWA would provide the facilities. Additional facilities are not needed at this time as the clinic space is not used after 5:00pm. This mid-level provider would need to be supervised by a current licensed physician on the staff of TOMAGWA.

TOMAGWA would operate the clinic under its current reduced fee schedules and charity/indigent guidelines. This would improve access to care for the working uninsured that cannot afford to take off during business hours and pay normal physician office rates. We are currently proposing that the expanded hours of operations for this clinic would be from 5:00pm until 9:00pm Monday through Friday. Payment for each office visit would be based on the current TOMAGWA fee schedule and charity care guidelines.

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

- Expanded hours to a see a targeted 10 patients per day
- Reduce preventable admissions by 4%
- Reduce readmissions by 4%
- Reduce overuse of the emergency room 5%

Starting Point/Baseline:
The clinic does not currently have after-hours operations. The baseline for the clinic visits would be zero. However, the hospital does see these patients via the emergency room and in the inpatient setting. The top acute care hospital admissions DRG's (excluding births) for Tomball Regional Medical Center for the eight months ending August 31, 2012 for Medicaid and uninsured patients are:

DRG	Number of Cases	Hospital Charges
Cellulitis w/o cc/mcc	**37**	**$967,678**
Esophagitis, Gastrent $ misc Digest disorders w/o MCC	**28**	**$610,525**
Simple pneumonia & pleurisy w mcc	**15**	**$551,345**
Chronic Obstructive Pulmonary Disease w MCC	**14**	**$455,147**

These admissions are identified as conditions that with proper treatment and patient educations may either be prevented or the severity can be reduced. By improving access to primary care providers these patients can receive the outpatient treatment and care plans that they have not been receiving or have been depending on the hospital emergency room to provide.

Rationale:

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

Project Components:

- **Expand primary care** clinic space
- Expand primary care clinic hours
- Expand primary care clinic staffing

Unique community need identification number the project addresses:

- CN.1 Inadequate access to primary care
- CN.2 Inadequate access to specialty care
- CN.6 Inadequate access to treatment and services designed for special needs populations, including disabled, homeless, children, elderly
- CN.7 Insufficient access to care coordination practice management and integrated care treatment programs
- CN.8 High rates of inappropriate emergency department utilization
- CN.11 High rates of chronic disease and inadequate access to treatment programs and services for illnesses associated with chronic disease, including: Cancer, Diabetes, Obesity, Cardiovascular disease, Asthma, AIDS/HIV

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

This project proposes to add one practioneer and extend the hours of operation of the indigent care clinic. By increasing these available resources we will meet the following community needs.

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

- IT-2.5 Reduce admissions COPD
- IT-2.10 Flu and pneumonia Admissions rates
- IT-3.1 Potentially preventable re-admissions 30 day
- IT -9.2 ED appropriate utilization

Reasons/Rationale for selecting the outcome measures:
By making services and education available to the low income population, patient will be able to identify mild illnesses and receive treatment prior to the conditions requiring emergency services. This will shorten the recovery time and therefore improve the overall health of the patient population.

<u>Relationship to other performing providers' projects in RHP:</u>
Healthcare treatment cannot focus to only the acute or chronic encounter and properly treat the patient. It is critical that our region focuses to patient education and community education to ensure a proactive and responsive approach to healthcare needs. The education models represented in the Region 3 RHP plan can be identified in the Initiative Grid (addendum) and all focus to outcome measures such as appropriate utilization, patient satisfaction scores, and standalone chronic condition scores such as diabetes and asthma.

<u>Plan for Learning Collaborative:</u> We plan to participate in a region-wide learning collaborative as offered by the anchor for Region 3, Harris Health System. Our participation in this collaborative with other performing providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our region's health care system.

<u>Project Valuation:</u>
The value of the project is based on two parts:

1. Cost of expanding capacity via the staffing of the clinic with mid-level provider and support staff as detailed in the Category 1 table. With over 8,300 area population at or below the poverty guidelines, this supports the need for 3-4 primary care providers.
2. Payment reductions and reduced uncompensated care for reduced admissions, readmissions and ED visits.

131044305.1.1	1.1.2	1.1.2.	EXPAND EXISTING PRIMARY CARE CAPACITY: EXPAND PRIMARY CARE ACCESS FOR UNINSURED POPULATIONS WITHIN AND AROUND TOMBALL
Tomball Regional Medical Center			*288523801*
Related Category 3 Outcome Measure(s):	288523801.3.1 288523801.3.2 288523801.3.3 288523801.3.4	*IT 2.5* *IT-2.10* *IT -3.1* *IT -9.2*	*COPD Admission Rate* *Flu and Pneumonia Admission rates* *Potentially preventable re-admission within 30 day* *ED appropriate Utilization*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
P-5. Milestone: Train/hire additional primary care providers and staff and/or increase the number of primary care clinics for existing providers P-5.1. Metric: Documentation of increased number of providers and staff and/or clinic sites. Goal: 1 new provider Data Source: Documentation of completion of all items described by the RHP plan for this measure. Hospital or other Performing Provider report. Milestone 1 Estimated Incentive Payment *(maximum amount):* $214,572	P-4. Milestone: Expand the hours of a primary care clinic, including evening and/or weekend Hours P-4.1. Metric: Increased number of hours at primary care clinic over baseline Goal: 1,040 additional hours Data Source: Clinic documentation . Milestone Estimated Incentive Payment: $ 220,928	I-12. Milestone: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services to a total of 1950. I-12.1. Metric: Documentation of increased number of visits. Demonstrate improvement over prior reporting period Goal: 1300 visits Data Source: Registry, EHR, claims or other Performing Provider source Milestone Estimated Incentive Payment: $ 227,472	I-12. Milestone: Increase primary care clinic volume of visits and evidence of improved access for patients seeking services to a total of 2600. I-12.1. Metric: Documentation of increased number of visits. Demonstrate improvement over prior reporting. Goal: 1339 visits Data Source: Registry, EHR, claims or other Performing Provider source Milestone Estimated Incentive Payment: $ 234,211
Year 2 Estimated Milestone Bundle Amount: $214,572	Year 3 Estimated Milestone Bundle Amount: $ 220,928	Year 4 Estimated Milestone Bundle Amount: $ 227,472	Year 5 Estimated Milestone Bundle Amount: $ 234,211
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:** $ 897,183			

B. Category II

Baylor College of Medicine

Pass 1

Project Option 2.1.1- Develop, implement, and evaluate action plans to enhance/eliminate gaps in the development of various aspects of PCMH standards: The Fifth Ward Model – Inter-professional Primary Care

Unique RHP Project ID: 082006001.2.1
Performing Provider Name/TPI: Baylor College of Medicine/082006001

Summary:
Provider: Baylor Family and Community Medicine partners with multiple community-based healthcare organizations in the Harris County region to provide high quality, evidence-based care to underserved areas.
Intervention: This project will provide high quality, accessible, low-cost primary healthcare for under- or uninsured patients.
Need for the Project: This clinic will serve patients in the Greater Fifth Ward area of Houston, which has been indentified by the U.S. Department of Health and Human Services as a medically underserved area.
Target Population: Under- and uninsured patients who do not currently have a medical home.
Category 2 Expected Benefits:

- The clinic will provide medical homes for up to 5,000 patients by DY5.
- Patients will receive comprehensive, coordinated services by an interprofessional team of practitioners.
- Patients will receive high quality care founded on evidence-based guidelines. Specific areas of clinical focus such as family planning, prenatal care or adolescent health care will be developed to meet the specific needs of the population.

Category 3 Outcomes:

- IT-1.10: Improve HbA1c control by 15% over baseline by DY5.
- IT-1.20: Improve weight management by 10% over baseline by DY5.
- IT-12.2: Improve cervical cancer screening by 10% over baseline by DY5.

Project Option 2.1.1- Develop, implement, and evaluate action plans to enhance/eliminate gaps in the development of various aspects of PCMH standards: The Fifth Ward Model – Inter-professional Primary Care

Unique RHP Project ID: 082006001.2.1
Performing Provider Name/TPI: Baylor College of Medicine/082006001

Project Description:

The Fifth Ward Model Inter-Professional Primary Care Practice Demonstration Project will bring together an interdisciplinary team of healthcare professionals including physicians, mid-level providers (nurse practitioners and physicians' assistants), nurses (RNs, LVNs), nursing assistants, clinical pharmacists (PharmDs), social workers, health educators, and mental health professionals (psychologists, licensed professional counselors) to provide interdisciplinary primary healthcare to patients residing in a medically underserved community of Houston (the 5th ward).

The practice will be located at the Pleasant Hill Baptist Church Center for Spiritual Growth, Health and Wellness, a facility focused on holistic health being developed in partnership with the 5th Ward Re-development Corporation; the Rice University Kinder Institute and Urban Health Program; the Duke Divinity School; YES Prep, an urban educational specialist; Can Do Houston, an urban food specialist; and the Baylor College of Medicine Department of Family and Community Medicine.

The primary care practice will be developed as a high performing Patient Centered Medical Home (PCMH), providing broad spectrum primary health care services including health promotion and disease prevention, care of acute illnesses and injuries, care of common chronic diseases, care of common mental health problems, well woman, prenatal and gynecological services, care of infants and children, geriatric care, rehabilitative and palliative care through a multidisciplinary primary care team, with each team member practicing at the "top" of his or her training and professional license. The practice will be certified as a level 3 Patient Centered Medical Home, use a modern electronic medical record with a secure patient internet portal, and provide high quality care based on the most current evidence-based clinical practice guidelines, continuously measuring and striving to improve its processes and care outcomes.

The practice will serve as a demonstration project and laboratory for training healthcare professional students to work in inter-professional teams, involving faculty and students from Baylor College of Medicine, Prairie View A&M University School of Nursing, the University of Houston School of Pharmacy, Department of Psychology and School of Social Work, the University of Texas School of Public Health, etc.

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

The goal of this project is to provide comprehensive, patient-centered primary care to patients who live in a medically underserved area. It relates to the regional goals by providing patient-centered, coordinated care. It also uses existing infrastructure by partnering with Pleasant Hill Baptist Church to build a clinic within its existing space.

Challenges and how to address:

Clinic leadership will be challenged to develop relationships with other integrated healthcare systems for the provision of specialty and hospital care services and to ensure seamless

integration with secondary and tertiary levels of care. The team will partner with other RHP DSRIP participants who are committed to ensuring access for this patient population. All professional staff must be open to developing and learning a new model of providing primary healthcare. One of the core components of the project is to engage all providers in process improvement so as to ensure their commitment to implementing successful care models.

5-Year Expected Outcome for Provider and Patients:
The goal is to increase access to primary care with achievement of NCQA recognition of the clinic as a PCMH. Expected outcomes also include improved immunization rates, cervical screening rates, HbA1c control and weight management, overall providing the best opportunity for the health and well-being of this community.

Starting Point/Baseline:
This is a new clinic; baseline data are not available and will be determined during the first year of the clinic opening.

Rationale:
This project will enhance healthcare value by increasing primary healthcare access to an underserved population of the community and decreasing their use of emergency rooms, as well as hospitalization for downstream complications that can be prevented with timely primary care (ambulatory sensitive conditions). Healthcare value will be enhanced by training learners from multiple healthcare professions in a high-performing, model Patient Centered Medical Home where high quality primary care is provided by an inter-professional team, resulting in more cost-efficient and higher quality care, i.e. higher value care. This contributes to the RHP goals by increasing access to patient-centered primary care.

Project Components:
The Inter-Professional Primary Care Clinic is proposed under option 2.1.1. The following project requirements will be completed over DY 2-5:

a) Utilize a gap analysis to assess the clinic's NCQA PCMH readiness. The gap analysis will be conducted in DY3 and DY4 in preparation for the NCQA application in DY4-5.
b) Conduct feasibility studies to determine necessary steps to achieve PCMH status. Feasibility studies will be completed in conjunction with the gap analyses.
c) Conduct educational sessions for practitioners, clinic staff and leadership about the PCMH model. Educational sessions will be conducted as new providers are hired and as the clinic prepares to apply for NCQA accreditation. Education will continue as a component of the quality improvement sessions in DY3-5.
d) Conduct quality improvement activities. This will be included as the teams develop and implement evidence-based clinical practice guidelines for the patient population served. Once the guidelines are implemented, they will be reviewed and updated annually based on lessons learned. (I-X.1, I-X.2)

Milestones & (Metrics):

- Process Milestones and Metrics: P-4 (P-4.1); P-5 (P-5.1); P-X (P-X.1)
- Improvement Milestones and Metrics: I-17 (I-17.2); I-19 (I-19.2); I-X (I-X.1, I-X.2, I-X.3)

Workforce development is one of the project cornerstones. Designing a curriculum for the inter-professional team is proposed as a DY2 milestone under option P-X. One proposed metric is to enter into agreements with local health professional schools to ensure trainees of all types have an opportunity to learn and participate in a PCMH environment. Subsequent metrics include expanding the number of health professions involved in the inter-professional training. The goal is to ensure many types of healthcare providers are trained in the PCMH model and have an opportunity to participate in care delivery improvement. The inter-professional team will develop evidence-based clinical practice guidelines and monitor patient outcomes monthly to drive process improvement and ensure high quality care. The specific guideline will be determined once the clinic has enrolled patients in order to ensure the guidelines represent the salient health issues of the patient population. Decision support tools (e.g. smart forms) will be embedded within the electronic health record (EHR). The monthly reports will measure adherence to the (process of care) guidelines as well as disease-specific outcomes of care. Success of these implemented guidelines will be measured further in the Category 3 outcomes, such as HbA1c control.

Unique community need identification number the project addresses:

- CN1 – Access to primary care
- CN4 – Coordinated care for chronic conditions
- CN6 – Improved immunization compliance

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

This clinic will transform delivery by training many types of healthcare providers in the PCMH model. All providers will be engaged in process improvement initiatives to ensure the delivery of continuous integrated care. The beneficiaries are patients who live in a medically underserved area, where access to care is limited at best, so this clinic will help fill that gap.

Related Category 3 Outcome Measures:

OD-1 Primary Care and Chronic Disease Management

- IT-1.10 – Diabetes care: HbA1c poor control (>9.0%)
- IT-1.20 – Weight management
- IT-12.2 – Cervical cancer screening (HEDIS 2012)

Reasons/rationale for selecting the outcome measure(s):

The Fifth Ward has been identified as a medically underserved area[197] and is predominantly comprised of residents who identify themselves as Black, Hispanic or Latino[198]. The Category 3 outcome measures selected below each address health care issues that affect minority and poor populations disproportionately. These specific measures will reflect the Fifth Ward Clinic's success in providing access to and improving utilization of preventive services.

Improvements in HbA1c control can improve patient quality of life and cost of care by reducing the lifetime incidence of blindness, end-stage renal disease (ESRD) and coronary artery

[197] U.S. Department of Health and Human Services, Health Resources and Services Administration. Find Shortage Areas: MUA/P by State and County. http://muafind.hrsa.gov/index.aspx. Accessed October 1, 2012

[198] United States Census 2010. 2010 Census Interactive Population Search. http://2010.census.gov/2010census/popmap/. Accessed October 1, 2012. Census Tracts 2111, 2113.

disease in patients with type 2 diabetes[199]. Black and Hispanic patients have higher rates of diabetes and higher mortality rates due to diabetes[200] than white patients. African Americans are more likely to develop ESRD. The Health of Houston Survey 2010 indicated that the Near Northside-Fifth Ward area of the city has the highest rate of diabetes in the city – 20 percent.

Weight management is a proposed outcome measure under option IT-1.20. According to the Health of Houston Survey in 2010, 32% of Houston area adults were obese, compared to 29% across the State of Texas[201] with a high prevalence among non-Hispanic blacks (51% higher) and Hispanics (21% higher)[202]. In the Near Northside-Fifth Ward area, 37 percent of residents are obese – again the highest rate in the city. Obese patients face a higher risk of developing diabetes[203], but weight loss can significantly reduce that risk[204]. Helping patients achieve healthier weights can reduce mortality and morbidity and their attendant costs associated with diabetes.

Improvements in cervical cancer screening can reduce the incidence of cervical cancer by as much as 93%, while also decreasing associated mortality and lowering treatment costs[205]. Black and Hispanic women have much higher rates of incidence and mortality when compared to the general population[206]. Additionally, this will reflect the success of providing access to preventive services at the clinic.

Relationship to Other Projects:

Like the Baylor Teen Health Clinic (project 082006001.1.1), the Fifth Ward Clinic will provide primary care services in a medically underserved area. However, the clinic is situated in a different geographic area and targets the entire family rather than a specific age cohort.

Relationship to Other Performing Providers in the RHP:

Primary Care/Ambulatory Care clinics are a top priority to Region 3 due to the acuity of the regional patient mix, population concentration, and lack of primary care access points for our patient base. The regional approach of collaboration as well as existing patient referral pattern relationships allowed our team to properly identify the community needs based on the necessity of population, uninsured, and medically underserved patient bases. This program is consistent with our region and similar to numerous initiatives in our RHP plan sharing both concepts as

[199] Huang ES, Zhang Q, Brown SES, Drum ML, Meltzer DO, Chin MH. The Cost-Effectiveness of Improving Diabetes Care in the U.S. Federally Qualified Community Health Centers. *Health Services Research*, 2007; 42(6 Pt 1): 2174-2193.

[200] Agency for Healthcare Research and Quality, Diabetes Disparities Among Racial and Ethnic Minorities.

[201] Institute for Health Policy, *Health of Houston Survey 2010: A First Look*, University of Texas School of Public Health. https://sph.uth.edu/research/centers/ihp/health-of-houston-survey-2010/. Accessed October 3, 2012.

[202] Centers for Disease Control and Prevention, Differences in Prevalence of Obesity among Black, White and Hispanic Adults – United States, 2006-2008. http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5827a2.htm. Accessed October 3, 2012.

[203] Mokdad AH, Ford ES, Bowman BA, Dietz WH, Vinicor F, Bales VS, Marks JS. Prevalence of Obesity, Diabetes and Obesit-Related Health Risk Factors, 2001. *Journal of the American Medical Association,* 2003; 289(1): 76-79.

[204] National Prevention Council, *National prevention Strategy,* Washington, DC: U.S. Department of Health and Human Services, Office of the Surgeon General, 2011.

[205] U.S. Preventive Services Task Force. Screening for Cervical Cancer: Recommendations and Rationale. *Agency for Healthcare Research and Quality,* 2003, Pub No 03-515A.

[206] Centers for Disease Control and Prevention, Cervical Cancer Rates by Race and Ethnicity, 1999-2008. http://www.cdc.gov/cancer/cervical/statistics/race.htm. Accessed October 2, 2012.

well as outcome measures focused to percent improvement over baseline of patient satisfaction scores, reduction of inappropriate ED utilization, and third next available appointment status. The Region 3 Initiative Grid attached as a RHP Plan addendum reflects a grid of relationship for all initiatives.

Plan for Learning Collaborative:

We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system.

Project Valuation:

The value of this project was determined by an econometrics assessment of access to primary care, immunizations and cervical screening, as well as the care and risks associated with obesity and diabetes. The value assigned to primary care is based on cost avoidance of emergency room visits. The difference between the cost of an emergency room visit and the cost of a primary care visit for primary-care-treatable conditions per visit was calculated for the age groups in question[207].

Historical data were reviewed to determine the percentage of preventive and acute care visits. Rather than assume that all acute care visits could result in an emergency room visit, the project value conservatively estimates that a fraction of acute care visits results in an avoided emergency room visit. Improvements in HbA1c control were valued based on the current rate of adult diabetes in Houston[18] and the annual differential medical cost savings of controlled and uncontrolled diabetes[208]. The total value was calculated based on the expected improvement in the clinic patient population. The value of weight reduction was calculated based on the percentage of the population that is obese[18] and not currently diagnosed with diabetes[20]. Of those patients, it is expected that a 5-7% reduction in weight will reduce the risk of diabetes by 58%[21]. The annual savings[21] was applied to the number of diabetes cases avoided due to weight management for the duration of the Waiver.

Immunization rate value was based on the recommended doses administered to children by age 2[209], the cost of each dose[210], and the cost savings per dollar spent on immunizations[211]. This value was multiplied by the number of patients expected to be affected (the number of children as a percentage of the total patient population). For vaccines that require additional doses beyond age 2, the total savings were prorated for the remaining duration of the Wavier.

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[207] School of Public Health, *Houston Hospitals Emergency Department Use Study: January 1, 2010 through December 31, 2010,* Houston, Texas: University of Texas Health Science Center at Houston, 2012.

[208] Dall TM, Roary M, Yang W, Zhang S, Zhang Y, Arday DR, Gantt CJ, Chen YJ. Health Care Use and Costs for Participants in a Diabetes Disease Management Program, United States, 2007-2008. *Preventing Chronic Disease*, 2011; 8(3): A53.

[209] CDC, Recommended Immunization Schedules for Persons Aged 0 through 19 Years, United States, 2012.

[210] CDC Vaccine Price List, http://www.cdc.gov/vaccines/programs/vfc/awardees/vaccine-management/price-list/index.html. Accessed October 3, 2012.

[211] Every Child by Two, Economic Value of Vaccines, 2003. http://www.ecbt.org/advocates/economicvaluevaccines.cfm. Accessed October 3, 2012.

The value of cervical screening was based on the differential costs of treating localized lesions and cancers and treating regional and distant cancers[212]. The initial, interim and pro rata final stage costs are calculated based on the current incidence of cancer rates in Texas[213] and the reduction of invasive rates when screening occurs every two years[23]. The total value for the project was combined and distributed across measures to ensure category 3 outcome measurements comprised 5%, 10%, 15% and 20% of the project value in DY2-5. Distribution among the components was based on the weighted value of the measure.

[212] Texas Cancer Registry, The Cost of Cancer in Texas 2007, Texas Department of State Health Services, 2009. Publication No 10-13121.
[213] CDC, National Breast and Cervical Cancer Early Detection Program. http://www.cdc.gov/cancer/nbccedp/data/summaries/texas.htm. Accessed October 4, 2012.

082006001.2.1	***2.1.1***	***2.1.1.A-D***	***THE FIFTH WARD MODEL – INTER-PROFESSIONAL PRIMARY CARE***
Baylor College of Medicine			082006001
Related Category 3 Outcome Measure(s):	*IT-1.10* *IT-1.20* *IT-12.2*	*082006001.3.3* *082006001.3.4* *082006001.3.5*	*Improved HbA1c Control* *Improved Weight Control* *Improved Cervical Cancer Screening*
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-4]: Develop primary care staffing plan Metric 1 [P-4.1]: Expand primary care team member roles Goal: Expand primary care team member roles Data Source: Job descriptions Milestone 1 Estimated Incentive Payment: $ 411,000 **Milestone 2** [P-5]: Determine appropriate panel size for provider teams. Metric 1 [P-5.1]: Determine panel size Goal: Document panel size by provider type and team Data Source: Documentation from needs assessment Milestone 2 Estimated Incentive Payment: $ 411,000 **Milestone 3** [P-X]: Design curriculum and teaching methodology for inter-professional primary healthcare team training Metric 1 [P-X.1]: Enter into collaborative agreements with health	**Milestone 4** [I-19]: Expand medical home principles. Metric 1 [I-19.2]: Increase number of patient-centered visits. Goal: 75% capacity utilization per provider based on panel size. Data Source: EHR Milestone 4 Estimated Incentive Payment: $ 500,000 **Milestone 5** [I-17]: Population health management Metric 1 [P-17.2]: Establish baseline percentage of patients receiving recommended immunizations by age 2. Data Source: EHR Milestone 5 Estimated Incentive Payment: $ 140,000 **Milestone 6** [I-X]: Implement evidence-based guidelines and process improvement initiatives. Metric 1 [I-X.1]: Implement evidence-based clinical guidelines. Goal: Implement 3 evidence-based guidelines. Data Source: HER	**Milestone 7** [I-19]: Expand medical home principles. Metric 1 [I-19.2]: Number of patient-centered visits compared to DY 3. Goal: 30% increase in total number of patients seen compared to DY3. Data Source: EHR / practice management system Milestone 7 Estimated Incentive Payment: $ 500,000 **Milestone 8** [I-17]: Population health management Metric 1 [I-17.2]: Increase percentage of pediatric patients receiving recommended immunizations by age 2. Goal: increase by 5% compared to baseline (DY 3). Data Source: EHR Milestone 8 Estimated Incentive Payment: $ 150,000 **Milestone 9** [I-X]: Implement evidence-based guidelines and process improvement initiatives. Metric 1 [I-X.1]: Implement evidence-based clinical guidelines.	**Milestone 10** [I-19]: Expand medical home principles. Metric 1 [I-19.2]: Number of patient-centered visits compared to DY 4. Goal: 25% increase in total number of patients seen compared to DY4. Data Source: EHR / practice management system Milestone 10 Estimated Incentive Payment: $ 400,000 **Milestone 11** [I-18] Obtain NCQA medical home recognition Metric1 [I-18.1]: Medical home recognition. Goal: Medical home recognition for Fifth Ward Clinic. Data Source: Documentation of NCQA accreditation Milestone 11 Estimated Incentive Payment: $ 400,000 **Milestone 12** [I-17]: Population health management Metric 1 [I-17.2]: Increase percentage of pediatric patients receiving recommended immunizations by age 2.

082006001.2.1	*2.1.1*	*2.1.1.A-D*	*THE FIFTH WARD MODEL – INTER-PROFESSIONAL PRIMARY CARE*
Baylor College of Medicine			082006001
Related Category 3 Outcome Measure(s):	*IT-1.10* *IT-1.20* *IT-12.2*	*082006001.3.3* *082006001.3.4* *082006001.3.5*	*Improved HbA1c Control* *Improved Weight Control* *Improved Cervical Cancer Screening*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
professional schools Goal: Collaborative agreements with health professional schools executed Data Source: Documentation of collaborative agreements Milestone 3 Estimated Incentive Payment: $ 411,000	Metric 2 [I-X.2]: Report process and outcomes measures monthly. Goal: Implement reports. Data Source: EHR Milestone 6 Estimated Incentive Payment: $ 634,300	Goal: Implement 2 additional evidence-based guidelines. Data Source: HER Metric 2 [I-X.2]: Document process improvements. Goal: Document improvements for 3 existing guidelines. Data Source: Process improvement documentation. Milestone 9 Estimated Incentive Payment: $ 653,000	Goal: increase by 10% compared to baseline (DY 3). Data Source: EHR Milestone 12 Estimated Incentive Payment: $ 160,000 **Milestone 13** [I-X]: Implement evidence-based guidelines and process improvement initiatives. Metric 1 [I-X.2]: Document process improvements Goal: Document improvements for all 5 guidelines. Data Source: Process improvement documentation. Milestone 13 Estimated Incentive Payment: $ 361,000
Year 2 Estimated Milestone Bundle Amount: $ 1,233,000	Year 3 Estimated Milestone Bundle Amount: $ 1,274,300	Year 4 Estimated Milestone Bundle Amount: $1,303,000	Year 5 Estimated Milestone Bundle Amount: $1,321,000
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over DYs 2-5)***:** $ 5,131,000			

City of Houston Department of Health and Human Services

Pass 1

Project Option - 2.6.3 Engage community health workers in an evidence-based program to increase health literacy of a targeted population.

Unique Project ID: 0937740-08.2.1

Performing Provider Name/TPI: City of Houston Department of Health and Human Services/0937740-08

Project Summary: Provider: The performing provider, Houston Department of Health and Human Services (HDHHS) is the public health authority for Houston, Texas with a population of 2.1 million in 2010. HDHHS has 1,100 employees and a budget of $100,245,403. HDHHS serves the City of Houston through 44 distinct programs. HDHHS provides core public health services to all Houston residents such as air and water quality monitoring and restaurant inspections; birth and death certificates; leadership in emergencies such as hurricanes; operates a comprehensive regional reference laboratory, provides communicable disease prevention and control services and disease surveillance and a variety of health and human services such as the Women, Infants and Children (WIC) nutrition program, senior nutrition services, family planning, oral health services and immunizations via a network of 4 health centers, 14 WIC sites and the Harris County Area Agency on Aging.

Intervention(s): This new project proposes to utilize community health workers to provide 24 sessions of essential education and assessment related to fall prevention and safety to 500 low income older adults. Based on other home visitation programs, the population is expected to be 90% Black or Hispanic. The program will also provide intervention to reduce hazards in the home to 100 of the 500 low income older adults initially recruited into the program.

Need for the Project: The risk for a fall increases exponentially with advancing age. Older adults often seek care at the ER for falls related injuries that are preventable. Preventing falls requires a multifactorial approach with assessment and management. This program will provide education, evaluation/assessment and fall-related hazard mitigation at home and follow up by identifying hazards that impair safety and health in the home as part of an evidence-based fall prevention intervention.

Target Population: The project will target older adults aged 60 and referrals and recruitment to this program will be generated by home visitation programs of the performing provider or its partners such as Harris County Area Aging Agency (HCAAA), Houston Department of Health &Human Services (HDHHS)Tuberculosis (TB) Control and other department programs (Communicable Diseases, etc.).

Category 1 or 2 expected patient benefits: Increase access to health promotion programs and activities using innovative program by 5% by DY4 and by 10% by DY5 over baseline numbers.

Category 3 outcomes: **IT-9.4:** (ED appropriate utilization) Reduce by 5% each the number of ED visits among program participants and number of 911 calls made for falls in older adults 60 years and over from specific zip codes over baseline in DY4 and by 10% over baseline in DY5.

Project Option - 2.6.3 Engage community health workers in an evidence-based program to increase health literacy of a targeted population: Healthy Homes Fall Prevention Initiative
Unique Project ID:0937740-08.2.1
Performing Provider Name/TPI: City of Houston Department of Health and Human Services / 0937740-08
Project Description:
The Healthy Homes Fall Prevention (HHFP) project proposes to utilize community health workers to provide essential education related to fall prevention and safety as critical components to the health and well-being of older adults (60+ years) in the community and prevent unnecessary ER usage for preventable falls in the home.
This initiative will follow a three-pronged approach: education, evaluation/assessment and follow up. This initiative will engage community health workers in an evidence-based program to increase health literacy of a targeted population. One innovative aspect of the initiative is follow-up home visiting for referrals generated by programs that already visit homes of older adults in specific high-risk zip codes that have a disproportionately high number of ER visits for falls.. Through partnerships with other Houston Department of Health and Human Services (HDHHS) programs, at-risk older adults will be identified and enrolled in the HHFP Initiative.
Issues addressed by the Safe and Healthy Homes concept are critical to the ability of seniors to age safely in place and to enjoy improved quality of life. Educating older adults on the principles of healthy homes will promote reduction of hazards in the home environment; reduce emergency room visits and reduce costs of rehabilitation. Additionally, education will be provided for home care givers to help reinforce the principles of healthy homes.
Many older adults seek care at the ER several times a year for fall related injuries. Preventing falls requires a multifactorial approach with assessment and management (CDC, 2012). The HHFP program proposes to utilize an evidence based approach of home hazard assessment and education for reducing the risk of falling. The average cost of emergency room visit for adults (aged 50-85 years) due to unintentional falls in the US, is estimated to be $3323 per visit. This is inclusive of Medical Cost and Work Loss Cost. [1]
The project will target 500 older adults aged 60 and over and provide education on the value of a safe and healthy home by identifying hazards that impair safety and health in the home, per year. Program staff will also perform 100 home inspection interventions to evaluate safety in the home, perform needs assessments, conduct periodic follow up inspections, facilitate limited remediation and refer seniors to other support programs to reduce hazards, per year.
1... Centers for Disease Control. Fall Risks in Older Adults. http://www.cdc.gov/features/fallrisks/. Accessed on 11/5/12.
The referrals to HHFP will be generated through currently existing programs such as Harris County Area Aging Agency (HCAAA), the Houston Fire Department(HFD)/Emergency Medical Team (EMT), Houston Department of Health &Human Services (HDHHS)Tuberculosis (TB) Control and other departmental(Communicable Diseases, etc.) home visiting programs.

Goals and Relationship to Regional Goals:
Project Goals:
The primary goal of this program is to prevent fall related accidents that result in Emergency Room (ER) visits
- Educate older adults on principles of Healthy Homes
- Reduce environmental hazards in the home

- Prevent fall related accidents that result in Emergency Room (ER) visits
- Reduce 9-1-1 calls to the Houston Fire Department

This project meets the following regional goal by implementing an education and follow-up model that prevents falls and potential unnecessary emergency room visits for older adults:

- Transform health care delivery from a disease-focused model of episodic care to a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary or duplicative services, and builds on the accomplishments of our existing health care system.[1,2]

Challenges:

Some of the challenges anticipated with implementation of this initiative include difficulty in gaining trust of older adults and convincing them to modify behaviors that lead to poor health outcomes. The project will build upon relationships already established by referring program staff and use evidence based models that will lead to behavior modification.

5-Year Expected Outcome for Provider and Patients:

The performing provider expects a reduction in the number of ER visits and calls to EMT for preventable injuries (e.g., falls)

Starting Point/Baseline:

In 2010, the overall rate of nonfatal fall injury episodes for which a health-care professional was contacted was 43 per 1000 persons. Persons aged > 75 years had the highest rate (115 per 1000 persons). Because this is a new initiative, a new baseline for the population that is the target of this project will be established in Year 3 in order to determine improvements and project effectiveness in subsequent years.

1. Stakeholder input from RHP 3Working Group Members throughout the Region (including providers, consumers, hospital and clinic administrators, government officials, researchers, and advocacy groups)
2. The State of Health – Houston and Harris County, 2012.

Rationale:

The average cost of emergency room visit for adults (aged 50-85 years) due to unintentional falls in the US, is estimated to be $3323 per visit. This is inclusive of Medical Cost and Work Loss Cost. With an estimated 350 high risk individuals enrolled by the HHFP program, assuming that the program could prevent even one ER visit per year/person for unintentional falls in our enrolled population, the cost savings to the ER and the Health care system is $1,163,050 per year. Nationally, falls account for 52.4% of unintentional injuries (HCUP, 2012). In Texas, 46.7% of unintentional injuries were due to falls (Healthcare Cost and Utilization Project, 2012)[1].

Risk for suffering a serious fall related injury increases exponentially with advancing age. Nationally, approximately one third of elderly adults experienced a fall (Hausdorff et al., 2001)[2] each year. Older adults comprise a large number of ER visits due to falls. Even more disconcerting is the fact that there has been a sharp year to year increase in the number of fatal falls in older adults in the past 10 years. Many older adults seek care at the ER several times a year for fall related injuries. Preventing falls requires a multifactorial approach with assessment and management (Centers for Disease Control, 2012)[3]. The HHFP program proposes to utilize one such evidence based approach of home hazard assessment and education for reducing the risk of falling.

In 2010, the overall rate of nonfatal fall injury episodes for which a health-care professional was contacted was 43 per 1,000 population. Persons aged ≥75 years had the highest rate (115 per 1000).[3] . The direct medical costs for fall related injuries nationally is about $20 billion annually and is expected to increase substantially over the next decade as the population ages .

Project Components: There are no required project components for the project option.

The Healthy Homes project will put in place a Quality Improvement process that will continuously evaluate and improve processes for improvement. This is particularly necessary since this is a new program and there will be need to clarify procedures, revise protocols, and additional training of staff. The goal of continuous quality improvement is to establish a cyclical, continuous process of planning, assessing, monitoring, analyzing, measuring and evaluating performance to improve desired outcomes. A Plan-Do-Study-Act cycle with an initial intervention implementation on a small number of target population members and gradually scaling up to greater numbers is an essential component of this methodology. This will enable this program to recognize successes and failures early in program implementation and correct them as necessary.

Unique community need identification numbers the project addresses:

The Healthy Homes Initiative also addresses the issues addressed in the following community needs assessments:

- CN.8 High rates of inappropriate emergency department utilization[1,2]
- CN.23 Lack of patient navigation, patient and family education and information programs.[1,2]

1. Healthcare Cost and Utilization Project (HCUP), 2012. Emergency Department Data Evaluation.Report # 2005-02.US Department of Health and Human Services.Agency for Healthcare Research and Quality.From http://www.hcup.us.ahrq.gov/nedsoverview.jsp.Accessed on 7/29/12.

2. Hausdorff JM, Rios DA, Edelberg, HK. Gait variability and fall risk in community-living older adults: a 1 year prospective study. Arch Phys Med Rehabil; 82: 1050-6.

3. WISQARSTM Web-based Injury Statistics Query and Reporting System).From www.cdc.gov/ncipc/wisqars/, Accessed on 7/29/12.

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

The project is a new innovation which provides services in the home to reduce falls and potential ambulance transports and emergency room visits.

Related Category 3 Outcome Measures:

OD- 9 – Right Care, Right Setting

IT-9.4 Milestone: Other Outcome Improvement Target (ED appropriate utilization – Stand-alone measure)

- Reduce ED visits related to falls in home settings(including ACSC)
- Metric: Number of 911 Calls for falls among adults age 60 and older from specific zip codes during measurement period

- Metric: Number of ED visits for falls among adults age 60 and older from specific zip codes during measurement period

Reasons/rational for the selecting the outcome measures:

We chose the “Other Outcome Improvement Measure” as our outcome because of the prevalence of falls among older adults due to structural conditions in the home that are preventable and remediable. According to the United States Preventive Task Force recommendations, decreasing the incidence of falls would also improve the socialization and functioning of older adults who have previously fallen and fear falling again http://www.uspreventiveservicestaskforce.org/uspstf11/fallsprevention/fallsprevrs.htm. The burden of falls on patients and the health care system is large. Decreasing the incidence of falls would also improve the socialization and functioning of older adults who have previously fallen and fear falling again. Many other interventions could potentially be useful to prevent falls, but because of the heterogeneity in the target patient population, multiplicity of predisposing factors, and additive or synergistic nature, their effectiveness is not known. Despite this, a cost effective solution to avoid falls in older adults and the subsequent inappropriate usage of ER, a comprehensive Fall Prevention intervention in high risk communities is relatively easy to implement.

Relationship to Other Projects and Plan for Learning Collaborative:

We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region’s healthcare system.

Healthcare treatment cannot focus to only the acute or chronic encounter and properly treat the patient. It is critical that our region focuses to patient education and community education to ensure a proactive and responsive approach to healthcare needs. The education models represented in the Region 3 RHP plan can be identified in the Initiative Grid (addendum) and all focus to outcome measures such as appropriate utilization, patient satisfaction scores, and standalone chronic condition scores such as diabetes and asthma.

Project Valuation:

HDHHS utilized two categories to calculate value for each DSRIP project. The first category is Prioritization and the second is Public Health Impact (see attachment for HDHHS Valuation Tool). HDHHS scored the project on a scale of 1 (poor) to 9 (exceptional) for each of the six factors that comprise the Prioritization category. The Prioritization category includes the following factors: 1) Transformational Impact, 2) Population Served / Project Size, 3) Alignment with Community Needs 4)Cost Avoidance 5) Partnership Collaboration, and 6)Sustainability. Each factor was then given a weighted score based on the score rated and a pre-determined percentage weight. The six weighted scores were added to get a composite score for the Prioritization category.
Public Health includes activities which seek to achieve the highest level of health for the greatest number of people. Public Health also focuses on preventing problems from happening or re-occurring through programs and activities that promote and protect the health of the entire community. As a public health department, HDHHS added an additional valuation category of Public Health Impact that looked at projects through a public health lens. The Public Health Impact category includes the following factors: 1) Alleviate Health Disparity, 2) Control

Communicable and Chronic Disease , 3) Prevention Orientation, 4) Population Health Focus, 5) Access and Connection to Health Services and 6) Evidence Based Health Program. HDHHS scored the project on a scale of 1 (poor) to 9 (exceptional) for each of the six factors that comprise the Public Health Impact category. Each factor was then given a weighted score based on the score rated and a pre-determined percentage weight. The six weighted scores were added to get a composite score for the Public Health Impact category.

HDHHS gave the Prioritization score a weight of 25% and the Public Health Impact score a weight of 75% to determine the overall project value for the plan. The Healthy Homes Fall Prevention project received a composite Prioritization score of 5.4 and a Public Health Impact score of 6.

0937740-08.2.1	2.6.3	N/A	Project Title: Healthy Homes Fall Prevention Initiative
Performing Provider Name: City of Houston Department of Health and Human Services			HDHHS -0937740-08
Related Category 3 Outcome Measures:	0937740-08,-03,-07.3.4	IT-9.4	Other Outcome Improvement Target
Year 2 **(10/1/2012 – 9/30/2013)**	Year 3 **(10/1/2013 – 9/30/2014)**	Year 4 **(10/1/2014 – 9/30/2015)**	Year 5 **(10/1/2015 – 9/30/2016)**
Milestone 1 [P –X]:Complete a planning process for the implementation of a program to educate the elderly in fall prevention, engage partners, identify current capacity and resources needed, and develop a timeline Metric 1 [P-X.1]: Development of a report documenting implementation plans, partnerships and necessary resources, and implementation timeline Goal: Completion of planning process and report Data Source: Completed report that includes information identified above Milestone 1 Estimated Incentive Payment: $593,798.23 **Milestone 2** [P-1]: Conduct a needs assessment to identify the Conduct an assessment of health promotion programs that involve community health workers at local and regional levels. Metric 1[P-1.1]: Provide report documenting target population	**Milestone 4** [P-4]: Execution of a learning and diffusion strategy for testing, spread and sustainability of best practices and lessons learned. Metric 1[P-4.1]: Document learning and diffusion strategic plan Goal: Develop dissemination tools for evidence based Fall prevention program in target population Data Source: Documentation of implementation of Learning and Diffusion materials developed by program Milestone 4Estimated Incentive Payment: $987,173.10 **Milestone 5** [P-5]: Execution of evaluation process for project innovation. Metric 1[P-5.1]: Document evaluative process, tools and analytics. Goal: Initiate evaluation of programs and connections/referrals to care for target population Data Source: Program documentation	**Milestone 6** [P-X]: Establish baseline of target Metric 1[P-X.1]:Collect data to establish target population baseline Goal: Establish Baseline Data Source: Documentation of target population, as designated in the project plan. Milestone 6 Estimated Incentive Payment: $1,050,890.02 **Milestone 7** [I-6]: Identify number of patients in defined population receiving innovative intervention consistent with evidence-based model. Metric 1[I-6.1]: Proportion of unique patients receiving evidence based intervention Goal: Increase by 5% Number of unique target population served over Yr.3 (baseline) in Fall Prevention Program Numerator: Total number unique of patients in defined population who received innovative Fall Prevention intervention	**Milestone 8** [I-8]: Increase access to health promotion programs and activities using innovative project option. Metric 1 [I-8.1]: Increase percentage of target population reached. Goal: Increase by 10% over baseline Data Source: Documentation of target population reached, as designated in the project plan. Milestone 8 Estimated Incentive Payment: $1,015,593.96 **Milestone 9** [I-6]: Identify number of patients in defined population receiving innovative intervention consistent with evidence-based model. Metric 1 [I-6.1]: Proportion of unique patients receiving evidence based intervention Goal : Increase by 10% over baseline the Proportion of unique target population served over Yr. 3 in Fall Prevention Program Numerator: Total number of

0937740-08.2.1	*2.6.3*	*N/A*	*Project Title: Healthy Homes Fall Prevention Initiative*
Performing Provider Name: City of Houston Department of Health and Human Services			*HDHHS -0937740-08*
Related Category 3 Outcome Measures:	*0937740-08,-03,-07.3.4*	*IT-9.4*	Other Outcome Improvement Target
Year 2 **(10/1/2012 – 9/30/2013)**	Year 3 **(10/1/2013 – 9/30/2014)**	Year 4 **(10/1/2014 – 9/30/2015)**	Year 5 **(10/1/2015 – 9/30/2016)**
characteristics, gaps in services, ideal number of patients targeted per year, priority high volume zip codes to target for fall prevention program. Goal: Determine the need and scope of fall prevention program Data Source: Program documentation, needs assessment survey Milestone 2 Estimated Incentive Payment: $593,798.23 **Milestone 3** [P-X2]: Select evidence-based Healthy Homes – Fall Prevention initiative for older adults using best practice guidelines Metric 1[P-X2.1]: Document selection of evidence based innovational Fall prevention strategy and plan. Goal: Select appropriate Fall Prevention intervention for target population Data Source: Program Documentation Milestone 3 Estimated Incentive Payment: $593,798.23	Milestone 5 Estimated Incentive Payment: $987,173.10	Denominator: Total number of patients in defined population referred to Fall Prevention Program. Data Source: Program Documentation Milestone 7 Estimated Incentive Payment: $1,050,890.02	unique patients in defined population who received innovative Fall Prevention intervention Denominator: Total number of patients in defined population referred to Fall Prevention Program. Data Source: Program Documentation Milestone 9 Estimated Incentive Payment: $1,015,593.96

0937740-08.2.1	***2.6.3***	***N/A***	***Project Title: Healthy Homes Fall Prevention Initiative***		
Performing Provider Name: City of Houston Department of Health and Human Services					*HDHHS -0937740-08*
Related Category 3 Outcome Measures:	*0937740-08,-03,-07.3.4*		*IT-9.4*	Other Outcome Improvement Target	
Year 2 **(10/1/2012 – 9/30/2013)**	Year 3 **(10/1/2013 – 9/30/2014)**		Year 4 **(10/1/2014 – 9/30/2015)**		Year 5 **(10/1/2015 – 9/30/2016)**
Year 2 Estimated Milestone Bundle Amount: $1,781,395	Year 3 Estimated Milestone Bundle Amount: $1,974,346		Year 4 Estimated Milestone Bundle Amount: $2,101,780		Year 5 Estimated Milestone Bundle Amount: $2,031,188
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over DYs 2-5):* $7,888,709					

Project Option 2.9.1 - Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care

Unique Project ID: 0937740-08.2.2

Performing Provider Name/TPI: Houston Department of Health &Human Services/0937740-08

Project Summary: Provider: The performing provider, Houston Department of Health and Human Services (HDHHS) is the public health authority for Houston, Texas with a population of 2.1 million in 2010. HDHHS has 1,100 employees and a budget of $100,245,403. HDHHS serves the City of Houston through 44 distinct programs. HDHHS provides core public health services to all Houston residents such as air and water quality monitoring and restaurant inspections; birth and death certificates; leadership in emergencies such as hurricanes; operates a comprehensive regional reference laboratory, provides communicable disease prevention and control services and disease surveillance and a variety of health and human services such as the Women, Infants and Children (WIC) nutrition program, senior nutrition services, family planning, oral health services and immunizations via a network of 4 health centers, 14 WIC sites and the Harris County Area Agency on Aging.

Intervention(s): Care Houston Links is a new program that will provide care coordination to reduce the frequency of non-urgent ambulance runs and ER visits and link 911 callers to appropriate primary and preventive care in lieu of unnecessary emergency room care. The new program builds upon the lessons learned from a predecessor program, Care Houston, that provided follow-up for frequent 911 callers. Care Houston Links will provide follow-up, education, navigation and case management to all clients with non-emergent conditions who are referred from ETHAN, the new EMS telehealth program. The project will provide new services to assure that patients referred from ETHAN are linked with a medical home.

Need for the Project: There are over 100,000 non-emergency transports made by Houston Fire Department (HFD) with certain zip codes having a high percentage of 911 calls. Data from HFD shows that 80% of the transports were non-emergency related.

Target Population: All individuals that utilize Emergency Room (ER) for non-emergent, primary care needs and are transported by ambulance to the ER, will benefit from this project. 60% of the Care Houston program clients were Medicaid clients and 15% uninsured; 60% were African Americans, 30%-Hispanic and 8% white .

Category 1 or 2 expected patient benefits: Our DY 4 goal is to improve by 5% in DY4 and 10% over baseline numbers in DY5 the number of PCP referrals for patients without a medical home who use the ED, urgent care, and/or hospital services, and enrolled in the program.

Category 3 outcomes:

IT-9.4: Other Improvement Target (ED Appropriate utilization for those needing non-emergent care and transported by ambulance and enrolled in this program). Our goal is to reduce by 5% below baseline the proportion of non-emergent ED visits (arrived by ambulance transportation) in DY4 and 7% below baseline in DY5 among those enrolled in the program.

Project Option 2.9.1 - Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care: Identify frequent ED users and use navigators as part of a preventable ED reduction program. Train health care navigators in cultural competency.
Unique Project ID:0937740-08.2.2
Performing Provider Name/TPI: City of Houston Department of Health and Human Services/0937740-08

Project Description:
CareHouston Links proposes to provide care coordination that will reduce the frequency of non-urgent ambulance runs and ER visits and link 911 callers to appropriate primary and preventive care in lieu of unnecessary emergency room care.

CareHouston Links is an expansion of the CareHouston program that was launched as a partnership between the Houston Department of Health Human Services (HDHHS) and the Houston Fire Department (HFD) Emergency Medical Services in 2006. CareHouston Links will expand the existing program throughout the City of Houston and integrate its services with the HFD Emergency TeleHealth and Navigation (ETHAN) Program. CareHouston Links will provide case management support to ensure clients who were referred by the ETHAN program receive appropriate follow up care and are linked to a medical home. The CareHouston Links navigators will follow up with the patient to determine if the patient followed the advice provided by the ETHAN physician. The counselor/case manager will work with the client/family and their health care provider to ensure continued compliance. In situations where the client failed to follow the advice provided, the counselor will determine and record what actually occurred and the reasons why the advice was not carried out. The counselor will assess these issues and develop a care plan to address them and ensure clients are linked to the appropriate care. Additionally, the CareHouston Links program would continue the education and referral services that were provided to frequent 911 callers through the CareHouston program.

CareHouston Links is designed to address the challenges that are faced by the City of Houston in providing emergency health services to the residents of the City of Houston. According to a report from 2008, from University of Texas School of Public Health, visits to the ER were rising due to primary care cost rising. In 2008, 10.8% of all primary care related ED visits arrived by ambulance transport and 20.9% of all other ED visits arrived by ambulance.Current data shows that there are over 100,000 non-emergency transports made by HFD. HFD has also documented certain zip-codes that have a high percentage of 911 calls. The CareHouston Links project addresses these challenges by expanding a program that has proven to reduce repeat calls to 911 and thereby reducing the use of expensive emergency services through the use of face to face follow-up, education and navigation services. The new program will build upon these past successes and not only reduce 911 calls and ambulance runs but also link callers with primary care resources as an alternative to use of expensive emergency services The zip codes that generate a large volume of 911 calls that are non-emergent will be a primary target for this program. These zip codes will be identified by the Houston Fire Department and Emergency Medical Services data system for the previous year. The pilot was conducted in 77051 and 77033 which comprise the Sunnyside neighborhood in Houston .The methods were validated for two pilot zip codes.

Goals and Relationship to Regional Goals:
The goal of this project is to utilize community health workers, case managers, or other types of health care professionals as patient navigators to provide enhanced social support and culturally competent care to vulnerable and/or high-risk patients. These patient navigators will help and support these patients to navigate through the continuum of health care services. Patient Navigators will ensure that CareHouston Links patients receive coordinated, timely, and site-appropriate health care services and will assist in connecting patients to primary care physicians and/or medical home sites, as well as diverting non-urgent care from the Emergency Department to site-appropriate locations.
Project Goals:

1. Expand CareHouston program to other targeted low income, underserved high risk communities and partner with the ETHAN (Telehealth) Program.
2. Enhance service to the community by reducing inappropriate emergency room visits
3. Increase the number of clients appropriately linked to a medical home
4. Increase the number of clients consistently using their medical home
5. Reduce the need for hospitalizations and improve the quality of life of clients.

This project meets the following regional goals:

- Increase access to primary and specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their condition, regardless of where they live or their ability to pay.
- Transform health care delivery from a disease-focused model of episodic care to a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary or duplicative services, and builds on the accomplishments of our existing health care system

Challenges:
The performing provider anticipates challenges in educating patients and families to use the program, working with Houston Fire Department and other EMS/Ambulance Services to meet alternative transportation needs of clients and overcoming barriers (such as appointment wait times) to link patients to a medical home. Additionally, the provider anticipates system capacity challenges that may be encountered by clients in follow-up on referrals for other needed services. The provider will seek to form ongoing working partnership with others providers of health care and social services to develop workable solutions to anticipated barriers.

5 Year Expected Outcome for Provider and Patient:
The CareHouston Links Program expects to reduce the number of ER visits and 911 calls to EMS for non-emergencies in high volume zip codes and thereby reduce costs to the health care system. The program also expects that patients will be linked to medical homes and be appropriately educated and supported to access services in the right setting.

Starting Point/ Baseline:
The number of referrals to CareHouston program in YR 2 will be used as an initial baseline for the program.

Rationale:

The CareHouston Links project will utilize health care workers, case managers/workers or other types of health professionals needed to engage with patients in a culturally and linguistically appropriate manner which is essential to guiding patients through integrated health care delivery systems. Patient navigators help patients and their families navigate the fragmented maze of doctors' offices, clinics, hospitals, out-patient centers, payment systems, support organizations and other components of the healthcare system. Referrals are made to social services, home health care services, FQHCs and other medical homes, as indicated. Additional follow-up in the CareHouston Links program would include home visits and patient education that would ensure that the clients are linked to appropriate services. Other assistance would include referrals to private ambulance services and Harris County rides to avoid inappropriate use of EMS and provide care coordination. Linking, assessing and referring clients to appropriate services will reduce their need to use 9-1-1 services. This program will facilitate communication among patients, family members, survivors and healthcare providers; coordinate care among providers; arrange financial support and assisting with paperwork; arrange transportation and child care; ensure that appropriate medical records are available at medical appointments; facilitate follow-up appointments and conduct community outreach and build partnership with local agencies and groups.

Cost savings from this program include savings related to reduction in ED use and redirecting and connecting patients to medical homes and services for chronic care management and reduction in EMS transports. The target group for this project are residents who access emergency services for circumstances that would be more appropriately addressed through alternative systems of care. Annually, the HFD makes over 100,000 transports for non-emergency reasons. The results from the currently ongoing CareHouston program are a robust indicator that patient navigation services are a viable solution to the challenge of assuring that residents access primary and preventive services in lieu of emergency services where appropriate. The challenge that led to the development of the CareHouston program was the observation by HFD EMS personnel that they were making frequent ambulance runs to the same addresses and seeing no long term solution to the client's health issues. The medical director of Houston's EMS services, who also serves as the Public Health Authority, was familiar efforts by the HDHHS to assess and meet health and social service with targeted outreach initiatives in the community. To document the challenge and the effectiveness of the intervention, HFD reviewed data from April 1, 2006-June 30, 2006 for the targeted pilot area, the Sunnyside community and found that 18 patients accounted for 113 EMS responses via 9-1-1 during this period. These patients were referred to the HDHHS and were contacted in the first part of July. These same patients were reevaluated for 911 service requests at the end of September. Following contact by HDHHS personnel, the 18 addresses/patients (including several who declined participation in the program), accounted for only 33 responses, a decrease of 70.80%. Eight of the 18 study patients, approximately 40% of the identified patients, had no requests for 911 services. Through the CareHouston program, frequent 911 callers identified by HFD are referred to HDHHS for follow-up by HDHHS navigators and case managers. Clients are assessed to determine underlying problems such as lack of education regarding health condition or transportation needs. HDHHS staff educates residents and families about their health and medical condition, the proper use of the EMS system, alternate transportation services and any other unmet needs. Referrals are made to social services, home health care services and medical homes, as indicated. The program is staffed by counselors, navigators and public health nurses who reach out to the individuals referred through phone, mail, home visits or the HFD/EMS Services.

Project Components:

CareHoustonLinks program will address all of the following project components defined for the project option 2.9.1 to establish/expand a patient care navigation program.

a) Identify frequent ED users and use navigators as part of a preventable ED reduction program. Train health care navigators in cultural competency. The program will provide appropriate training and education to patient navigators so that they are equipped to address the needs of multiple racial/ethnic and socio-economically diverse populace of Houston.

b) Deploy innovative health care personnel, such as community health workers and other types of health professionals as patient navigators. The program will have a strong community base component so that there is greater buy in from the target communities.

c) Connect patients to primary and preventive care. The patient navigators will be skilled in connecting patients to primary care and will follow up to ensure that patients are making the primary care visits.

d) Increase access to care management and/or chronic care management ,including education in chronic disease self-management. Since many of the patients that will be enrolled in the program are expected to have multiple chronic conditions, navigators will connect them to disease self-management programs that currently exist in the community.

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

The performing provider will utilize trained health care navigators to identify ED users, increase access to care management and education programs, reduce ED use and non-emergency ambulance runs and connect patients to primary and preventive care. HDHHS will build upon the experience and success of the CareHouston program to implement the CareHouston Links program. Additionally, HDHHS will conduct quality improvement activities for the project as described in the RHP planning protocol.

The performing provider will also institute a Plan-Do-Study-Act cycle in place. This will address Quality Improvement (QI) on a consistent basis. The study protocol, processes and staff training will be tested as a pilot in DY3. The goal of continuous quality improvement is to establish a cyclical, continuous process of planning, assessing, monitoring, analyzing, measuring and evaluating performance to improve desired outcomes. Thorough documentation of processes will ensure followup for quality improvement. This will give the program an opportunity to make modifications and improvements as needed by the time the outcomes (Improvement Targets) are beginning to be tracked in DY4-5. The QI process will happen on a continual basis.

Unique community need identification numbers the project addresses:

- CN-8 High rates of inappropriate emergency department utilization
- CN-20 Lack of access to programs providing health promotion education, training and support, including screenings, nutrition counseling, patient education programs
- CN-23 Lack of patient navigation, patient and family education and information programs.

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

The existing CareHouston program has been reprogrammed as CareHouston Links. The program will be expanded to include the following: 1) addition of patient care teams to expand the number of patients that can be seen in the program 2) an increase in referrals to the program to include not only frequent 911 callers but also callers that were determined through the telehealth program to need an alternative form of care other than emergency room care 3) a more robust follow-up program to not only make referrals to medical homes but also provide actual navigation support and follow-up to connect clients to medical homes and to assure usage 4) an increase in the number of 911 callers referred to the program by changing the criteria for inclusion in the program.

Related Category 3 Outcome Measures:

OD- 9 Right Care, Right Setting

IT-9.4Other Outcome Improvement Target (ED appropriate utilization due to enrollment in CareHouston Links Program)

- Rate of Non Emergent 911 callers referred to CareHouston Links

Reasons/rationale for selecting the outcome measures:

We chose the above outcome measure because it will allow us to track the tangible benefits of implementation of CareHouston Links. Since the CareHouston program's implementation in 2006, the HFD EMS unit has experienced a 72% decrease in 911 calls from specific geographic areas allowing them to redirect more than $4.6 million to other services.

By expanding to other targeted low income, underserved high risk communities, with a large volume of 911 calls, the program could expand HDHHS's capacity to connect and link clients to needed services in a timely manner and further reduce costs associated with non-emergency EMS transports and inappropriate ER visits .Linking, assessing and referring clients to appropriate services will reduce their need to use 911 services. Each time an ambulance service is dispatched to transport patients; the cost is approximately $1470. During Fiscal Year 2012, the Care Houston program diverted 1,458 clients from using EMS transports to emergency departments for non-emergencies, diverting costs of $2,143,260.

Relationship to Other Projects and Plan for Learning Collaborative:

We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system.

The ability to properly identify and monitor specific patients with chronic conditions or frequent emergency department utilization trends will allow the region to accurately mange the very large patient base. Patient navigation includes a comprehensive list of tasks as well as unique provider types based on the focus of the initiative and will help the focus of cost containment, emergency department utilization, and chronic disease management. The Region 3 Initiative Grid in the addendum allows for a cross reference of all initiatives proposed within this concept.

Project valuation:

HDHHS utilized two categories to calculate value for each DSRIP project. The first category is Prioritization and the second is Public Health Impact (see attachment for HDHHS Valuation Tool). HDHHS scored the project on a scale of 1 (poor) to 9 (exceptional) for each of the six factors that comprise the Prioritization category. The Prioritization category includes the following factors: 1) Transformational Impact, 2) Population Served/Project Size, 3) Alignment with Community Needs 4)Cost Avoidance,5) Partnership Collaboration, and 6)Sustainability. Each factor was then given a weighted score and a pre-determined percentage weight. The six weighted scores were added to get a composite score for the Prioritization category.

Public Health includes activities which seek to achieve the highest level of health for the greatest number of people. Public Health also focuses on preventing problems from happening or re-occurring through programs and activities that promote and protect the health of the entire community. As a public health department, HDHHS added an additional valuation category of Public Health Impact that looked at projects through a public health lens. The Public Health Impact category includes the following factors: 1) Alleviate Health Disparity, 2) Control Communicable and Chronic Disease , 3) Prevention Orientation, 4) Population Health Focus, 5) Access and Connection to Health Services, and 6) Evidence Based Health Program. HDHHS scored the project on a scale of 1 (poor) to 9 (exceptional) for each of the six factors that comprise the Public Health Impact category. Each factor was then given a weighted score based on the score rated and a pre-determined percentage weight. The six weighted scores were added to get a composite score for the Public Health Impact category.
HDHHS gave the Prioritization score a weight of 25% and the Public Health Impact score a weight of 75% to determine the overall project value for the plan. The CareHouston Links Program received a composite Prioritization score of 7.15 and a Public Health Impact score of 7.

0937740-08.2.2	*2.9.1*	*2.9.3(a-c)*	*PROJECT TITLE: CareHouston Links*
Performing Provider Name: City of Houston Health and Human Services			*TPI - 0937740-08*
Related Category 3 Outcome Measure(s):	0937740-08.3.5	*IT – 9.4*	*Other Outcome Improvement Target (ED appropriate utilization)*
Year 2 **(10/1/2012 – 9/30/2013)**	Year 3 **(10/1/2013 – 9/30/2014)**	Year 4 **(10/1/2014 – 9/30/2015)**	Year 5 **(10/1/2015 – 9/30/2016)**
Milestone 1 [P – X1]: Plan scope, range, current capacity and needed resources for CareHouston Links Metric 1: Provide report detailing Program Planning Materials, Meeting minutes, Sign-in sheets, Draft Clinical Protocols, Staff Qualifications, Staffing Plan Goal: Produce a comprehensive report documenting all points above Metric 2: Provide report providing final protocols, List of Partners/Stakeholders, Final Implementation Plan Goal: Produce a comprehensive report documenting all points above Data Source for Milestone 1: Program Documentation Milestone 1 Estimated Incentive Payment: $732,540.13 **Milestone 2 [P –X 2]:** Establish Baseline data for the number of non-emergent calls and visits that are the target of this program for a 12 month	**Milestone 4[P-3]:** Provide care management/navigation services to targeted patients. Metric 1 [P-3.1]: Increase in the number or percent of targeted patients enrolled in the program Baseline: Establish baseline number of patients enrolled in program Data Source: Enrollment reports Numerator: Number of targeted patients enrolled in the program Denominator: Total number of targeted patients identified Milestone 4 Estimated Incentive Payment: $1,217,827.67 **Milestone 5 [P-X]:** Establish baselinenumber of PCP referrals for patients without a medical home who use the ED, urgent care, and/or hospital services. Metric 1 [P-X.1]: Collect data to establish baseline number of PCP referrals for patients without a medical home who use the ED, urgent	**Milestone 6 [I-6]:** Increase number of PCP referrals for patients without a medical home who use the ED, urgent care, and/or hospital services. Metric 1 [I-6.1]: Increase medical home empanelment of patients referred from navigator program. Goal: Increase by 5% over baseline the number of patients that were given PCP referrals Data Source: Performing Provider administrative data on patient encounters and scheduling records from CareHouston Links patient navigator program. Numerator: Number of new patients referred for services from Patient Navigator Program (CareHouston Links) that are seen in primary care setting and empanelled to the medical home. Denominator: Number of new patients referred for services from Patient Navigator Program (CareHouston Links) from repeat 911 callers.	**Milestone 7 [I-6]:** Increase number of PCP referrals for patients without a medical home who use the ED, urgent care, and/or hospital services. Metric 1 [I-6.1]: Increase medical home empanelment of patients referred from navigator program. Goal: Increase by 10% over baselinethe number of patients that were given PCP referrals Data Source: Performing Provider administrative data on patient encounters and scheduling records from CareHouston Links patient navigator program. Numerator: Number of new patients referred for services from Patient Navigator Program (CareHouston Links) that are seen in primary care setting and empanelled to the medical home. Denominator: Number of new patients referred for services from Patient Navigator Program

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0937740-08.2.2	***2.9.1***	***2.9.3(a-c)***	***PROJECT TITLE: CareHouston Links***
Performing Provider Name: City of Houston Health and Human Services			*TPI - 0937740-08*
Related Category 3 Outcome Measure(s):	0937740-08.3.5	*IT – 9.4*	*Other Outcome Improvement Target (ED appropriate utilization)*
Year 2 **(10/1/2012 – 9/30/2013)**	Year 3 **(10/1/2013 – 9/30/2014)**	Year 4 **(10/1/2014 – 9/30/2015)**	Year 5 **(10/1/2015 – 9/30/2016)**
period. Metric 1: Number of non-emergent 911 calls by zip code Metric 2: Number of non-emergent ED visits by zip code Baseline: the total number of Year 2 calls and visits (12 months) by zip code Milestone 2 Estimated Incentive Payment: $732,540.13 **Milestone 3 [P-2.1]:** Expand a health care navigation program to provide support to patient populations who are most at risk of receiving disconnected and fragmented care including program to train the navigators, develop procedures and establish continuing navigator education. Metric 1 [P-2.1]: Number of people trained as patient navigators. Workforce development plan for patient navigator recruitment, training and education Goal: Complete workforce development plan	care, and/or hospital services. Baseline: Establish percentage of patients that were given PCP referrals Data Source: Performing Provider administrative data on patient encounters and scheduling records from CareHouston Links patient navigator program. Milestone 5 Estimated Incentive Payment: $1,217,827.67	Milestone 6 Estimated Incentive Payment: $2,595,864.29	(CareHouston Links) from repeat 911 callers. Milestone 7 Estimated Incentive Payment: $2,505,778.22

0937740-08.2.2	***2.9.1***	***2.9.3(a-c)***	***PROJECT TITLE: CareHouston Links***
Performing Provider Name: City of Houston Health and Human Services			*TPI - 0937740-08*
Related Category 3 Outcome Measure(s):	0937740-08.3.5	*IT – 9.4*	*Other Outcome Improvement Target (ED appropriate utilization)*
Year 2 **(10/1/2012 – 9/30/2013)**	Year 3 **(10/1/2013 – 9/30/2014)**	Year 4 **(10/1/2014 – 9/30/2015)**	Year 5 **(10/1/2015 – 9/30/2016)**
Data Source: Documentation of workforce development plan Milestone 3 Estimated Incentive Payment: $732,540.13			
Year 2 Estimated Milestone Bundle Amount: $2,197,620	Year 3 Estimated Milestone Bundle Amount: $2,435,655	Year 4 Estimated Milestone Bundle Amount: $2,592,864	Year 5 Estimated Milestone Bundle Amount: $2,505,778
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundles amounts over DYs 2-5)****:*** $9,731,918			

Project Option - Project Option 2.9.1- Establish/Expand a Patient Care Navigation Program
Unique Project ID: 0937740-08.2.3
Performing Provider Name/TPI: Houston Department of Health and Human Services/0937740-08
Project Summary: Provider: The performing provider, Houston Department of Health and Human Services (HDHHS) is the public health authority for Houston, Texas with a population of 2.1 million in 2010. HDHHS has 1,100 employees and a budget of $100,245,403. HDHHS serves the City of Houston through 44 distinct programs. HDHHS provides core public health services to all Houston residents such as air and water quality monitoring and restaurant inspections; birth and death certificates; leadership in emergencies such as hurricanes; operates a comprehensive regional reference laboratory, provides communicable disease prevention and control services and disease surveillance and a variety of health and human services such as the Women, Infants and Children (WIC) nutrition program, senior nutrition services, family planning, oral health services and immunizations via a network of 4 health centers, 14 WIC sites and the Harris County Area Agency on Aging.
Intervention(s): This expansion project will use patient navigators to connect 300 new at risk HIV diagnosed individuals to appropriate care. Linkage to care will consist of active referrals to primary medical care, mental health, substance abuse, support services, and services for basic needs such as food and housing. Utilizing a Community-Based (Non-Medical) Case Management model, this program will also identify frequent ED utilizers and use navigators as part of a preventable ED reduction program. This project will support HIV patients through the continuum of health care.

Need for the Project: Newly diagnosed HIV patients are frequently at risk for receiving fragmented care because of being disconnected from the health care system. . The race/ethnicity of patients in HIV linkage program last year were 68% African American, 29% Hispanic and 3% White. The current service linkage program is funded through Ryan White. The Houston Area rate for enrolling newly diagnosed individuals into care falls below the average for Texas as a whole (68.6 percent) as well as the national target (85.0 percent). HIV related hospitalizations account for a significant portion of health care costs every year. Many of these visits occur when patients are not receiving continuous care to manage their infections. This expansion enhances HDHHS' ability to increase the number patients who are linked to clinical care, increase the number of patients receiving continuous clinical care and thereby reduce the number of HIV related hospitalizations which will result in significant cost savings.

Target Population: Newly diagnosed HIV patients are the target group for this project. Particular targets are high risk groups such as males, African Americans and injection drug users who are known to have lower service linkage rates than the average for the Houston region.

Category 1 or 2 expected patient benefits: Increase number of PCP referrals for patients without a medical home who use the ED, urgent care, and/or hospital services by 5% over baseline in DY4 and by 10% over baseline in DY5.

Category 3 outcomes: **IT-9.4:** (ED appropriate utilization) Reduce by 5% each the number of ED visits among program participants and number of 911 calls made for falls in older adults 60 years and over from specific zip codes over baseline in DY4 and by 10% over baseline in DY5.

Project Option 2.9.1- Establish/Expand a Patient Care Navigation Program: HIV Service Linkage Expansion Program

Unique Project ID: 0937740-08.2.3
Performing Provider Name/TOI: City of Houston Department of Health and Human Services / 0937740-08

Project Description:

This Program will expand service linkage to provide navigation services to targeted patients with HIV who are at high risk of disconnect from institutionalized health care.

This project will use patient navigators to connect at risk HIV diagnosed individuals to appropriate care. Linkage to care will consist of active referrals to primary medical care, mental health, substance abuse, support services, and services for basic needs such as food and housing. Utilizing a Community-Based (Non-Medical) Case Management model, this program will also Identify frequent ED utilizers and use navigators as part of a preventable ED reduction program.

The Houston Area has placed a high priority on ensuring early linkage into HIV clinical care and treatment for those newly diagnosed through widespread HIV testing and awareness efforts. For example, a unique local service category within the Ryan White HIV/AIDS Program for linking the newly diagnosed into HIV clinical care (e.g., Service Linkage Workers) was created in 2008. Current estimates of those linked to care in the Houston Area are as follows:

1. Of newly diagnosed HIV infected individuals diagnosed in the Houston Area, 65.1 percent linked to HIV clinical care within the national standard of three months following diagnosis. The Houston area rate falls below the average for the state of Texas as a whole (68.6 percent) as well as the national target (85.0 percent).
2. Certain demographic groups in the Houston Area have lower than community-wide aggregate linkage to care rates. Known at risk groups such as males, blacks/African Americans, and Injection drug users (IDU) all have linkage to care rates below the Houston area average. Those in the age category of 13 to 24 years also have a lower than average linkage to care rate.

The Houston Area has adapted the Case Management (Non-Medical) service category for the purpose of linking the newly-diagnosed into primary HIV medical care. Defined locally as Community-Based (Non-Medical) Case Management, services provided under this adapted category are called Service Linkage. Service Linkage Workers (SLW) or patient navigators are often co-located at HIV testing sites.

The Houston area places a high priority on widespread access to HIV testing in both targeted and routine settings, using all available technologies. The Expanded Testing Initiative (ETI) supports routine opt-out HIV screening at local emergency rooms; and community-based organizations provide targeted counseling and testing to those at high risk. Of all publicly-funded HIV tests offered in the Houston Area in 2010, 1.2 percent were positive, which translates into almost 600 HIV+ individuals who became aware of their status in that year alone.The Ryan White HIV/AIDS Program Part A contracts with the HDHHS to place service linkage workers at HDHHS locations where individuals are newly-diagnosed, including routine HIV testing sites at

local emergency rooms and medical institutions and public STD clinics, for the purpose of linking these individuals to HIV care, treatment, and support services. The Service Linkage Worker Outcome Measure requires each newly-diagnosed client to be linked to a Ryan White HIV/AIDS Program-funded primary medical care or case management provider within 120 days of contact.

This Performing provider currently serves 300 HIV patients that are at or below 300% of Poverty Level. This program will expand the current linkage program to serve 300 additional new HIV patients who do not meet eligibility requirements for Ryan White funding (i.e. at or below 300% of poverty and non- Medicaid eligible) or who cannot be served by Ryan White funding because service capacity has been exceeded.

The Houston Department of Health and Human Services (HDHHS) is funded by the Ryan White HIV/AIDS Program to employ Service Linkage Workers (SLW) who connect newly-diagnosed individuals to Ryan White HIV/AIDS Program-funded primary HIV medical care. SLWs at the HDHHS are also cross-trained in disease investigation and can provide partner services for the newly-diagnosed. SLWs also provide referrals to non-HIV related services such as those for co-morbid conditions, behavioral health concerns, and social support services including housing, food, employment, transportation, and child care.

The performing provider will also institute a Plan-Do-Study-Act cycle in place for this expansion program. This will address Quality Improvement (QI) on a consistent basis. The goal of continuous quality improvement is to establish a cyclical, continuous process of planning, assessing, monitoring, analyzing, measuring and evaluating performance to improve desired outcomes. The study protocol, processes and staff training will be tested as a pilot in DY3. Thorough documentation of processes will ensure followup for quality improvement. This will give the program an opportunity to make modifications and improvements as needed by the time the outcomes (Improvement Targets) are beginning to be tracked in DY4-5. The QI process will happen on a continual basis.

Goals and Relationship to Regional Goals

The goal of this project is to utilize patient navigators (called Service linkage workers) to provide targeted, non-medical community-based case management, including active referrals to primary medical care, mental health, substance abuse, support services, and services for basic needs such as food and housing for newly diagnosed HIV patients in a geographic area with low rates of linkage to care for the target population.

Project Goals:

The overall goal of the project is to help and support HIV patients through the continuum of health care services so that patients can receive coordinated, timely services when needed with smooth transitions between health care settings. The project will expand access to the existing care management program for individuals who are HIV positive.

This project meets the following regional goals:

- Increase access to primary and specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their condition, regardless of where they live or their ability to pay.

- Transform health care delivery from a disease-focused model of episodic care to a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary or duplicative services, and builds on the accomplishments of our existing health care system,

Challenges

The program anticipates some challenges in implementation of the program. Some of these challenges are successful hiring and training of new staff for the program, maintaining ongoing collaboration with primary care providers and ensuring clients have access to immediate medical care when necessary to avoid hospitalization and developing a system that will ensure ongoing retention into care after the required time allotted to Service Linkage workers has expired. These challenges will be met by ongoing training and workforce development efforts. Additionally a strong follow up component will be added to the project so that referrals are followed up and receive appropriate care.

5- Year Expected Outcome for Provider and Patients:

Goals from the Joint Comprehensive Plan:

1. Target linkage to care efforts to vulnerable points in the HIV system (e.g., at initial diagnosis, before the first medical visit, after the initial visit, etc.) where individuals are more likely to not seek care or to fall out of care, particularly *newly-diagnosed Persons living with HIV or AIDS (*PLWHA).
2. Intensify retention and engagement activities with *currently in-care* PLWHA, focusing on community education, system enhancements, and health literacy
3. Adopt strategies to re-engage *out-of-care* PLWHA and other "prior positives" to return to care

Starting Point/Baseline:

Baseline data on navigation program after implementation will be collected in Year 2 of the project.

Rationale:

HIV related hospitalizations account for a significant portion of national health care costs every year. Many of these visits occur when patients are not receiving continuous care to manage their infections. By increasing the number of newly diagnosed HIV positive patients who are linked to clinical care within three months, and increasing the number of patients who receive continuous clinical care, the number of HIV related hospitalizations can be greatly reduced, resulting in significant cost savings.

Project Components: This project will address all the components of a navigation program. Required core project components:

a) Identify frequent ED users and use navigators as part of a preventable ED reduction program. Train health care navigators in cultural competency. – We plan to work with hospital ED and Expanded Testing Initiative(community based testing) to assist newly diagnosed HIV patients navigate through the health care system. Our navigators (service linkage workers) will be trained in cultural competency to reflect the diverse population in Houston.

b) Deploy innovative health care personnel, such as case managers/workers, community health workers and other types of health professionals as patient navigators. – Our navigators will use a non-medical case management model to address the needs to the patients.

c) Connecting patients to primary and preventive care - Our navigators will ensure that the patients are connected to primary and preventive care so that they are better equipped to manage their conditions with a specified time period after their diagnosis and entry into the Service Linkage Program..

d) Increase access to care management and/or chronic care management, including education in chronic disease self-management – Our navigators will also provide information and instruction on chronic disease care and self management.

e) Conduct quality improvement for project using methods such as rapid cycle improvement. Activities may include, but are not limited to, identifying project impacts, identifying "lessons learned," opportunities to scale all or part of the project to a broader patient population, and identifying key challenges associated with expansion of the project, including special considerations for safety-net populations - Our navigation program will conduct continuous quality improvements and share lessons learned.

Unique community need identification numbers the project addresses

The HIV Service Linkage Expansion Program also addresses the issues addressed in the following community needs assessments:

- CN.11 High rates of chronic disease and inadequate access to treatment programs and services for illnesses associated with chronic disease, including AIDS/HIV1,2
- CN.23 Lack of patient navigation, patient and family education and information programs.1,2

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

This project is an expansion of an existing HIV Service Linkage program which is funded by federal dollars. The project will add additional service linkage workers to serve more HIV positive individuals who are at risk from being disconnected from the health care system.

Related Category 3 Outcome Measures:

OD- 9 Right Care, Right Setting
IT-9.4 Other Outcome Improvement (ED Appropriate Use)
Numerator: Number of HIV patients that are in Service Linkage Program that were admitted to a hospital in the past 6 months.
Denominator: Total number of HIV patients enrolled in Service Linkage Program during the same time period.
Data Source: Service Linkage Database, Patient electronic records
Reasons/rationale for selecting the outcome measures:
We chose "Other Outcome Improvement" under Outcome Domain 9 (Right Care Right Setting) due to the high ED utilization for newly diagnosed HIV patients who may suffer from multiple comorbidities. Providing navigation services to HIV patients who are at high risk of disconnect from institutionalized health care is critical to reduce ED and inpatient use for potentially

preventable admissions in HIV patients. The Houston Area has placed a high priority on ensuring early linkage into HIV clinical care and treatment for those newly diagnosed through widespread HIV testing and awareness efforts.

Relationship to Other Projects and Plan for Learning Collaborative:

We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system.

The ability to properly identify and monitor specific patients with chronic conditions or frequent emergency department utilization trends will allow the region to accurately mange the very large patient base. Patient navigation includes a comprehensive list of tasks as well as unique provider types based on the focus of the initiative and will help the focus of cost containment, emergency department utilization, and chronic disease management. The Region 3 Initiative Grid in the addendum allows for a cross reference of all initiatives proposed within this concept.

Project Valuation:

HDHHS utilized two categories to calculate value for each DSRIP project. The first category is Prioritization and the second is Public Health Impact (see attachment for HDHHS Valuation Tool). HDHHS scored the project on a scale of 1 (poor) to 9 (exceptional) for each of the six factors that comprise the Prioritization category. The Prioritization category includes the following factors: 1) Transformational Impact, 2) Population Served / Project Size, 3) Alignment with Community Needs, 4)Cost Avoidance 5) Partnership Collaboration, and 6)Sustainability. Each factor was then given a weighted score based on the score rated and a pre-determined percentage weight. The six weighted scores were added to get a composite score for the Prioritization category.

Public Health includes activities which seek to achieve the highest level of health for the greatest number of people. Public Health also focuses on preventing problems from happening or re-occurring through programs and activities that promote and protect the health of the entire community. As a public health department, HDHHS added an additional valuation category of Public Health Impact that looked at projects through a public health lens. The Public Health Impact category includes the following factors: 1) Alleviate Health Disparity, 2) Control Communicable and Chronic Disease , 3) Prevention Orientation, 4) Population Health Focus, 5) Access and Connection to Health Services and 6) Evidence Based Health Program. HDHHS scored the project on a scale of 1 (poor) to 9 (exceptional) for each of the six factors that comprise the Public Health Impact category. Each factor was then given a weighted score based on the score rated and a pre-determined percentage weight. The six weighted scores were added to get a composite score for the Public Health Impact category.

HDHHS gave the Prioritization score a weight of 25% and the Public Health Impact score a weight of 75% to determine the overall project value for the plan. The HIV Service Linkage Expansion received a composite Prioritization score of 6.5 and a Public Health Impact score of 6.

0937740-08.2.3	**2.9.1**	***2.9.1 (a-e)***	***Project Title: HIV Service Linkage Expansion Program***
Performing Provider Name: City of Houston Department of Health and Human Services			*HDHHS -**0937740-08***
Related Category 3 Outcome Measures: *0937740-08.3.6*	*IT-9.4 Milestone: ED appropriate utilization (Stand-alone 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 – X1]: Plan scope, range, current capacity and needed resources for the Service Linkage Expansion Program. Metric 1: Service Linkage Program Planning Materials, Meeting minutes, Sign-in sheets, Staff Qualifications, Staffing Plan Goal: Provide report documenting all process measures listed above Data Source: Program Documentation Milestone 1 Estimated Incentive Payment: $687,237.74 **Milestone 2 [P – 2]:** Establish a health care navigation program to provide support to HIV populations who are most at risk of receiving disconnected and fragmented care including program to train the navigators, develop procedures and establish continuing navigator education. Metric 1[P-2.1]: Establish optimum number of people that should be trained as patient navigators, number of navigation procedures, or number	**Milestone 4 [P-3.]** Provide care management/navigation services to targeted patients. Metric 1[P-3.1]: Increase in the number or percent of targeted patients enrolled in the program Goal: Implement program as per plan Data Source: Enrollment reports Milestone 4 Estimated Incentive Payment: $761,675.80 **Milestone 5 [P-5]**: Provide reports on the types of navigation services provided to patients using the ED as high users or for episodic care. Metric 1[P-5.1]: Collect and report on all the types of patient navigator services provided. Goal: Report on types of navigation services provided for different sub-populations in the target population to understand service usage. Data Source: Program documentation Milestone 5 Estimated Incentive Payment: $761,675.80	**Milestone 7 [I-6]:** Increase number of PCP referrals for patients without a medical home who use the ED, urgent care, and/or hospital services. Metric 1[I-6.4]: Percent of patients without a primary care provider who are given a scheduled primary care provider appointment Goal: Increase PCP referrals by 5% over baseline Data Source: Performing Provider administrative data on patient encounters and scheduling records from patient navigator program Milestone 7 Estimated Incentive Payment: $2,432,514.11	**Milestone 8 [I-6]**: Increase number of PCP referrals for patients without a medical home who use the ED, urgent care, and/or hospital services. Metric 1[I-6.4]: Percent of patients without a primary care provider who are given a scheduled primary care provider appointment Goal: Increase PCP referrals by 10% over Baseline Data Source: Performing Provider administrative data on patient encounters and scheduling records from patient navigator program. Milestone 7 Estimated Incentive Payment: $2,350,813.70

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0937740-08.2.3	**2.9.1**	*2.9.1 (a-e)*	***Project Title: HIV Service Linkage Expansion Program***
Performing Provider Name: City of Houston Department of Health and Human Services			*HDHHS -**0937740-08***

Related Category 3 Outcome Measures:	*0937740-08.3.6*	*IT-9.4 Milestone: ED appropriate utilization (Stand-alone 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)**
of continuing education sessions for patient navigators. a. Workforce development plan for patient navigator recruitment, training and education Goal: Provide report documenting workforce development for patient navigators (service linkage workers) Data Source: program Documentation Milestone 2 Estimated Incentive Payment: $687,237.74 **Milestone 3 [P-X2**]: Develop and test data base created for HIV Service Linkage navigation program Metric 1[P-X2.1]: Determine and provide documentation of type of system and IT resources needed. Metric 2[P-X2.2]: Select, install and test navigation data system Goal: Database that has capacity for efficient reporting of project outcomes and processes Data Source: Program documentation	**Milestone 6 [P-X3] :**Establish baseline for number of PCP referrals for patients without a medical home who use the ED, urgent care, and/or hospital services. Metric 1 [P-X.3]: Collect data to determine number patients without a primary care provider who are given a scheduled primary care provider referral Goal: Establish baseline for connecting program enrollees to primary care Data Source: Performing Provider administrative data on patient encounters and scheduling records from patient navigator program. Milestone 6 Estimated Incentive Payment: $761,675.80		

DRAFT

0937740-08.2.3	**2.9.1**	***2.9.1 (a-e)***	***Project Title: HIV Service Linkage Expansion Program***
Performing Provider Name: City of Houston Department of Health and Human Services			*HDHHS -**0937740-08***
Related Category 3 Outcome Measures:	*0937740-08.3.6*	*IT-9.4 Milestone: ED appropriate utilization (Stand-alone measure)*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 3 Estimated Incentive Payment: $687,237.74			
Year 2 Estimated Milestone Bundle Amount: $2,061,713	Year 3Estimated Milestone Bundle Amount: $2,285,027	Year 4 Estimated Milestone Bundle Amount: $2,432,514	Year 5 Estimated Milestone Bundle Amount: $2,350,814
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundles amounts over DYs 2-5)**:*** $9,130,068			

Project Option - 2.7.1 Implement innovative evidence-based strategies to increase appropriate use of technology and testing for targeted populations (TB patients or suspected TB patients)

Unique Project ID: 0937740-08.2.4

Performing Provider Name/TPI: City of Houston Department of Health and Human Services/0937740-08

Project Summary: Provider: The performing provider, Houston Department of Health and Human Services (HDHHS) is the public health authority for Houston, Texas with a population of 2.1 million in 2010. HDHHS has 1,100 employees and a budget of $100,245,403. HDHHS serves the City of Houston through 44 distinct programs. HDHHS provides core public health services to all Houston residents such as air and water quality monitoring and restaurant inspections; birth and death certificates; leadership in emergencies such as hurricanes; operates a comprehensive regional reference laboratory, provides communicable disease prevention and control services and disease surveillance and a variety of health and human services such as the Women, Infants and Children (WIC) nutrition program, senior nutrition services, family planning, oral health services and immunizations via a network of 4 health centers, 14 WIC sites and the Harris County Area Agency on Aging.

Last year, a similar project with a smaller scope, utilizing just two testing modalities served 396 TB patients, of which 119 were completely uninsured. 103 of these were African Americans and 191 were White Hispanic. This project intends to serve 1316 individuals per year to improve TB outcomes.

Intervention(s): The performing provider will implement interventions to rapidly identify and treat TB to reduce TB morbidity and to shorten recovery time for TB patients, by utilizing two testing modalities (the Nucleic Amplification Test and the QuantiFERON test) and a combination INH and RPT Therapy course to meet the program goals.

Need for the Project: This project provides a community level, comprehensive evidence based care to patients that have active or latent TB, and their contacts and suspects. Currently hospitals experience a delay in properly diagnosing TB patients due to the testing methodologies currently used. The project will rapidly and accurately identify cases and provide a short term therapy that cuts down on number of days of hospital stay. According to HCUP, in 2006 TB-related hospital stays accounted for $752 million in hospital costs, and Medicaid covered 24.4 percent of all TB stays.

Target Population: The target population will be at risk vulnerable populations such as the homeless, chronically ill low income population, refugee and new immigrant population, the indigent and those without access to care or without a medical home who are routinely reported to the performing provider for active or latent TB.

Category 1 or 2 expected patient benefits: Increase the number or percent of patients in defined population receiving innovative intervention consistent with evidence-based model by 5% over baseline in DY4 and by 10% over baseline in DY5.

Category 3 outcomes: IT-4.10 Other Outcome Improvement Target: Average length of stay for patients diagnosed with TB. Decrease average length of stay by 2% in DY4 and by 5% over baseline in DY5.

Project Option - 2.7.1 Implement innovative evidence-based strategies to increase appropriate use of technology and testing for targeted populations: Tuberculosis Rapid Identification, Treatment and Recovery Project

Unique Project ID: 0937740-08.2.4
Performing Provider Name/TPI: City of Houston Department of Health and Human Services /0937740-08
Project Description:

The **Tuberculosis Rapid Identification, Treatment and Recovery Project** proposes to utilize three modalities of testing and treatment to reduce Tuberculosis morbidity in Houston. The three modalities are 1) Nucleic Acid Amplification Test for rapid identification of cases 2) QuantiFERON test for greater accuracy in identification of TB and 3) Combination INH and RPT Therapy for reducing the period of treatment to a 12 week directly observed therapy (DOT) instead of the previously used 9 month INH treatment. The project will utilize nurse case managers, community outreach workers, patient navigators and other partners to implement this project in the community. The program enrollees will be recruited from the reported cases due to mandatory reporting and their contacts. Additionally, health care providers and hospitals will be another venue for recruitment.

According to World Health Organization, economically poor and vulnerable populations, cultural/ethnic minorities, migrant populations, gypsies and travelers, homeless people and substance users are all at greater risk of Tuberculosis (TB) infection and disease and are likely to have worse treatment outcomes than the general population. Their complex needs are often overlooked and they experience barriers to access routine health care.Vulnerable populations such as the homeless, chronically ill low income population, those without access to care or without a medical home face the greatest burden of morbidity from Tuberculosis (TB). Among many vulnerable groups TB can be treatable and preventable with timely and accurate diagnosis and treatment. Studies have shown about 5 to 10 percent of those with latent TB infection in the United States will develop TB disease if not treated. People with latent TB infection who have weakened immune systems, including those with HIV/AIDS or diabetes, are more likely to develop TB disease after infection. For those reasons, treatment is important (3). These potential future TB cases could be admitted to hospitals for diagnoses and treatment resulting in significant costs to the healthcare system.

United States law requires that anyone with active TB must be reported to the health department. The Health Department staff is required to work with the patient's healthcare provider and the patient to make sure that a safe and effective treatment regimen is completed. This project will expand the performing provider’s (Houston Health and Human Services) capacity to serve TB patients and contacts, through the *addition* of trained TB outreach and nurse case management specialists. The project will proactively engage patients and providers in TB case management. This Project proposes to utilize patient navigators to rapidly identify active TB cases, infectious cases and more accurately screen contacts for TB infection, and reduce the length of treatment through the introduction of short course therapy.

Utilizing the CDC guidelines and the Texas Department of State Health Services Tuberculosis Branch standing delegation orders, the Performing Provider, Houston TB Bureau, will implement the use of 3HP in the treatment latent tuberculosis patients in order to increase patient compliance and completion of therapy and decrease the number of patient at risk for

progression to active TB disease. The project replaces the existing system (protocol) of testing to diagnose TB disease with a quicker more reliable method

The Houston TB Bureau will adopt cost-effective diagnostic and treatment approaches. Program Nurse case managers will engage in collaboration with medical providers and hospital infection control staff to recommend the use of the nucleic acid amplification test on bacteriology specimens. The nurse case managers will also provide education and consultations and will recommend for bacteriology specimens to be processed at the HDHHS laboratory.

The following sections provide additional details on the testing modalities that will be used:

Nucleic Acid Amplification Test: The use of nucleic acid amplification test (NAAT) will assist in the rapid identification of active TB disease in patients with positive bacteriology acid fast bacilli (AFB) smears within 72 hours, compared to the traditional culture that takes up to six to eight weeks. The result of this test will guide the physician's treatment plan, including the use of medications. The use of NAAT at the program level will ensure more effective contact investigation by curtailing the number of unwarranted contact investigations. Also, the use of NAAT will assist the hospitals in making the decision to move patients from more expensive isolation rooms to possible outpatient treatment. The anticipated patient length of stay at a hospital is 1-14 days; difficult cases with multiple health conditions may require up to 60 days, the average length of time for contagious TB clients to convert, as reported by the Texas Department of Infectious Disease in San Antonio.

Furthermore, outpatient treatment of tuberculosis is more cost effective since the main determinant of cost in treating TB is hospital stay. If a patient is already admitted when the diagnosis of TB is made, it may not be necessary to keep the patient in the hospital while waiting for sputum to convert to negative. Smear/culture positive patients may be discharged from the hospital as long as certain criteria are met... The Houston Health and Human Services (HDHHS)laboratory will be available to perform the NAAT on the specimens collected for rapid identification of possible TB disease.

QuantiFERON test: The use of the QuantiFERON test will provide a more accurate screening for TB infection by decreasing the number of patients with "false positive" results who would need evaluation. The QFT has been found to be more specific and sensitive than the traditional tuberculin skin test (TST). Patients identified through contact investigation (beginning with the foreign born and individuals in congregate settings) will be screened using the QFT. The implementation of QFT-G in the field will reduce the costs associated with clinic visits by individuals who are not truly positive reactor (including costs for doctor visits, chest X-rays and medications). QFT-G requires a single visit to complete the testing process for TB infection. TST requires two or more visits to complete the testing process. The initial targeted population for QFT-G test would be those who live in congregate settings; including homeless shelters and drug rehabilitation centers. As the project progresses, the use of this test can be expanded to include foreign born individuals and household contacts.

Community outreach workers in the field will perform the QuantiFERON test on persons identified as contacts to patients with active tuberculosis or suspected of having tuberculosis. The outreach staff will transport the blood specimens to the HDHHS laboratory. The HDHHS laboratory will provide results to the TB Bureau. The community outreach workers will notify the patients of the results and will coordinate medical follow up as needed.

Nurse Case Managers will communicate with providers the benefits of prescribing a new two-drug short course treatment to patients with latent tuberculosis infection. The nurse case

managers will also provide education and consultations. The short course treatment will be provided by community outreach workers in the field through directly observed therapy (DOT).

Combination INH and RPT: A new two-drug short course regimen treatment for contacts identified as needing treatment for latent TB infection (LTBI) will be used in the field. This new two-drug regimen (3HP, Isoniazid and Rifapentine) is recommended by the Centers for Disease Control and Prevention (CDC). The combination regimen of INH and RPT given as 12 weekly DOT doses is recommended as an equal alternative to 9 months of daily self-supervised INH for treating LTBI in otherwise healthy patients aged ≥12 years who have a predictive factor for greater likelihood of TB developing, which includes recent exposure to contagious TB, conversion from negative to positive on an indirect test for infection (i.e., interferon-γ release assay or tuberculin skin test), and radiographic findings of healed pulmonary TB (see Precautions). HIV-infected patients who are otherwise healthy and are not taking antiretroviral medications also are included in this category (2).

The implementation of this short course regimen (3HP) is to be provided via directly observed therapy (DOT) in the field for a course of 12-16 weeks as opposed to the traditional therapy of 9 months of Isoniazid. The 3HP will be used for treatment of LTBI to foreign born contacts, HIV-infected patients and difficult to manage contacts.

The nurse case managers will engage in collaboration with medical providers and hospital infection control staff to recommend the use of the nucleic acid amplification test on bacteriology specimens and the short course treatment (3HP). The nurse case managers will also provide education and consultations.

Target Zip Codes:

This program is city wide in Houston, Texas.

Goals and Relationship to Regional Goals:

This project seeks to utilize the NAAT, QFT and 3HP and a combination of nurse case managers and community outreach workers to provide comprehensive integrated care for TB patients, in order to reduce the number of days of hospitalization for those with TB and those with latent TB.

Project Goals:

- To accurately and rapidly identify and rule out TB disease.
- To work collaboratively with providers in hospitals and communities to diagnose and manage more patients with TB Through the program the performing provider will:
- Rapidly and accurately identify cases
- Partner with other healthcare providers and navigate patients to appropriate care
- To decrease the number of days a patient will need to stay in isolation room.
- To decrease the number of contacts needing medical evaluation and medications
- To Increase the number of contacts completing treatment for LTBI, thus decreasing the number of future cases.

This project meets the following regional goals:

- Increase access to primary and specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their condition, regardless of where they live or their ability to pay.

Challenges:

The challenges that the performing provider expects are related to information dissemination, buy-in from patients and providers, training staff on new treatment management and testing technique, working with chosen provider who will perform an increased volume of laboratory

testing, training in phlebotomy techniques, and finally effectively promoting the program. Continuous effort will be made to provide required in service and training to program staff so that they are better equipped to handle issues as they arise. The TB Bureau will utilize nurse case managers to promote the use of NAAT and 3HP among providers and hospital settings.

5-Year Expected Outcome for Provider and Patients:
The performing provider expects that the overall health outcomes will improve for those with TB (active, latent and at-risk) who are served by the program in Houston. There is cost savings to the health care system though rapid identification, reduced hospital stays, fewer medical procedures, and fewer false positives.

Starting Point/Baseline:

Baseline data will be collected during Year 2-3 of the program.

Rationale:

The implementation of QFT-G in the field will reduce the costs associated with clinic visits by individuals who are not truly positive reactor (including costs for doctor visits, chest X-rays and medications). QFT-G requires a single visit to complete the testing process for TB infection. TST requires two or more visits to complete the testing process. The initial targeted population for QFT-G test would be those who live in congregate settings; including homeless shelters and drug rehabilitation centers. As the project progresses, the use of this test can be expanded to include foreign born individuals and household contacts.

This new two-drug regimen (3HP, Isoniazid and Rifapentine) is recommended by the Centers for Disease Control and Prevention (CDC). The combination regimen of INH and RPT given as 12 weekly DOT doses is recommended as an equal alternative to 9 months of daily self-supervised INH for treating LTBI in otherwise healthy patients aged ≥12 years

Project Components:

This project option does not have any specified components. However, this project will have built in quality improvement strategies such as lessons learned, participation in continuous quality improvement and utilizing the PDSA process to make quality improvements (QI). The performing provider will refine protocol and processes by making improvements based on the initial batch of enrollment into the program. The goal of continuous quality improvement is to establish a cyclical, continuous process of planning, assessing, monitoring, analyzing, measuring and evaluating performance to improve desired outcomes. The QI activities will continue on an ongoing basis to assure that the intervention is being delivered with high integrity. Some elements of the program are new and some aspects are an expansion on existing program components and QI activities with incremental improvements will be put in place for both components.

Unique community need identification numbers the project addresses:

- CN.6 - Inadequate access to treatment and services designed for special needs populations, including disabled, homeless, children, elderly. 4,5
- CN.20 - Lack of access to programs providing health promotion education, training and support, including screenings, nutrition counseling, and patient education programs. 4,5

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

The project provides comprehensive care to TB patients that have active or latent TB. This project will implement a comprehensive evidence based disease prevention program by rapid testing, accurate diagnosis and reduced treatment time for patients diagnosed with TB. The project staff will be trained to approach patients in a culturally appropriate manner. Additionally, the implementation of the new short form therapy protocol is new to the management of TB disease for the program.

Related Category 3 Outcome Measures:
IT-4.10 Other Outcome Improvement Target – Reduce number of days of hospitalization of TB patients

Reasons/rationale for the selecting the outcome measures:

We selected the above outcome measure because the goal of this program is to reduce hospital stays through a comprehensive diagnosis and treatment strategy. According to HCUP, in 2006 TB-related hospital stays accounted for $752 million in hospital costs, and Medicaid covered 24.4 percent of all TB stays. Hospital stays principally for TB had an average cost of $20,100 and an average length of stay of 15 days—more than twice the cost and three times the length of the average non-maternal, non-neonatal stay (HCUP, 2008). Therefore, our outcome measures of reduced hospital admissions for TB, are appropriate because of the savings to the healthcare system.

Relationship to Other Projects and Plan for Learning Collaborative:

We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system.
The ability to properly identify and monitor specific patients with chronic conditions or frequent emergency department utilization trends will allow the region to accurately mange the very large patient base. Patient navigation includes a comprehensive list of tasks as well as unique provider types based on the focus of the initiative and will help the focus of cost containment, emergency department utilization, and chronic disease management. The Region 3 Initiative Grid in the addendum allows for a cross reference of all initiatives proposed within this concept.

Project Valuation:

HDHHS utilized two categories to calculate value for each DSRIP project. The first category is Prioritization and the second is Public Health Impact (see attachment for HDHHS Valuation Tool). HDHHS scored the project on a scale of 1 (poor) to 9 (exceptional) for each of the six factors that comprise the Prioritization category. The Prioritization category includes the following factors: 1) Transformational Impact, 2) Population Served / Project Size, 3) Alignment with Community Needs 4)Cost Avoidance 5) Partnership Collaboration and 6)Sustainability. Each factor was then given a weighted score based on the score rated and a pre-determined percentage weight. The six weighted scores were added to get a composite score for the Prioritization category.

Public Health includes activities which seek to achieve the highest level of health for the greatest number of people. Public Health also focuses on preventing problems from happening or re-occurring through programs and activities that promote and protect the health of the entire community. As a public health department, HDHHS added an additional valuation category of Public Health Impact that looked at projects through a public health lens. The Public Health

Impact category includes the following factors: 1) Alleviate Health Disparity, 2) Control Communicable and Chronic Disease , 3) Prevention Orientation, 4) Population Health Focus, 5) Access and Connection to Health Services and 6) Evidence Based Health Program. HDHHS scored the project on a scale of 1 (poor) to 9 (exceptional) for each of the six factors that comprise the Public Health Impact category. Each factor was then given a weighted score based on the score rated and a pre-determined percentage weight. The six weighted scores were added to get a composite score for the Public Health Impact category.
HDHHS gave the Prioritization score a weight of 25% and the Public Health Impact score a weight of 75% to determine the overall project value for the plan. The TB Rapid Identification, Treatment and Recovery Project received a composite Prioritization score of 7.15 and a Public Health Impact score of 7.

References:

1. CDC - Morbidity and Mortality Weekly Report. *Updated Guidelines for Using Interferon Gamma Release Assays to Detect Mycobacterium tuberculosis Infection – United States, 2012*. June 25, 2010/Vol.59/No. RR-5: 10
2. CDC - Morbidity and Mortality Weekly Report. *Recommendations for Use of an Isoniazid-Rifapentine Regimen with Direct Observation to Treat Latent Mycobacterium tuberculosis Infection.* December 9, 2011/Vol.60/No. 48: 1650
3. CDC – New, Simpler Way to Treat Latent TB Infection. http://www.cdc.gov/Features/TuberculosisTreatment/
4. Stakeholder input from RHP 3Working Group Members throughout the Region (including providers, consumers, hospital and clinic administrators, government officials, researchers, and advocacy groups)
5. The State of Health – Houston and Harris County, 2012.
6. Mazurek, G.H., Villarino, M.E. Guidelines for using QuantiFERON Test for diagnosing latent Mycobacterium tuberculosis Infection. MMWR, jan 31, 2003, 52(RR02): 15-18.
7. Healthcare Cost and Utilization Project (2008). Tuberculosis stays in US Hospitals, 2006. Statistical Brief #60.

0937740-08.2.4	*2.71*	*2.7.1*	*TB RAPID IDENTIFICATION, TREATMENT AND RECOVERY PROJECT*
Performing Provider Name: Houston Department of Health and Human Services			*HDHHS -0937740-08.2.4*
Related Category3 Outcome Measures:	*0937740-08.3.7*	*IT-4.10*	*Other Outcome Improvement Target*
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Milestone 1 [P – X1]: Plan scope, range, current capacity and needed resources for the TB Program. Metric 1: [P-X1.1] TB Program Planning Materials, Meeting minutes, Sign-in sheets, Staff Qualifications, Staffing Plan Goal: Provide report documenting all process measures listed above Data Source: Program Documentation Milestone 1 Estimated Incentive Payment: $748,692.81 **Milestone 2** [P – 1]: Development of innovative evidence-based project for targeted population. Metric 1 [P-1.1]: Document innovational strategy and plan Goal: Develop project to reduce morbidity in target population. Data Source: Program Documentation Milestone 2 Estimated Incentive Payment: $748,692.81 **Milestone 3** [P-X2]: Develop and test data base created for navigation	**Milestone 4 [P-2]** Implement evidence-based innovational project for targeted population Metric 1 [P-2.1]: Document implementation strategy and testing outcomes. Goal: Implement program as per plan Data Source: Documentation of implementation and Enrollment reports Milestone 4 Estimated Incentive Payment: $829,787.37 **Milestone 5** [P-3]: Execution of learning and diffusion strategy for testing, spread and sustainability. Metric 1 [P-3.1]: Document learning and diffusion plan Goal: Establish strategies for rapid spread of awareness of innovation Data Source: Program documentation of implementation Milestone 5 Estimated Incentive Payment: $829,787.37 **Milestone 6** [I-5]: Identify number or	**Milestone 7** [I-5]: Identify number or percent of patients in defined population receiving innovative intervention consistent with evidence-based model. Metric 1 [I-5.1]: Increase the number of individuals receiving the innovative interventions. Goal: Increase proportion of individuals receiving interventions by 5% over baseline (established in Yr 3) Data Source: Documentation of target population reached, as designated in the project plan. Milestone 7 Estimated Incentive Milestone 7 Estimated Incentive Payment: $883,345.85 **Milestone 8** [P-X2]: Identify number of hospitals utilizing innovative intervention consistent with evidence-based model. Metric 1 [P-X2.1]: Document the number of Hospitals utilizing the innovative interventions.	**Milestone 10** [I-5]: Identify number or percent of patients in defined population receiving innovative intervention consistent with evidence-based model. Metric 1 [I-5.1]: Increase the number of individuals receiving the innovative interventions. Goal: Increase proportion of individuals receiving interventions by 10% over baseline (established in Yr 3) Data Source: Documentation of target population reached, as designated in the project plan. Milestone 10 Estimated Incentive Payment: $1,280,515.61 **Milestone 11** [I-X1]: Identify number of hospitals utilizing innovative intervention consistent with evidence-based model. Metric 1 [I-5.1]: Increase the number of Hospitals utilizing the innovative interventions.

0937740-08.2.4	2.71	2.7.1	TB RAPID IDENTIFICATION, TREATMENT AND RECOVERY PROJECT
Performing Provider Name: Houston Department of Health and Human Services			*HDHHS -0937740-08.2.4*
Related Category3 Outcome Measures:	*0937740-08.3.7*	*IT-4.10*	*Other Outcome Improvement Target*
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
program Metric 1 [P-X2.1]: Determine and provide documentation of type of system and IT resources needed. Metric 2 [P-X2.2]: Select, install and test navigation data system Goal: Database that has capacity for efficient reporting of project outcomes and processes Data Source: Program documentation Milestone 3 Estimated Incentive Payment: $748,692.81	percent of patients in defined population receiving innovative intervention consistent with evidence-based model. Metric 1 [I-5.1]: TBD by Performing Provider based on milestone described above Baseline: Establish Baseline of proportion of individuals receiving innovative intervention. Data Source: Documentation of target population reached, as designated in the project plan. Milestone 6 Estimated Incentive Milestone 6 Estimated Incentive Payment: $829,787.37	Baseline: Establish the baseline number of hospitals utilizing innovative interventions Data Source: Documentation of target population reached, as designated in the project plan Milestone 8 Estimated Incentive Payment: $883,345.85 **Milestone 9** [I-X1]: Increase number of hospitals utilizing innovative intervention consistent with evidence-based model. Metric 1 [I-X1.1]: Increase the number of Hospitals utilizing the innovative interventions. Goal: Increase the number of hospitals utilizing innovative interventions by 3 % over baseline Data Source: Documentation of target population reached, as designated in the project plan Milestone 9 Estimated Incentive Payment: $883,345.85	Goal: Increase the number of hospitals utilizing innovative interventions by 10% over baseline c. Data Source: Documentation of target population reached, as designated in the project plan Milestone 11 Estimated Incentive Payment: $1,280,515.61

DRAFT

0937740-08.2.4	***2.71***	***2.7.1***	***TB RAPID IDENTIFICATION, TREATMENT AND RECOVERY PROJECT***
Performing Provider Name: Houston Department of Health and Human Services			*HDHHS -0937740-08.2.4*
Related Category3 Outcome Measures:	*0937740-08.3.7*	*IT-4.10*	*Other Outcome Improvement Target*
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Year 2 Estimated Outcome Amount: $2,246,078	Year 3 Estimated Outcome Amount $2,489,362	Year 4 Estimated Outcome Amount $2,650,038	Year 5 Estimated Outcome Amount $2,561,031
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundles amounts over DYs 2-5)**:*** $9,946,509			

Project Option 2.2.6 - Expand Chronic Care Management Models "Other" project option

Unique Project ID: 0937740-08.2.5

Performing Provider Name/TPI: City of Houston Department of Health and Human Services/0937740-08

Project Summary:

Provider: The performing provider, Houston Department of Health and Human Services (HDHHS) is the public health authority for Houston, Texas with a population of 2.1 million in 2010. HDHHS has 1,100 employees and a budget of $100,245,403. HDHHS serves the City of Houston through 44 distinct programs. HDHHS provides core public health services to all Houston residents such as air and water quality monitoring and restaurant inspections; birth and death certificates; leadership in emergencies such as hurricanes; operates a comprehensive regional reference laboratory, provides communicable disease prevention and control services and disease surveillance and a variety of health and human services such as the Women, Infants and Children (WIC) nutrition program, senior nutrition services, family planning, oral health services and immunizations via a network of 4 health centers, 14 WIC sites and the Harris County Area Agency on Aging.

Intervention(s): The Diabetes Awareness and Wellness Network (DAWN) Center is a new initiative serving 400 participants (75 diagnosed diabetics, 125 with pre-diabetes glucose levels and 200 at risk for diabetes) per year from DY 3-5 The Center will provide complementary wellness programming and offer prevention and intervention services and coordination of care for those with diabetes or at risk for diabetes through enhanced education, physical activity, self-management education, hemoglobin A1C tracking and monitoring, BMI measurements, behavioral change coaching, and case management. Participants will be recruited from 3 FQHC's, County Hospital based diabetes center and one dialysis center that all serve low income Medicaid patients.

Need for the Project: Comprehensive disease management can reduce costs based on less hospitalizations, decrease in loss of productivity, decrease in absenteeism, and decrease in unemployment from disease-related disability. Diabetes patients or those at risk for diabetes receive the greatest benefit from disease management or health enhancing behaviors to lower their risks to develop diabetes. According to the Houston Hospitalizations at a Glance Report, chronic conditions accounted for 78% of all adult preventable hospitalizations in Houston, with 26% of those being related to diabetes. 22% of adult preventable hospitalizations in the Council District D where this project is targeted are diabetes-related.

Target Population: Individuals with diabetes or at risk for diabetes residing in an underserved area (Third Ward) with a high incidence of diabetes will benefit from the comprehensive wellness program.

Category 1 or 2 expected patient benefits: Increase proportion of patients with disease self-management goals in the DAWN Center by 5% over baseline in DY 4 and by 10% over baseline in DY5.

Category 3 outcomes: IT-1.10 Diabetes care: Decrease HbA1c poor control by 2% over baseline in Wellness Center enrollees in DY4 and IT-1.10 Diabetes care: Decrease HbA1c poor control by 5% over baseline in DAWN enrollees in DY5.

Project Option 2.2.6 -Expand Chronic Care Management Models "Other": DAWN Center

Unique Project ID: 0937740-08.2.5
Performing Provider Name/TPI: City of Houston Health and Human Services / 0937740-08

Project Description:
This project would establish acomprehensive, community based Diabetes Wellness Centerin an underserved community with one of the highest incidence rates of diabetes

The Diabetes Awareness and Wellness Network (DAWN) Center will provide complementary wellness programming and offer prevention and intervention services and coordination of care for those with diabetes and other chronic conditions. The process and improvement targets have been chosen based on the project goals of chronic care self-management, care transitions, self-management goal setting, and a community based coordinated system of care.The DAWN center will be located in the Third Ward community in Houston in Council District D.

The DAWN Center will consist of four distinct but interrelated components:
1) Active Living and Healthy Eating Campaign
The campaign will focus on promoting healthy lifestyles such as active living and healthy eating through policy and environmental change strategies using appropriate strategies in apreviously identified geographically targeted population. Campaigns currently exist which promote an individual's responsibility for their health; this new campaign would expand that message to promote the understanding of how environments and livability impact health and the role individuals can take to improve their health (social-ecological model).
2) Enhanced Education and Self-Management
The Enhanced Education and Self-Management Component will includes complementary wellness programming in existing facilities located in an identified geographically targeted area most at risk of debilitating chronic disease outcomes. This component incorporates evidence-based behavior supports such as Stanford's Diabetes Self-Management Program[214] and Merck's Diabetes Conversation Maps,[215]
with monitored fitness rooms and interventions, nutrition education and produce programs as well as care coordination to ensure access to and utilization of primary health care. These activities are coupled with clinical screenings and referrals, medication management coaching and telephonic follow-up to improve quality of life and reduce the incidence of hospitalization.
3) Geographically Targeted Registry Pilot
Clinical surveillance techniques have historically been used to study infectious diseases. Databases have been created to monitor HIV/STD/influenza/SARS outbreaks. Registries have now also been developed for cancer as a way to monitor incidence and determine prevalence and possible causes. As diabetes approaches epidemic proportions, there is an increasing interest in disease registries for various chronic diseases, but particularly for diabetes.

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[214] Stanford School of Medicine. Diabetes Self-management Program. http://patienteducation.stanford.edu/programs/diabeteseng.html. Accessed: 11-07-12
[215] http://www.journeyforcontrol.com/journey_for_control/journeyforcontrol/for_educators/conversation_maps/. Accessed: 11-07-12.

The implementation of a geographically targeted registry pilot will include tracking the individual hemoglobin levels and diagnosis codes reported by clinical laboratories serving the targeted population. Collecting the hemoglobin A1C test results and compiling the results submitted would allow HDHHS to track:

1. The prevalence of diabetes among people tested in the targeted population
2. Level of control by people with diabetes within various demographic groups in the area
3. Trends for new diagnoses of diabetes in the area
4. Estimated health care costs associated with diabetes and testing. The results could also be used for conducting cost-benefit analyses for seeking research, prevention and education funding. Ultimately, results would be used to determine the best interventions for implementation for the targeted populations.

4) Care Transition

It is statistically likely that the DAWN participants will be at high risk of preventable hospitalization. DAWN will utilize the Coleman Model for Care Transition (http://www.caretransitions.org) to guide interdisciplinary work to avoid preventable hospitalizations through a liaison relationship with three hospitals that frequently serve the target population. During the four-week Care Transitions program, patients with complex care needs and family caregivers work with a “Transition Coach” and learn self-management skills that will ease their transition from hospital to home. The coach is a licensed staff person (social worker or nurse) who has received training in the Care Transitions Intervention program. This intervention is centered on four pillars: 1. Medication self-management; 2. The Personal Health Record; 3. Timely primary care/specialty care follow up; and 4. Knowledge of red flags that indicate a worsening in their condition and how to respond. The DAWN Care Transition Coach will provide family education on preventable hospitalizations and assist in training community-based resources that can assist individuals with limited family support.

Goals and Relationship to Regional Goals:

The overall goal of this program is to empower people to make lifestyle changes to stay healthy and self-manage their chronic conditions.

Project goals:

1. Promote health behavior change and improve overall quality of life
2. Reduce risk for progressive disease impacts;
3. Increase healthy disease management behaviors;
4. Build natural (individual) supports for health maintenance;
5. Monitor and assess effective intervention for subpopulations impacted by diabetes;
6. Reduce Potentially Preventable Admissions/Readmissions (PPA/PPR)

This project meets the following Regional Goals:

The DAWN Center Project also meets the regional goals:

- Increase access to primary and specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their condition, regardless of where they live or their ability to pay.
- Transform health care delivery from a disease-focused model of episodic care to a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary or duplicative services, and builds on the accomplishments of our existing health care system.

Challenges:
In developing the Active Living and Healthy Eating Campaign, two challenges that we anticipate are the development of messages that resonate with diverse community populations and the determination of the most appropriate channels of communication. To overcome these challenges we will work in partnership with a group of community based organizations that serve the diverse populations that will be utilizing the Center. We will conduct focus groups and use the results to develop messages and select appropriate channels of communication. A second challenge is the development of an electronic records system to reflect progress on behavior change program goals. This challenge will be met by meeting with other entities that have faced a similar challenge and learning from them. Two challenges anticipated through the geographically-targeted registry pilot include "getting buy-in from providers" and determining whether to make the registry mandatory or voluntary. Getting buy-in from providers will be accomplished by providing an orientation and tour for providers. Providers will then know that the DAWN Center wants to partner with them to provide services that they cannot provide and at a location that is convenient for the patient. The challenge with the registry has to do with whether or not the Center wants to provide an "opt out" option to participants. The Center staff will work with participants to assure them that the registry will allow the Center to track progress and provide alternative activities for the successful management of their diabetes. In order to make "care transition" successful, the development of liaison relationships with key hospitals and providing home-based care for clients with limited family support will be key. These challenges will be met by working with the Area Agency on Aging (AAA, housed within the Houston Health Department) in the area of training. AAA has run a similar program and has learned how to work with hospitals and clients with limited family support.

5-Year Expected Outcome for Provider and Patients:
HDHHS expects to see improved self-management of diabetes by patients served at the DAWN center. Additionally there is an expected avoidance of preventable hospital admissions for patients with diabetes who are served by the center.

Starting Point/Baseline:
Baseline data for the project will be established by the end of the first year of program implementation (DY3).

Rationale:
A review of literature (Economic Costs of Diabetes in the U.S. in 2007) indicates that a program similar to the Diabetes Awareness and Wellness Network (DAWN) Center that focuses on enhanced education, physical activity, self-management education, hemoglobin A1C tracking and monitoring, BMI measurements, behavioral change coaching, and case management can reduce costs based on less hospitalizations, decrease in loss of productivity, decrease in absenteeism, and decrease in unemployment from disease-related disability(www.ncbi.nlm.nih.gov/pubmed/18308683).

The prevalence of Diabetes in in Greater Third Ward-Macgregor-Gulfgate area of City of Houston,where the DAWN Center will be based has a high prevalence of diabetes.This area is

one of the 28 geographic units within Harris County used by Houston Health Survey 2010.[216]As per Census 2010 data, Blacks represent more than half (52.78%) of the total population residing in this area. Similarly, 35.39% of the population is Hispanics. Almost 40 % of the total population living in the area is 40 years and older.

Overall, in the U.S. diabetes prevalence rate is almost twice among Blacks and Hispanics compared to Non-Hispanic whites.[217] Similarly, educational attainment among the residents-a proxy measure of overall health of the community- is low in the proposed area. For example, percentage of residents with less than a high school degree among 25 years or older was 31 compared to 21% in Houston [(3).] Similarly percentage of residents (18 years and older) with household income less than 100% of federal poverty level in the proposed area is 39%, a higher rate compared to Houston as a whole (26%). According to Houston Health Survey (2010), the unemployment rate among adults (18 years +) was 22 %, higher than Houston average of 16%. Other indicators of health such as percentage of population reporting 7 or more days of poor physical health in the past month was higher among the residents of the proposed area compared to Houston average. Higher rates of obesity was reported in the proposed area (34%) compared to Houston average of 30%. Diabetes diagnosis was also slightly higher than the Houston average, 12 % vs. 11% respectively [(1).]

As per the Houston Health Survey (2010), described in the previous page, diabetes diagnosis in Harris County is 9.5 % among Non-Hispanic Whites, 15.2 % among Non-Hispanic Blacks, 11% among Hispanics and 5.8 % among Asians. Among all races, the prevalence is 11.1 %. Among Non-Hispanic Blacks, women have higher rates (17.3%) than the men (12%).

On the HCUP website, some "outcomes/effectiveness research" reports indicated that better adherence to diabetes medications means fewer hospitalizations and emergency department visits. The researchers used a database containing information on 5 million individuals covered by employer-sponsored health insurance and included prescription drug insurance claims, employer health plans, hospitalizations, and ED visits. The final sample consisted of 56,744 individuals with Type 2 diabetes, who required oral anti-diabetic medications to manage their condition. When adherence rates were raised from 50% to 100%, although diabetic drug costs increased substantially; for payers, this still resulted in a savings of $1.12 in hospital care for every dollar that was spent on diabetes medications. When reduced ER costs were taken into consideration, a total cost savings of $1.14 for every additional dollar spent on medications were realized.

Project Components:

This project option does not have any required core components..

However, the DAWN project will include a component to conduct systematic quality improvement for the project.

Activities will include Identifying project impacts, "lessons learned," opportunities to scale all or part of the project to a broader patient population, and key challenges associated with expansion

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[216]Institute for Health Policy UTSPH. Health of Houston Survey. https://sph.uth.edu/research/centers/ihp/health-of-houston-survey-2010/ . 2012. 9-15-2012.

[217]Centers for Disease Control and Prevention. National diabetes fact sheet: national estimates and general information on diabetes and pre-diabetes in the United States . 2011. Atlanta, GA, U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2011.

of the project, including special considerations for safety-net populations. Due to the performing provider's experience and established networks in serving low income population in the County, this program will benefit from these experiences. Nevertheless, program processes will be refined and improved through a Plan-Do-Check-Act process. The goal of continuous quality improvement is to establish a cyclical, continuous process of planning, assessing, monitoring, analyzing, measuring and evaluating performance to improve desired outcomes. It is expected that revisions to the protocol, training requirements, partnership processes and expectations will need to be clarified on a regular basis. These program components will be improved through the PDSA process. Initial program enrollment of a small number of target population in DY3 will help iron out the program weaknesses and allow for a continuous improvement process.

Unique community need identification numbers the project addresses:
The DAWN Center also addresses the issues addressed in the following community needs assessments:

- CN.1 Inadequate access to primary care
- CN.8 High rates of inappropriate emergency department utilization
- CN.10 High rates of preventable hospital admissions
- CN.20 Lack of access to programs providing health promotion education, training and support, including screenings, nutrition counseling, patient education programs
- CN.23 Lack of patient navigation, patient and family education and information programs.

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
DAWN is a new initiative which places a comprehensive health and wellness center in a targeted community at risk for poor health outcomes.

<u>**Related Category 3 Outcome Measures:**</u>
OD-1 Primary Care and Chronic Disease Outcomes:
IT-1.10 Diabetes care: HbA1c poor control (>9.0%)17- NQF 0059 (Stand-alone measure)

- a Numerator: Percentage of patients 18-75 years of age with diabetes (Type 1 or Type 2) who hadhemoglobin A1c (HbA1c) control > 9.0%.
- b Denominator: Members 18 to 75 years of age as of December 31 of the measurement year withdiabetes (Type 1 and Type 2)

Reasons/rationale for the selecting the outcome measures:

We chose this Outcome Measure because the DAWN Center aims to reduce prevalence and promote management of Diabetes in a high risk area. One of the most important indicators of blood sugar control is HbA1c. Clinically healthy range for HbA1c is less than 5.7%, values between 5.7% and 6.4% are considered pre-diabetes and values higher than 6.4 are referred to as diabetes. For a diabetic patient, it is recommended to maintain the HbA1C level below 6.5-7 % [(1).] HbA1C indicates how well one is controlling the blood sugar over the last 60-90 days, which helps the patients and their care providers to adjust the diet, physical activity and medication accordingly. HbA1C is also considered as the' gateway' to care for individuals with type-2 diabetes

According to the *Houston Hospitalizations at a Glance Report,* chronic conditions accounted for 78% of all adult preventable hospitalizations in Houston, with 26% of those being

related to diabetes. This same report indicates that in Council District D, (most consistent with the targeted service area of the DAWN Center) the annual average cost of adult preventable hospitalizations for District D is $69,644,160 (the highest annual average cost for any District). Additionally, 22% of adult preventable hospitalizations in District D are diabetes-related. City Council District D has the second highest number of preventable diabetes hospitalizations (2,420). It also has the highest average cost per discharge of adult preventable hospitalizations by Council District ($32,038).
Additionally, the literature (*Economic Costs of Diabetes in the U.S. in 2007,Diabetes Care31: 596-615, 2008*) indicates that a program similar to the Diabetes Awareness and Wellness Network (DAWN) Center that focuses on enhanced education, physical activity, self-management education, hemoglobin A1C tracking and monitoring, BMI measurements, behavioral change coaching, and case management can reduce costs based on less hospitalizations, decrease in loss of productivity decrease in absenteeism, and decrease in unemployment from disease-related disability.

Relationship to Projects and Plan for Learning Collaborative:

We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system.

Healthcare treatment cannot focus to only the acute or chronic encounter and properly treat the patient. It is critical that our region focuses to patient education and community education to ensure a proactive and responsive approach to healthcare needs. The education models represented in the Region 3 RHP plan can be identified in the Initiative Grid (addendum) and all focus to outcome measures such as appropriate utilization, patient satisfaction scores, and standalone chronic condition scores such as diabetes and asthma.

Project Valuation:

HDHHS utilized two categories to calculate value for each DSRIP project. The first category is Prioritization and the second is Public Health Impact (see attachment for HDHHS Valuation Tool). HDHHS scored the project on a scale of 1 (poor) to 9 (exceptional) for each of the six factors that comprise the Prioritization category. The Prioritization category includes the following factors: 1) Transformational Impact, 2) Population Served / Project Size, 3) Alignment with Community Needs 4)Cost Avoidance 5) Partnership Collaboration, and 6)Sustainability. Each factor was then given a weighted score and a pre-determined percentage weight. The six weighted scores were added to get a composite score for the Prioritization category.

Public Health includes activities which seek to achieve the highest level of health for the greatest number of people. Public Health also focuses on preventing problems from happening or re-occurring through programs and activities that promote and protect the health of the entire community. As a public health department, HDHHS added an additional valuation category of Public Health Impact that looked at projects through a public health lens. The Public Health Impact category includes the following factors: 1) Alleviate Health Disparity, 2) Control Communicable and Chronic Disease , 3) Prevention Orientation, 4) Population Health Focus, 5) Access and Connection to Health Services and 6) Evidence Based Health Program. HDHHS

scored the project on a scale of 1 (poor) to 9 (exceptional) for each of the six factors that comprise the Public Health Impact category. Each factor was then given a weighted score based on the score rated and a pre-determined percentage weight. The six weighted scores were added to get a composite score for the Public Health Impact category. HDHHS gave the Prioritization score a weight of 25% and the Public Health Impact score a weight of 75% to determine the overall project value for the plan. DAWN received a composite Prioritization score of 7.10 and a Public Health Impact score of 7.

0937740-08.2.5	2.2.6	N/A	Project Title: DAWN Center
Performing Provider Name: City of Houston Department of Health and Human Services			HDHHS -0937740-08
Related Category 3 Outcome Measures:	0937740-08.3.8	IT-1.10	Diabetes care: HbA1c poor control (>9.0%)- NQF 0059

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1 [P –X1]: Plan scope, range, current capacity and needed resources for DAWN Center. Metric 1: DAWN Program Planning Materials, Meeting minutes, Sign-in sheets, Logic Model, Draft Clinical Protocols, Staff Qualifications, Staffing Plan Goal: Produce a comprehensive document identifying results of planning and including information listed above. Data Source: Report developed by project staff. Milestone 1 Estimate Amount: $1,123,092.70 **Milestone 2 [P-X2]:** Develop and test Data systems Metric 1: Select, install and test data system Baseline/Goal: Install an efficient and effective data system to capture outcome and process data Data Source: Documentation of installation of data system	**Milestone 3 [P-11]**: Develop and implement program to assist patient to better self-manage their chronic conditions (Diabetes) Metric 1[P-11.1]: Increase the number of patients enrolled in a Diabetes self-management program Goal: Implementation of DAWN programs Numerator: Number of patients enrolled in a Diabetes self-management program for a given chronic condition Denominator: Number of patients with given chronic condition enrolled in DAWN Center Data source: EHR, DAWN Program documentation, class enrollment and attendance records Milestone 3 Estimate Amount: $1,244,740.33 **Milestone 4 [P-13]:** Develop and implement program for diabetes care managers to support primary care clinics Metric 1 [P-13.1]: Diabetes care	**Milestone 5 [I-18]:** Improve the percentage of patients with self-management goals Metric 1 [I-18.1]: Patients with self-management goals Goal: Increase by 5% over baseline the proportion of patients with self-management goals in DAWN Center. (Baseline established in Yr3) Data Source: Registry of DAWN Numerator: The number of patients with the specified chronic condition/MCC in the DAWN registry with at least one recorded self-management goal Denominator: Total number of patients with the specified chronic condition/MCC in the DAWN registry Milestone 5 Estimate Amount: $1,325,081.88 **Milestone 6 [I-21]**: Improvements in access to care of patients receiving chronic care management services using innovative project option.	**Milestone 7 [I-18]:** Improve the percentage of patients with self-management goals Metric 1 [I-18.1]: Patients with self-management goals Goal: Increase by 10% over baseline the proportion of patients with self-management goals in DAWN Center. Data Source: Registry of DAWN Numerator: The number of patients with the specified chronic condition/MCC in the registry with at least one recorded self-management goal Denominator: Total number of patients with the specified chronic condition/MCC in the DAWN registry Milestone 7 Estimate Amount: $1,280,576.60 **Milestone 8 [I-21]** Improvements in access to care of patients receiving chronic care management services using innovative project option. Metric 1 [I-21.2]: Documentation of

0937740-08.2.5	***2.2.6***	***N/A***		***Project Title: DAWN Center***
Performing Provider Name: City of Houston Department of Health and Human Services				*HDHHS* -0937740-08
Related Category 3 Outcome Measures:	*0937740-08.3.8*		*IT-1.10*	*Diabetes care: HbA1c poor control (>9.0%)- NQF 0059*

Year 2 **(10/1/2012 – 9/30/2013)**	Year 3 **(10/1/2013 – 9/30/2014)**	Year 4 **(10/1/2014 – 9/30/2015)**	Year 5 **(10/1/2015 – 9/30/2016)**
Milestone 2 Estimate Amount: $1,123,092.70	manager support for primary care clinics in target area Goal: Documentation and implementation of plan Data source: Evidence of diabetes management care coordination clinic plan in target area Milestone 4 Estimate Amount: $1,244,740.33	Metric 1 [I-21.2]: Documentation of increased number of unique patients served by innovative program. Demonstrate improvement over prior reporting period. Goal: Increase by 5% over baseline (Baseline established in Yr 3) Total number of unique patients encountered in the clinic for reporting period. Data Source: DAWN Registry, EHR, Program Documentation Milestone 6 Estimate Amount: $1,325,081.88	increased number of unique patients served by innovative program. Demonstrate improvement over prior reporting period. Goal: Increase by 10% over Baseline Total number of unique patients encountered in the clinic for reporting period. Data Source: DAWN Registry, EHR, Program Documentation Milestone 8 Estimate Amount: $1,280,576.60
Year 2 Estimated Milestone Bundle Amount: $2,246,185	Year 3Estimated Milestone Bundle Amount: $2,489,481	Year 4Estimated Milestone Bundle Amount: $2,650,164	Year 5Estimated Milestone Bundle Amount: $2,561,153
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over DYs 2-5)****:*** $9,946,983			

Project Option 2.13.2 - Implement other evidence-based project to provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in an innovative manner.

Unique Project ID: 0937740-08.2.6

Performing Provider Name/TPI: City of Houston Department of Health and Human Services/0937740-08

Project Summary: Provider: The performing provider, Houston Department of Health and Human Services (HDHHS) is the public health authority for Houston, Texas, the fourth largest city in the U.S., with a population of 2.1 million in 2010. Established in 1840, HDHHS has grown to a department of 1,100 employees. HDHHS provides core public health services to all Houston residents such as air and water quality monitoring; restaurant inspections; lead paint safety; cancer screening and family planning for the uninsured; communicable disease prevention and control; disease surveillance; birth and death certificates; leadership in emergencies such as hurricanes; services to seniors; WIC programs; immunizations; and others. HDHHS operates 11 multi-service centers, 6 health centers, 14 WIC (Women, Infants and Children nutrition program) sites, the Harris County Area Agency on Aging, a comprehensive regional reference laboratory, and 44 health and human service programs. While HDHHS provides services that benefit all Houston residents, the department also takes additional steps to support those most in need, such as low income mothers and children, the elderly, and minority populations.

Intervention(s): The performing provider will implement interventions 1)Visiting Nursing and / or community health worker services; 2) Substance abuse services involve a range of services for individuals (N=8000/year) who frequently display a range of mental and physical symptoms that indicate alcohol or other substance abuse in DY4-5.

Need for the Project: The new Sobering Center initiative provides a short term inpatient and outpatient facility where individuals arrested for being under the influence of alcohol or other substances need a facility where they are under medical supervision but not utilizing valuable health care resources at other settings such as hospitals admissions or the ER.

Target Population: The target population will be individuals that have been arrested by the Police Department for alcohol or other substance abuse issues and are taken to the Sobering Center.

Category 1 or 2 expected patient benefits: 5% decrease over baseline in preventable admissions and readmissions into Criminal Justice System of those who were previously arrested for public intoxication and have participated in Sobering Center program in past 6 months in DY4 and 7% decrease over baseline in DY5.

Category 3 outcomes: IT-9.4 Other: Decrease preventable admissions to ER/ hospitals/criminal justice setting due to non-emergent alcohol/other substance use intoxication in a 6 month period by 2% over baseline in DY4 and by 4% in DY5.

Project Option 2.13.2 - Implement other evidence-based project to provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in an innovative manner: Sobering Center

Unique Project ID: 0937740-08.2.6

Performing Provider Name/TPI: City of Houston Department of Health and Human Services / 0937740-08

Project Description:

Texas's mental health system provides rehabilitative services and pharmacotherapy to people with certain severe psychiatric diagnoses and functional limitations, but can serve only a fraction of the medically indigent population. It does not serve other high risk behavioral health populations and does not provide the range of services needed to deal with complex psychiatric, addiction and physical needs. These complex populations become frequent users of local public health systems. Each year, the Houston Police Department arrests and incarcerates over 17,000 individuals for Public Intoxication. The City of Houston Sobering Center will be an alternative means of handling public inebriates rather than constantly subjecting them to placement in a an emergency room or a jail facility. The Sobering Center will offer a continuum of care using a comprehensive multidisciplinary approach for intoxicated persons brought to the Emergency Department as well as picked up by the Police Department from other public locations in the city. The Center is loosely modeled after the McMillan Stabilization Project in San Francisco and the San Diego Serial Inebriate Program. The Center will offer a range of services for individuals who frequently display a range of mental and physical symptoms that indicate alcohol addiction. The primary services that will be offered are:

1) Monitoring participants for health and safety while at the center for 4-6 hours while they sober up
2) Screening and assessment once they sober up to gather history and determine needs
3) Development of service plans based on identified needs
4) Linking participants, who agree, to treatment and detox as needed

The Sobering Center is designed to be a short-term care facility designed as a safe location for police officers to transport individuals who are under the influence or alcohol or other substances. When operating fully, the Center is expected to serve 8000 individuals /year. The Sobering Center will monitor the residents for safety because of risks of alcohol poisoning, choking on vomit, suffocating, or because they may have undetected medical conditions or serious head injuries.

Target Zip Codes:

The project will be implemented city wide.

Goals and Relationship to Regional Goals:

Project Goals:

The goal of the project is to offer a community based facility where individuals that have been in contact with law enforcement due to public intoxication or other substance use can receive services and referrals to address their needs without being transported to the ER.

This project meets the following regional goals:

- Increase access to primary and specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their condition, regardless of where they live or their ability to pay.

Challenges:

One of the challenges for this project will be finding adequate resources for detoxification and effective, low to no cost treatment options for individuals who accept referral and treatment services. These challenges will be handled by developing a seamless referral and follow up process, regular inservice trainings and quality improvement checks, and an ongoing feedback process.

5-Year Expected Outcome for Provider and Patients:

The performing provider expects decrease in costs to public systems (ER, criminal justice system) related to alcohol and or other substance abuse and reduction in ER visits related to alcohol and other substances. Additionally, there should be an increase in referrals to treatment programs.

Starting Point/Baseline:

This is a new initiative. A baseline will be established in the first year of full operation (DY3).

Rationale:

Other cities adopting such sobering centers have seen reductions in arrests and jail time for these offenders, as well as fewer emergency room and hospital check-ins for this often indigent population, on top of the cost savings found in jail bed diversions. In San Antonio, in the first year alone, the sobering center led to $6 million in cost savings. After three years, total cost savings from reduced jail time, reduced hospitalizations, and other sources stretches over $25 million.

Project Components:

There are no required project components for this project. Nevertheless, since this is a new program, processes will be refined and improved through a Plan-Do-Check-Act process. The goal of continuous quality improvement is to establish a cyclical, continuous process of planning, assessing, monitoring, analyzing, measuring and evaluating performance to improve desired outcomes. It is expected that revisions to the protocol, training requirements, partnership processes and expectations will need to be clarified on a regular basis starting with the pilot implementation in DY3. These processes will be improved through the PDSA process. Initial program enrollment of a small number of target population will help iron out the program weaknesses and allow for a continuous improvement process.

Unique community need identification numbers the project addresses:

The Sobriety Center Project also addresses the issues addressed in the following community needs assessments:

- CN.6 Inadequate access to treatment and services designed for special needs populations, including disabled, homeless, children, elderly.
- CN.23 Lack of patient navigation, patient and family education and information programs.

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

This is a new initiative for the City of Houston. There is currently no facility similar to a Sobering center in Houston.

Related Category 3 Outcome Measures:

OD-9 Right Care, Right Setting:

IT – 9.4 Other Outcome Improvement Target (Non emergent ER visits and hospitalizations in Sobering Center Participants)
Rate: Preventable admissions to ER and hospitals due to alcohol/other substance use intoxication in Sobering Center Participants in previous 6 month period

Reasons/rational for the selecting the outcome measures:

This facility will result in cost savings to the Health Care system. There were 187,537 ER visits projected for 2012 (projected from data from Jan to June of 2012) in Harris County Hospital District of which approximately 3% were alcohol related. This means 5626 were alcohol related ER visits per year. Other cities adopting such sobering centers have not only seen reductions in arrests and jail time for these offenders, but also fewer emergency room and hospital check-ins for this often indigent population. This approach is more effective because it addresses the underlying issue of alcohol abuse inherent in most public intoxication offenses.

Relationship to Other Projects:

We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system.

The behavioral health crisis in Region 3 is considerable and the proposed initiatives in our RHP plan will only imply a small impression into the overall community need for treatment, but is a good start. The outpatient focus of many RHP Plan initiatives will help numerous facilities focus to treating the patients in an ambulatory setting as well as continued navigation of services with a focus to keeping patients from the inpatient unit. This initiative is similar to many others in the sense of the category of behavioral health. The Region 3 Initiative Grid attached in the addendum will show the relationship to other programs.

Project Valuation:

HDHHS utilized two categories to calculate value for each DSRIP project. The first category is Prioritization and the second is Public Health Impact (see attachment for HDHHS Valuation Tool). HDHHS scored the project on a scale of 1 (poor) to 9 (exceptional) for each of the six factors that comprise the Prioritization category. The Prioritization category includes the following factors: 1) Transformational Impact, 2) Population Served / Project Size, 3) Alignment with Community Needs, 4) Cost Avoidance, 5) Partnership Collaboration and 6)Sustainability. Each factor was then given a weighted score based on the score rated and a pre-determined percentage weight. The six weighted scores were added to get a composite score for the Prioritization category.

Public Health includes activities which seek to achieve the highest level of health for the greatest number of people. Public Health also focuses on preventing problems from happening or re-occurring through programs and activities that promote and protect the health of the entire

community. As a public health department, HDHHS added an additional valuation category of Public Health Impact that looked at projects through a public health lens. The Public Health Impact category includes the following factors: 1) Alleviate Health Disparity, 2) Control Communicable and Chronic Disease , 3) Prevention Orientation, 4) Population Health Focus, 5) Access and Connection to Health Services and 6) Evidence Based Health Program. HDHHS scored the project on a scale of 1 (poor) to 9 (exceptional) for each of the six factors that comprise the Public Health Impact category. Each factor was then given a weighted score based on the score rated and a pre-determined percentage weight. The six weighted scores were added to get a composite score for the Public Health Impact category.
HDHHS gave the Prioritization score a weight of 25% and the Public Health Impact score a weight of 75% to determine the overall project value for the plan. The Houston Sobering Center received a composite Prioritization score of 5.35 and a Public Health Impact score of 6.

0937740-08.2.6	*2.13.2*	*N/A*		*Project Title: Sobering Center*
Performing Provider Name: City of Houston Department of Health and Human Services				HDHHS - 0937740-08
Related Category 3 Outcome Measures:	0937740-08.3.9		*IT-9.4*	*Other Outcome Improvement Target (Non emergent ER visits and hospitalizations in Sobering Center Participants)*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P – X1] Project Planning -Plan scope, range, current capacity and needed resources for Sobering Center. Metric 1[1-X.1]: Develop a plan for implementing Sobering Center Program and provide report that includes: Planning Materials, Meeting minutes, Sign-in sheets, Draft Clinical Protocols, Staff Qualifications, and Staffing Plan Goal: Produce a comprehensive report documenting all information identified above Data Source: Report planning materials and final summary report Estimated Process Milestone 1 Amount: $580,373.32 **Milestone 2 [P-X2]**Needs Assessment customized for local context Metric 1: Conduct needs assessment, literature review for evidence-based practices and tailor intervention to local context Goal: Determine gaps in services for target population in the local context Data Source: Results of Needs Assessment	**Milestone 4 [P-X3]:** Implement project according to project plans Metric 1: Provide documentation of implementation Goal: Implement project and initiate the quality improvement process Data Source: Program Documentation Estimated Process Milestone 4 Amount: $964,854.56 **Milestone 5 [P-4]:** Evaluate and continuously improve interventions Metric 1 [P-4.1]: Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles a. Project reports including examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement (e.g., how the project continuously uses data such as weekly run charts or monthly dashboards to drive improvement) Goal: Use systematic quality improvement system Data Source: Program	**Milestone 6 [I-1].:** Criminal Justice Admissions/Readmissions Metric 1 [I-1.1]: Decrease over baseline in preventable admissions and readmissions into Criminal Justice System of those who were previously arrested for public intoxication and have participated in Sobering Center program in past 6 months. (Baseline TBD in DY 3) This would be measured every 6 months starting DY 4 to see if there was a decrease. Goal: Decrease in admissions and readmissions to criminal justice system by 5% over baseline in program participants Data Source: Police Department IT system, Program data Estimated Process Milestone 6 Amount: $2,054,261.86	**Milestone 7 [I-1].:** Criminal Justice Admissions/Readmissions Metric 1 [I-1.1]: Decrease over baseline in preventable admissions and readmissions into Criminal Justice System of those who were previously arrested for public intoxication and have participated in Sobering Center program in past 6 months. This would be measured every 6 months starting DY 4 to see if there was a decrease. Goal: Decrease in admissions and readmissions to criminal justice system by 7% over baseline in program participants Data Source: Police Department IT system, Program data Estimated Process Milestone 7 Amount: $1,985,265.74

0937740-08.2.6	***2.13.2***	***N/A***	***Project Title: Sobering Center***			
Performing Provider Name: City of Houston Department of Health and Human Services			HDHHS - 0937740-08			
Related Category 3 Outcome Measures:	0937740-08.3.9		*IT-9.4*	*Other Outcome Improvement Target (Non emergent ER visits and hospitalizations in Sobering Center Participants)*		

Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Estimated Process Milestone 2 Amount: $580,373.32 **Milestone 3 [P-2.1]:** Design community-based specialized interventions for target populations**.** Metric 1 [P-2.1]: Project plans which are based on evidence / experience and which address the Goal: Provide completed report providing information identified above Data Source: Program documentation, HER, claims, needs assessment survey/study Estimated Process Milestone 3 Amount: $580,373.32	Documentation Estimated Process Milestone 5 Amount: $964,854.56		
Year 2 Estimated Milestone Bundle Amount: $1,741,120	Year 3 Estimated Milestone Bundle Amount: $1,929,709	Year 4 Estimated Milestone Bundle Amount: $2,054,262	Year 5 Estimated Milestone Bundle Amount: $1,985,266
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over DYs 2-5)***:** $7,710,357			

Project Option 2.6.4 - Implement other evidence based project to implement health promotion programs in an innovative manner not described above.

Unique Project ID: 0937740-08.2.7

Performing Provider Name/TPI: City of Houston Department of Health and Human Services/0937740-08

Project Summary: Provider: The performing provider, Houston Department of Health and Human Services (HDHHS) is the public health authority for Houston, Texas with a population of 2.1 million in 2010. HDHHS has 1,100 employees and a budget of $100,245,403. HDHHS serves the City of Houston through 44 distinct programs. HDHHS provides core public health services to all Houston residents such as air and water quality monitoring and restaurant inspections; birth and death certificates; leadership in emergencies such as hurricanes; operates a comprehensive regional reference laboratory, provides communicable disease prevention and control services and disease surveillance and a variety of health and human services such as the Women, Infants and Children (WIC) nutrition program, senior nutrition services, family planning, oral health services and immunizations via a network of 4 health centers, 14 WIC sites and the Harris County Area Agency on Aging.

Intervention(s): The performing provider will implement interventions to provide an expansion of an evidence-based home visitation program for 100 first time mothers in an underserved area. This consists of 64 home visits over two and one half years for each client enrolled in the program with visits conducted weekly, bi-monthly and monthly.

Need for the Project: This expansion project provides a comprehensive evidence based care to underserved enrolled clients. Underserved clients would not normally have access to comprehensive services provided by such a program to improve birth outcomes for the child and health and social outcomes for the mother. Last year, the NFP served 146 clients with the home visitation program of which 66% were Medicaid clients.

Target Population: The target population will be women who live in a geographically identified area of the city who have high rates of low birth weights and low prenatal care rates. Recruitment for the program will be conducted from the performing provider's health clinics and WIC Centers.

Category 1 or 2 expected patient benefits: Increase the number or percent of patients in defined population receiving innovative intervention consistent with evidence-based model by 5% over baseline in DY4 and by 10% over baseline in DY5.

Category 3 outcomes: IT-8.2 Percentage of low birth weight babies - Reduce percentage of Low Birth- weight births by 2% in DY4 and by 4% in DY5 among women enrolled in the program. IT-8.1 Timeliness of Prenatal Care - Increase by 5% over baseline number of women that receive recommended prenatal and postnatal care in DY4 and by 10% over baseline in DY5.

Project Option 2.6.4 - Implement other evidence based project to implement health promotion programs in an innovative manner not described above.
Unique Project ID: 0937740-08.2.7

Performing Provider Name: City of Houston Department of Health and Human Services / 0937740-08

Project Description:

This project will expand the Nurse Family Partnership (NFP), an evidence-based home visitation program for first-time mothers. NFP utilizes Bachelor prepared, Registered Nurses to conduct home visits to address multiple needs of their clients.

Public health nurses are the backbone of Nurse-Family Partnership's (NFP) success. Since the program's inception, nurses have been instrumental in shaping and delivering this evidence-based, community health program. Because of their specialized knowledge and person-centered approach, the public health nurses who deliver the Nurse-Family Partnership program in their communities, establish trusted relationships with young, at-risk first time mothers. During home visits and follow-up contact, guidance is provided to address the emotional, social, and physical challenges these first-time moms face as they prepare to become parents. But most importantly, Nurse-Family Partnership Nurse Home Visitors make a measurable, long-lasting difference in the lives of their clients.

The NFP home visitation consist of 64 planned home visits over a two-and-a-half year period for each client. Home visits are conducted weekly, bi-monthly and monthly. The baby's father and other family members are encouraged to participate. Recruitment for NFP is conducted at Houston Department of Health and Human Services (HDHHS) Health Centers and WIC sites; other sources for recruitment include pregnancy testing centers, physician offices and self-referrals.

The greater Sunnyside area in Southeast Houston is the selected region for expansion of NFP services. Recent data revealed the Sunnyside area has an alarming rate of low weight births (14.7%), almost five (5) times the Healthy People 2010 goal of < 5.0 % . Approximately one out of five mothers report receiving late prenatal care. This area has a limited number of prenatal care facilities. According to Texas Department of Health and Human Services Commission, the Sunnyside area had a history of being disproportionately represented in the numbers of out of home placements related to abuse and neglectand is one of the highest in the state.

The NFP team consists of 1 Nurse Supervisor, 4 Bachelor of Science in Nursing prepared Registered Nurses and 1 administrative support person. Potential clients will be recruited from HDHHS Health and WIC sites, local high schools, area Pregnancy Centers, FQHCs, HMOs and other home visitation programs.

The visits consist of extensive prenatal, infant and childhood education. This comprehensive program expands to 2 ½ years, with visitations spanning weekly, bi-monthly and monthly. NFP currently collaborates with other programs that serve underserved families in low-income communities in Houston.

This intensive level of support has proven to improve outcomes relating to:

- Preventive health and prenatal practices for the mother – helping her find appropriate prenatal care, improve her diet, and reduce her use of tobacco, alcohol, and illegal

substances. Additionally, NFP nurses help the mother prepare emotionally for the arrival of the baby.

- Health and development education and care for both mother and child – providing individualized awareness of specific child development milestones and behaviors, as well as encouraging parents to use praise and other nonviolent techniques.
- Life coaching for the mother and her family – enabling economic self-sufficiency among mothers by encouraging them to develop a vision for their own futures, stay in school, find employment, and plan future pregnancies.

Currently, Houston Department of Health and Human Services (HDHHS) provides NPF services in the North, Northeast and Northwest regions of Houston/Harris County. There is an emphasis in the Acres Home area in North Houston, secondary to the high rates of infant low birth weight rates (lbw). Since implementation of the NFP program, the infant lbw rates have decreased.

Goals and Relationship to Regional Goals:
The goals of the NFP project is to improve birth outcomes in underserved areas by providing a comprehensive package of services to each enrolled client over a 30 month period by well trained nurse conducting home visitations.

Project Goals:
To expand the current Nurse Family Partnership Program to the Sunnyside community and:

1. Improve pregnancy outcomes
2. Improve child health and development
3. Improve economic self-sufficiency

This project meets the following regional goals:
This project will contribute to developing a culture of ongoing transformation and innovation that maximizes the use of technology and best-practices, facilitates regional collaboration and sharing, and engages patients, providers, and other stakeholders in the planning, implementation, and evaluation process. NFP is an evidence-based best practice promoted and supported by a national organization. The current program funded by the department of State Health Services is a statewide effort to improve perinatal outcomes through the NFP program.

Challenges:

One of the challenges that we anticipate are securing and maintaining a nursing staff with a suitable match between nurse's professional/personal goals and program requirements. Regular meetings and feedback with program staff will be used as one of the means of identifying potential problem areas and overcoming some of these challenges. Opportunities for trainings and continuing educaton will also be offered to the project staff. The professional and personal goals of the staff will be taken into account and steps will be taken to close gaps whenever possible.

5-Year Expected Outcome for Provider and Patients:
We expect improved perinatal outcomes and improvement in indicators of child health and well-being.

Starting Point/Baseline:

Baseline data will need to be collected since the program will be expanding into a new community. Baseline data will be sought from the Department's epidemiology area as well as

from previous assessments done on the Sunnyside community. Baseline will be established in Year 2.

Rationale:

The NFP program has been implemented at multiple locations throughout the US. Extensive evaluation of the program conducted nationally utilizing data from multiple sites, indicates that NFP participation is predictive of better birth outcomes, including fewer pre-term births. According to the national Nurse Family Partnership website (www.nursefamilypartnership.org/), data from the 1990 Nurse Family Partnership (NFP) Memphis trial noted that the NFP nurse-visited families gained academic and employment skills to become economically self-sufficient. According to this analysis, NFP services resulted in lower enrollment in Medicaid and Food Stamps, with a 9% reduction in Medicaid costs and an 11% reduction in Food Stamps costs in the 10 years following the birth of the child. Federal savings were estimated at 154% of costs, yielding a net 54% return on the federal investment.

A 2005 RAND Corporation analysis found a net benefit to society of $34,148 (and that was in 2003 dollars) per higher-risk family served, with the bulk of the savings accruing to government, equating to a $5.70 return for every dollar invested in Nurse-Family Partnership. The analysis also found that for the higher-risk families participating in the first trial in Elmira, New York, the community recovered the costs of the program by the time the child reached age four, with additional savings accruing throughout the lives of both mother and child.

Using the RAND Corporation's figure of net benefit to society of $34,148 per higher-risk family served, it is anticipated that the 100 higher-risk families that will be served by this expansion of NFP into the Sunnyside area will yield a cost savings over one year of $3,414,800 (RAND Report)[218]. Using a 2007 report by NFP, a net return to government of $17,180 per NFP family served was realized. Using these figures, a more conservative cost savings of $1,718,000 would be realized.

Project Components: N/A

This project will include a component to conduct quality improvement for the project. Activities will include

- Identifying project impacts, "lessons learned" to adapt and scale the program to the local context, paying attention to possibilities of expansion to low-income, underserved areas with a high proportion of minority populations with poor birth outcomes.

By leveraging the performing provider's experience and established networks in serving low income population, this program will benefit from these experiences. Program processes will be refined and improved through a Plan-Do-Check-Act process. The goal of continuous quality improvement is to establish a cyclical, continuous process of planning, assessing, monitoring, analyzing, measuring and evaluating performance to improve desired outcomes. It is expected that revisions to the protocol, training requirements, partnership processes and expectations will need to be clarified on a regular basis. These will be improved through the PDSA process. Initial program enrollment of a small number of target population will help iron out the program weaknesses and allow for a continuous improvement process.

218 What We Know and Don't Know About the Costs and Benefits of Early Childhood Interventions. L. Karoly, P.W. Greenwood, S.S. Everingham, J. Hoube, M.R. Kilburn, C.P. Rydell, M. Sanders, and J. Chiesa. RAND Corporation, Santa Monica, CA

Unique community need identification numbers the project addresses:

The Nurse Family Partnership Expansion Project also addresses the issues addressed in the following community needs assessments:

- CN.14 High rates of poor birth outcomes and low birth-weight babies
- CN.20 Lack of access to programs providing health promotion education, training and support, including screenings, nutrition counseling, patient education programs
- CN.23 Lack of patient navigation, patient and family education and information programs

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

The project is an expansion of HDHHS' existing Nurse Family Partnership program to a new community and to a number of pregnant women.

Related Category 3 Outcome Measures:

OD-8 NFP Outcomes:

IT-8.2 Percentage of Low Birth-Weight Births (CHIPRA/NQF # 1382)46 (Stand-alone measure)

- Numerator: The number of babies born weighing <2,500 grams at birth
- Denominator: All births
- Data source: Program Electronic Records

IT-8.1 Timeliness of Prenatal/Postnatal Care (CHIPRA Core Measure/NQF #1517) (Non-standalone measure)

- Numerator: Deliveries of live births for which women receive the following facets of prenatal and postpartum care:
- Received a prenatal care visit as a member of the organization in the first trimester or within 42 days of enrollment in the organization.
- Denominator: Deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year
- Data source: Program Electronic Records

Reasons/rationale for the selecting the outcome measures:

The two outcomes selected for the NFP project are 1) Reduce Pre-term birth (born too soon) and 2) Provide timely and adequate prenatal care because of extensive evidence that improvements in these outcomes are robust indicators of positive birth outcomes.

Pre-term birth is defined as babies born alive before 37 weeks of pregnancy is completed. Being born too soon places the life of the baby in a precarious position. According to the World Health Organization, pre-term birth is the leading cause of newborn deaths (death during the first 4 weeks of life) and the second leading cause of death in children under the age of five. Many cost

effective strategies have been identified and implemented to reduce pre-term birth and produce better birth outcomes such as home visitation programs and other interventions.

Provision of timely and adequate recommended prenatal care is extremely important to improve birth outcomes in low-income women who may typically not have access to regular primary and preventive care. Prenatal care given starting the first 3 months of pregnancy can have an impact on the health of the baby as well as the mother. Access to early prenatal care By allowing women and providers to identify and address health problems and behaviors that may cause particular harm during early fetal development, first-trimester prenatal care can lead to improved outcomes, according to the US Department of Health and Human Services. Early prenatal care is likely to matter most for women who are at elevated risk of poor birth outcomes due to smoking, poor nutritional status, HIV-positive status, or other serious health problems prior to pregnancy.

Relationship to Other Projects and Plan for Learning Collaborative:

We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system.

Healthcare costs are significantly increased within a patient base with such aggressive chronic conditions that have gone untreated. The initiatives focused to chronic disease management focus to conditions such as asthma, hypertension, and diabetes and are similar in the approach of managing & proactively treating chronic conditions in order to reduce 30-day readmission rates, inappropriate emergency department utilization, and healthcare costs. The Region 3 Initiative grid allows a cross reference of initiatives associated with chronic disease management. (addendum)

Project Valuation:

HDHHS utilized two categories to calculate value for each DSRIP project. The first category is Prioritization and the second is Public Health Impact (see attachment for HDHHS Valuation Tool. HDHHS scored the project on a scale of 1 (poor) to 9 (exceptional) for each of the six factors that comprise the Prioritization category. The Prioritization category includes the following factors: 1) Transformational Impact, 2) Population Served / Project Size, 3) Alignment with Community Needs 4)Cost Avoidance 5) Partnership Collaboration and 6)Sustainability. Each factor was then given a weighted score based on the score rated and a pre-determined percentage weight. The six weighted scores were added to get a composite score for the Prioritization category.

Public Health includes activities which seek to achieve the highest level of health for the greatest number of people. Public Health also focuses on preventing problems from happening or re-occurring through programs and activities that promote and protect the health of the entire community. As a public health department, HDHHS added an additional valuation category of Public Health Impact that looked at projects through a public health lens. The Public Health Impact category includes the following factors: 1) Alleviate Health Disparity, 2) Control Communicable and Chronic Disease , 3) Prevention Orientation, 4) Population Health Focus, 5) Access and Connection to Health Services and 6) Evidence Based Health Program. HDHHS scored the project on a scale of 1 (poor) to 9 (exceptional) for each of the six factors that

comprise the Public Health Impact category. Each factor was then given a weighted score based on the score rated and a pre-determined percentage weight. The six weighted scores were added to get a composite score for the Public Health Impact category.
HDHHS gave the Prioritization score a weight of 25% and the Public Health Impact score a weight of 75% to determine the overall project value for the plan. NFP received a composite Prioritization score of 6.95 and a Public Health Impact score of 7.

0937740-08.2.7	*2.6.4*	*N/A*	***Nurse Family Partnership Expansion***
City of Houston Department of Health and Human Services		*HDHHS -0937740-08*	
Related Category 3 Outcome Measures:	*0937740-08,-03,-07.3.10* *0937740-08,-03,-07.3.11*	*IT-8.1* *IT-8.2*	*Timeliness of Prenatal/Postnatal Care (CHIPRA/NQF # 1382)46* *Pre-term Delivery Rate (CHIPRA/NQF # 1382)46*

Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Milestone 1 [P-X1]: Conduct an assessment of health promotion programs that involve Nurse Home Visits at local and regional level. Metric 1 [P-X1.1]: Document completion of assessment Goal: Assess needs of community and leverage partnerships Data Source: Performing Provider assessment and summary of findings Process Milestone 1 Estimated Incentive Payment: $754,219.67 **Milestone 2 [P-2]:** Development of innovative Nurse Family Partnership evidence-based project for targeted population based on the needs assessment and community priorities . Metric 1 [P-2.1]: Document innovational strategy and plans for implementation in target area. Goal: Put all processes in place to implement evidence based programs. Data Source: Program Documentation. Documentation	**Milestone 3 [P-4]:** Execution of a learning and diffusion strategy for testing, spread and sustainability of best practices and lessons learned. Metric 1 [P-4.1]: Document learning and diffusion strategic plan Goal: Establish process and products for diffusion of message and lessons learned. Date Source: Performing Provider documentation of implementation by Performing Provider. Process Milestone 3 Estimated Incentive Payment: $626,934.65 **Milestone 4 [P-5]:** Execution of evaluation process for project innovation. Metric 1 [P-4.1]: Document evaluative process, tools and analytics. Goal: Perform process/improvement evaluation of project on a bi-yearly basis. Data Source: Performing Provider contract or other documentation of implementation	**Milestone 7 [P-X2]:** Develop outreach and marketing campaign Metric 1: Community or population outreach and marketing, staff training, implement intervention Goal: Disseminate knowledge of strategies through verbal and print media to improve birth outcomes in the community. Data Source: Program documentation of dissemination materials. Process Milestone 7 Estimated Incentive Payment: $1,334,800.07 **Milestone 8** [I-6]: Increase the number of patients in defined population receiving innovative intervention consistent with the Nurse Family Partnership evidence-based model. Metric 1 [I-6.1]: Percentage of women enrolled in Nurse Family Partnership based on milestone described above. Goal: Increase 5% over baseline which was established in Yr 3. Data Source: Documentation of	**Milestone 9**: [I-6]: Increase the number of patients in defined population receiving innovative intervention consistent with the Nurse Family Partnership evidence-based model. Metric 1 [I-6.1]: Percentage of women enrolled in Nurse Family Partnership based on milestone described above. Goal: Increase 10% over Baseline the number of patients receiving evidence based interventions Data Source: Documentation of target population reached, as designated in the project plan. Process Milestone 9 Estimated Incentive Payment: $2,579,936.77

0937740-08.2.7	*2.6.4*	*N/A*	***Nurse Family Partnership Expansion***
City of Houston Department of Health and Human Services		*HDHHS -0937740-08*	
Related Category 3 Outcome Measures:	*0937740-08,-03,-07.3.10* *0937740-08,-03,-07.3.11*	*IT-8.1* *IT-8.2*	*Timeliness of Prenatal/Postnatal Care (CHIPRA/NQF # 1382)46* *Pre-term Delivery Rate (CHIPRA/NQF # 1382)46*

Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
of evidence of innovational plan Process Milestone 2 Estimated Incentive Payment: $754,219.67	TBD by Performing Provider Process Milestone 4 Estimated Incentive Payment: $626,934.65 **Milestone 5** [P-3]: Test an evidence-based innovational project for targeted population Metric 1 [P-3.1]: Document testing outcomes. Goal: Pilot test evidence based program in Yr 3 to make corrections and ensure smooth implementation of project. Data Source: Documentation of Nurse Family Partnership testing in target area. Process Milestone 5 Estimated Incentive Payment: $626,934.65 **Milestone 6:** [I-6]: Identify baseline number or percent of patients in defined population receiving innovative intervention consistent with the Nurse Family Partnership evidence-based model. Metric 1 [I-6.1]: Percentage of women enrolled in Nurse Family Partnership based on milestone	target population reached, as designated in the project plan. Process Milestone 8 Estimated Incentive Payment: $1,334,800.07	

0937740-08.2.7	*2.6.4*	*N/A*	***Nurse Family Partnership Expansion***
City of Houston Department of Health and Human Services		*HDHHS -0937740-08*	
Related Category 3 Outcome Measures:	*0937740-08,-03,-07.3.10* *0937740-08,-03,-07.3.11*	*IT-8.1* *IT-8.2*	*Timeliness of Prenatal/Postnatal Care (CHIPRA/NQF # 1382)46* *Pre-term Delivery Rate (CHIPRA/NQF # 1382)46*

Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
	described above. Baseline: Establish number of patients receiving evidence based intervention. Data Source: Documentation of target population reached, as designated in the project plan. Process Milestone 6 Estimated Incentive Payment: $626,934.65		
Year 2 Estimated Milestone Bundle Amount: $2,262,659	Year 3 Estimated Milestone Bundle Amount: $2,507,739	Year 4 Estimated Milestone Bundle Amount: $2,669,600	Year 5 Estimated Milestone Bundle Amount: $2,579,937
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over DYs 2-5)***:** $10,019,935			

City of Houston Department of Health and Human Services

Pass 2

Project Option 2.7.1 Implement innovative evidence-based strategies to increase appropriate use of technology and testing for targeted populations- Colorectal Cancer Awareness and Screening (COCAS)

Unique Project ID: 0937740-08.2.8 / Pass 2

Performing Provider Name/TPI: City of Houston Department of Health and Human Services/0937740-08

Project Summary: Provider: The performing provider, Houston Department of Health and Human Services (HDHHS) is the public health authority for Houston, Texas, the fourth largest city in the U.S., with a population of 2.1 million in 2010. Established in 1840, HDHHS has grown to a department of 1,100 employees. HDHHS provides core public health services to all Houston residents such as air and water quality monitoring; restaurant inspections; lead paint safety; cancer screening and family planning for the uninsured; communicable disease prevention and control; disease surveillance; birth and death certificates; leadership in emergencies such as hurricanes; services to seniors; WIC programs; immunizations; and others. HDHHS operates 11 multi-service centers, 4 health centers, 14 WIC (Women, Infants and Children nutrition program) sites, the Harris County Area Agency on Aging, a comprehensive regional reference laboratory, and 44 health and human service programs.

Intervention(s): The interventions for this new colorectal cancer (CRC) awareness and screening (COCAS) project are to provide CRC screening for 500 individuals/year in DY4 and 5, for each of the two target geographic areas; in twelve spatially identified, primarily African American, high risk zip codes. It will involve: 1) Awareness raising small media campaign utilizing culturally appropriate messages, 2) CRC Education about Screening Guidelines and Recommendations, 3) Access to Community wide Non-invasive FIT testing, 4) Test taking training, 5) Testing by nationally accredited laboratory, 6) Sharing of test results, communication and Follow up protocol, and 7) Patient Care Navigation for getting individuals situated in a medical home in the targeted zip codes.

Need for the Project: Screening for CRC can test for disease in early stages before symptoms occur. This can prevent morbidity and mortality due to CRC. Significant disparities exist in CRC outcomes with low income, minorities having the poorest outcomes. Screening rates for CRC by a population level, non-invasive method (FOBT) is low in Harris County. This project aims to increase screening rates through a comprehensive program in high risk zip codes.

Target Population: The target population for this project are 50-75 year old men and women (in keeping with the screening guidelines) in twelve high risk zip codes (with previously identified age adjusted spatial clusters of late stage CRC diagnosis) indicating lack of timely screening.

Category 1 or 2 expected patient benefits: Increase number of patients in defined population receiving innovative intervention consistent with evidence-based model by 5% in DY4 and by 10% in DY5.

Category 3 outcomes: IT- 12.3 Increase Colorectal Cancer Screening in target population by 2% over baseline in DY4 and by 5% over baseline in DY5. IT- 11.3 Improve by 5% over baseline utilization rates of clinical preventive services (testing, preventive services) in target population with identified disparity in DY 4 and by 10% over baseline in DY5 .

Project Option 2.7.1 Implement innovative evidence-based strategies to increase appropriate use of technology and testing for targeted populations- The Colorectal Cancer Awareness and Screening (COCAS) project

Unique Project ID: 0937740-08.2.8 / Pass 2
Performing Provider: City of Houston Department of Health and Human Services/ 0937740-08.2.8

Project Description:
The Colorectal Cancer Awareness and Screening (COCAS) project aims to increase colorectal cancer screening rates by 5% over baseline in previously identified high risk zip codes among 50-75 year old males and females using FOBT and alleviate health disparities in CRC outcomes. Regular screening FOBT can reduce colorectal cancer deaths by 15-33% [1-3].

Community based cancer prevention interventions are categorized as one or a combination of the following: access to screening, mass media, small media, one on one and small group education, or a combination of these. The COCAS project will achieve its objectives by providing the following: 1) Awareness small media campaign utilizing culturally appropriate messages, 2) CRC Education about Screening Guidelines and Recommendations, 3) Access to Community wide Non-invasive FIT testing, 4) Test taking training, 5) Testing by nationally accredited laboratory, 6) Sharing of test results, communication and Follow up protocol, and 7) Patient Care Navigation for getting individuals to situated in a medical home in the targeted zip codes.

Colorectal cancer (CRC) is the third most common cancer and the third leading cause of cancer death in both men and women in the United States[4]. Despite a steady decline in overall cancer incidence and mortality rates[5,6], an estimated 141,210 new cases of colorectal cancer and 49,380 deaths from this disease are expected to occur in 2011. Certain cancers in minority groups have failed to decline[4] and relative geographic disparity in certain regions has remained stable[6] .

For 2012, The American Cancer Society's estimates the number of colorectal cancer cases in the United States are for 2012:

- 103,170 new cases of colon cancer
- 40,290 new cases of rectal cancer

The lifetime risk for developing colorectal cancer is about 1 in 20 (5.1%). This risk is slightly higher in men than in women[4].

Disparities in Colorectal Cancer Morbidity and Mortality

Colorectal cancer incidence and mortality show extreme health disparities, with a disproportionate burden occurring in certain minority populations, including African Americans and Alaska Natives.[2,3] The COCAS Project will aim to increase CRC screening at the community level among all individuals in the target zip codes but will particularly focus on African Americans since the greatest disparity in morbidity and mortality are among this population.

Why is screening and early detection important?

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. Current levels of screening in this country lag behind those of other developed countries. It has been estimated that attainment of goals for population colorectal cancer screening could save 18,800 lives per year.[1] The death rate (the number of deaths per 100,000 people per year) from colorectal cancer has been dropping for more than 20 years. There are a number of likely reasons for this. One is that polyps are being found by screening and removed before they can develop into cancers. Screening also allows more colorectal cancers to be found earlier, when the disease is easier to cure. In addition, treatment for colorectal cancer has improved over the last several years. As a result, there are now more than 1 million survivors of colorectal cancer in the United States.

Despite this, Texas falls in the list of States with the lowest screening rates in the country. According to the Behavioral Risk Factor Surveillance system (BRFSS), only 54.1-59.2% of adults aged 50-75 self-reported being up to date with colorectal cancer screening. http://www.cdc.gov/cancer/colorectal/statistics/screening_rates.htm.[7]

In over two decades of research it has been established that screening rates can be improved through a variety of community based and clinic based techniques.[8] (Pasick, Hiatt, & Paskett, 2004). The most effective interventions have combined multiple strategies to achieve the most optimum outcomes.

The COCAS Project will focus on increasing screening and removing barriers to screening among 50-75 year olds through community level evidence based strategies that are culturally appropriate in high risk zip codes. The project will provide materials for an awareness campaign in targeted zip codes, provide small group education, provide access to screening and lab testing facilities and enlist community health workers as patient navigators to connect all enrolled community members access to primary care, preventive care and a medical home. Assistance with enrollment and the effect of the Affordable Care Act on preventive care will be clarified. Those that need follow up care will be connected to a sliding scale (if needed) County facility through their medical home. All enrollees will be referred to a medical home and will be under the care of a medical provider, if they are not already.

United States Preventive Service Task Force (USPSTF) Assessment

Major organizations such as U.S. Preventive Services Task Force, USPSTF, (a group of experts convened by the U.S. Public Health Service), the American Cancer Society, and professional societies, have developed guidelines for colorectal cancer screening. The USPSTF recommends screening for colorectal cancer (CRC) using fecal occult blood testing, sigmoidoscopy, or colonoscopy, in adults, beginning at age 50 years and continuing until age 75 years and grades these screening strategies as an “A”. The USPSTF concludes that, for fecal occult blood testing, flexible sigmoidoscopy, and colonoscopy to screen for colorectal cancer, there is high certainty that the net benefit is substantial for adults age 50 to 75 years . The test used will be High-Sensitivity Fecal Occult Blood Test (FOBT) or Stool Test; or Fecal Immunochemical Test (FIT) Note: There are two types of FOBT: one uses the chemical guaiac to detect blood. The other—a fecal immunochemical test (FIT) uses antibodies to detect blood in the stool.

The COCAS Project will focus on removing barriers to FOBT testing at the community level by providing ready access to education, screening and testing and in encouraging adherence to screening guidelines. National results showed there was capacity to screen everyone in need of colorectal cancer screening within one year using fecal occult blood tests (FOBTs) followed by colonoscopy for those who tested positive.[1,2] Studies have shown that FOBT, when performed every 1 to 2 years in people ages 50 to 80, can help reduce the number of deaths due to colorectal

cancer by 15 to 33 percent (1-3). CDC conducted the study at the national level and in selected states (Colorado, Georgia, Iowa, Maine, Maryland, Massachusetts, Minnesota, Michigan, New Mexico, New York, North Carolina, South Carolina, Ohio, Texas, and Washington). National results showed that it would take five to 10 years to develop the resources to screen everyone as recommended using only colonoscopy or flexible sigmoidoscopy. However, several states had enough resources to screen with these two tests within three years.[1,2]

Target Zip Codes

To locate high risk areas, age-adjusted purely spatial cluster analysis identified twelve statistically significant clusters of CRC incidence. The primary cluster was located in south central Houston, an area referred to as "Sunnyside," a low-income African American community. Adjusting for area-level poverty made little discernible impact on the spatial distribution of these clusters, suggesting that poverty rate did not explain these findings. A similar analysis of late stage diagnosis identified 157 significant clusters across the study area, with the primary cluster again in the Sunnyside area. Adjusting for poverty eliminated all clusters with the exception of clusters in southeast Houston (Sunnyside) area for late-stage diagnosis, suggesting that areas with elevated late-stage CRC incidence were due to high poverty in these areas, with Sunnyside being an exception since factors in addition to poverty appeared to be contributing to the high rates. Significant spatial clustering of incidence appeared during two time intervals within the 13-year span of data. The earlier time period (1996-2001) shows a more widely dispersed arrangement of clusters in south central, southwest, and northwest Houston, with the primary cluster in the Southeast Houston (Sunnyside) area. The latter time period (2002-2007), however, indicates that clustering shifted toward north central and northeast Houston, with the strongest clustering in the northeast (Trinity/Houston Gardens) area

The COCAS Project will focus on these two areas of the city that were identified as having the most significant clustering of late stage diagnosis. The two areas and the corresponding zip codes are Sunnyside – 77021, 77033, 77045, 77047, 77048, 77051, 77054, 77061, 77087; Trinity-Houston Gardens – 77016, 77026, and 77028.

Goals and Relationship to Regional Goals:

The goals of the project are to increase screening rates in high risk zip codes and encourage adherence to screening guidelines in order to alleviate disparities in CRC outcomes in targeted areas.

Project Goals:

This project meets the following regional goals: Increase access to primary and specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their condition, regardless of where they live or their ability to pay.

Challenges:

The performing provider anticipates that there will be challenges in buy-in and recruitment from the target population. There are expected to be challenges in enlisting stakeholders and partners to make the COCAS project a success. Resistance and push back in behavior change regarding preventive care is also expected. The project team will prepare to address these challenges and will have strategies in place to conduct both passive and active recruitment into the COCAS project. The recruitment venues will be expanded to be community wide. Screening kits will be provided and access to testing will be facilitated for those enrolled in the COCAS Project.

5 Year Expected Outcome for Providers and Patients:
The performing provider expects that there will be an increase in screening knowledge, awareness and recommended guidelines. An increase in screening is also expected during this time in the target communities. The impact of the Affordable Care Act and its implications on cancer screening will also unfold during this time and changes are expected that will make available widespread screening in the community.

Starting Point/Baseline:
Baseline rates will be established in year 2-3 of the project. All improvements will be measured against the baseline.

Rationale:
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.

Previous research shows that access to screening and removal of barriers to access are the most effective means of improving screening rates. Assuring that there is appropriate followup after screening is critical for the successful implementation of an intervention.[8]

Project Components:
This project does not have specified components. However, the project will address : 1) Awareness campaign utilizing culturally appropriate messages, 2) CRC Education about Screening Guidelines and Recommendations, 3) Access to Community wide Non-invasive FIT testing, 4) Test taking training, 5) Testing by nationally accredited laboratory, 6) Sharing of test results, communication and Follow up protocol, and 7) Patient Care Navigation for getting enrolled individuals to situated in a medical home in the targeted zip codes.

Unique community need identification numbers that project addresses:
- CN.20 Lack of access to programs providing health promotion education, training and support, including screenings, nutrition counseling, patient education programs
- CN.22 Insufficient access to services that are specifically designed to address racial, ethnic and cultural health care disparities

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
The COCAS Project represents a new initiative because 1) it is a community based population health screening initiative 2) it addresses and aims to alleviate health disparities in CRC morbidity 3) it is targeted to specific geographic areas in the city 4) it aims to use materials and intervention strategies that are culturally appropriate 5) it will be one of the first widespread community screening projects where all aspects of access to screening and removal of barriers is addressed.

Quality improvement procedures will be put in place and lessons learned will be shared. Opportunities to scale up the COCAS project in additional high risk target areas will be examined.

Related Category 3 Outcome Measures:
IT- 12.3 Colorectal Cancer Screening
Improve CRC screening rates utilizing FOBT in targeted areas among individuals enrolled in COCAS
IT- 11.3 Improve utilization rates of clinical preventive services in target population with identified disparities- Improve utilization rates of preventive services (CRC Screening) following established guidelines to reduce disparities.

Reasons /rationale for selecting the outcome measures:

The two outcome measures selected were 1) Improve CRC screening rates at a large scale population level 2) Improve utilization of preventive services according to established guidelines to alleviate health disparities. The COCAS Project will promote FOBT testing at a community level. The national body of experts, USPSTF, has graded CRC Screening utilizing FOBT as "A", the highest rating for an intervention – which indicates that this Taskforce has established FOBT has having a significant net benefit in reducing morbidity and mortality due to CRC. The guidelines suggest that those that have a positive FOBT, will need to get a colonoscopy as a follow-up test to detect polyps or other conditions. Additionally, all those who were screened positive by FOBT have a high likelihood of getting follow-up screening, if needed, within one year since most States have the capacity to complete this.[1,2] Colonoscopy is recommended once every ten years and has some risks associated with it, in addition to being costly. It is not feasible to screen for CRC using colonoscopies at the widespread population level. FOBT is preferable at a widespread community level because of its easy administration, non-invasive nature, low cost and ease of follow-up.

Relationship to Other Projects and Other Performing Providers' Projects: The increase of primary care and specialty care will naturally result in additional ambulatory care encounters for our region patient base. The ambulatory initiatives cover items such as laboratory, PT/OT, social work, etc. and are a necessity of our patients to ensure a comprehensive treatment for access as well as cost avoidance. The Region 3 initiative grid in the addendum reflects all ambulatory operations initiatives.

Plan for Learning Collaborative:
Project results and lessons learned will be disseminated to other members in the regional learning collaborative to share lessons learned and discuss quality improvement strategies. We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system.

Project Valuation:
HDHHS utilized two categories to calculate value for each DSRIP project. The first category is Prioritization and the second is Public Health Impact (see attachment for HDHHS Valuation Tool). HDHHS scored the project on a scale of 1 (poor) to 9 (exceptional) for each of the six factors that comprise the Prioritization category. The Prioritization category includes the following factors: 1) Transformational Impact, 2) Population Served / Project Size, 3) Alignment with Community Needs, 4)Cost Avoidance, 5) Partnership Collaboration, and

6)Sustainability. Each factor was then given a weighted score based on the score rated and a pre-determined percentage weight. The six weighted scores were added to get a composite score for the Prioritization category.

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HDHHS gave the Prioritization score a weight of 50% and the Public Health Impact score a weight of 50% to determine the overall project value for the plan. CRC received a composite Prioritization score of 2.29 and a Public Health Impact score of 2.29.

Burch JA, Soares-Weiser K, St John DJ, et al. Diagnostic accuracy of faecal occult blood tests used in screening for colorectal cancer: a systematic review. *Journal of Medical Screening* 2007; 14(3):132–137. [PubMed Abstract]

PDQ® Cancer Information Summary. National Cancer Institute; Bethesda, Maryland. *Colorectal Cancer Screening—Health Professional*. Date last modified: 09/30/2011. Accessed 12/19/2011.

Ouyang DL, Chen JJ, Getzenberg RH, Schoen RE. Noninvasive testing for colorectal cancer: a review. *American Journal of Gastroenterology* 2005; 100(6):1393–1403. [PubMed Abstract]

American Cancer Society (2012). Cancer Facts and Figures. At www.cancer.org/research/cancerfactsfigures/acspc-031941. Accessed on 12/3/12.

RiesLAG, KosaryCL, HankeyBF, MillerBA, EdwardsBK (eds). SEER Cancer Statistics Review, 1973–1996. National Cancer Institute, Bethesda, MD. 1997.

Schootman,M., Lian, M., Deshpande, A. D., McQueen A., Pruitt, S. L. Jeffe D. B. (2011). Temporal trends in geographic disparities in small area level colorectal cancer incidence and mortality in the United States. Cancer causes and Control. 22:1173-1181.

Centers for Disease Control. Colorectal Cancer Screening Rates. At http://www.cdc.gov/cancer/colorectal/statistics/screening_rates.htm. Accessed on 12/3/12.

Pasick,R. J., Hiatt, R. A., & Paskett, E. D. (2004). Lessons learned from Community-Based Cancer Screening Intervention Research. Promoting Cancer Screening: Lessons learned and Future Directions for Research and Practice. Supplement to Cancer. September 1, 2004, Vol 101 (5); 1146-1164.

<table>
<tr><td>0937740-08.2.8</td><td>2.7.1</td><td colspan="2">N/A</td><td colspan="2">Colorectal Cancer Awareness and Screening Project (COCAS)</td></tr>
<tr><td colspan="4">Performing Provider Name: City of Houston Health and Human Services</td><td colspan="2">TPI - 0937740-08</td></tr>
<tr><td>Related Category 3 Outcome Measures:</td><td>0937740-08.3.12
0937740-08.3.13</td><td>IT-12.3
IT-11.3</td><td colspan="3">Colorectal Cancer Screening
Improve utilization rates of clinical preventive services in target population with identified disparity</td></tr>
</table>

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1 [P-X1]: Project Planning Metric: Engage stakeholders, identify resources and potential partnerships, develop relationships, develop implementation plan Goal: Produce a comprehensive report documenting all points above Data Source: Program Documentation Milestone 1 Estimated Incentive Payment: $184,839.67 **Milestone 2** [P-X2]: Establish baseline screening rates and adherence to screening guidelines in target zip codes. Metric 1[P-X2.1]: Community Assessment data reports Goal: Establish Screening and screening related baseline rates among target population. Milestone 2 Estimated Incentive Payment: $184,839.67 **Milestone 3** [P-X3]: Develop	**Milestone 4** [P-2]. Implement evidence-based innovational project for targeted population Metric 1 [P-2.1]: Document implementation strategy and testing outcomes. Goal: Implement evidence based program to increase screening in target population. Data Source: Performing Provider program materials or other documentation of implementation TBD by Performing Provider. Milestone 4 Estimated Incentive Payment: $155,585.75 **Milestone 5** [P-X3]: Plan evaluation design for innovational evidence based project. Metric 1 [P-X3.1]: Written evaluation plan documentation Goal: Develop systematic plan to evaluate project in order inform scaling of screening intervention project.	**Milestone 8** [I-5]: Identify number of patients in defined population receiving innovative intervention consistent with evidence-based model. Metric 1 [I-5.1]: Increase by 5% over baseline the number of individuals of target population reached. Goal: Increase by 5% over baseline. Data Source: Documentation of target population reached, as designated in the project plan. Milestone 8 Estimated Incentive Payment: $336,731 **Milestone 9** [I-7]: Increase access to disease prevention programs using innovative project option. Metric 1 [I-7.2]: Increased by 5% over baseline number of encounters as defined by intervention (e.g., screenings, education, outreach, etc.) a. Total number of visits for reporting period Data Source: Registry	**Milestone 10** [I-5]: Identify number of patients in defined population receiving innovative intervention consistent with evidence-based model. Metric 1 [I-5.1]: Increase by 10% over baseline the number of individuals of target population reached. Goal: Increase by 10% over baseline. Data Source: Documentation of target population reached, as designated in the project plan. Milestone 10 Estimated Incentive Payment: $324,192.50 **Milestone 11** [I-7]: Increase access to disease prevention programs using innovative project option. Metric 1 [I-7.2]: Increased by 7% over baseline number of encounters as defined by intervention (e.g., screenings, education, outreach, etc.) a. Total number of visits for reporting period

0937740-08.2.8	*2.7.1*	*N/A*	*Colorectal Cancer Awareness and Screening Project (COCAS)*
Performing Provider Name: City of Houston Health and Human Services			*TPI* - 0937740-08
Related Category 3 Outcome Measures:	***0937740-08.3.12*** ***0937740-08.3.13***	*IT-12.3* *IT-11.3*	*Colorectal Cancer Screening* *Improve utilization rates of clinical preventive services in target population with identified disparity*

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
culturally appropriate targeted materials for increasing awareness of CRC screening. Metric 1 [P-X3.1]: Plans and evidence of development of targeted materials. Goal: Development and adaptation of materials to be used for awareness building Milestone 3 Estimated Incentive Payment: $184,839.67	Milestone 5 Estimated Incentive Payment: $155,585.75 **Milestone 6** [P-3]: Execution of learning and diffusion strategy for testing, spread and sustainability. Metric 1 [P-3.1]: Document learning and diffusion strategic plan Goal: Diffusion of knowledge and strategy communicated over certain channels. Data Source: Performing Provider documentation of learning and diffusion strategy of implementation Milestone 6 Estimated Incentive Payment: $155,585.75 **Milestone 7** [P-4]. Milestone: Execution of evaluation process for project innovation. Metric 1 [P-4.1]: Document evaluative process, tools and analytics. Data Source: Performing Provider documentation of implementation of evaluation	Milestone 9 Estimated Incentive Payment: $336,731	Data Source: Registry Milestone 11 Estimated Incentive Payment: $324,192.50

0937740-08.2.8	*2.7.1*	*N/A*	*Colorectal Cancer Awareness and Screening Project (COCAS)*
Performing Provider Name: City of Houston Health and Human Services			*TPI* - 0937740-08
Related Category 3 Outcome Measures:	***0937740-08.3.12*** ***0937740-08.3.13***	*IT-12.3* *IT-11.3*	*Colorectal Cancer Screening* *Improve utilization rates of clinical preventive services in target population with identified disparity*

Year 2 (10/1/2012 – 9/30/2013)	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: Develop and implement an evaluation plan. Milestone 7 Estimated Incentive Payment: $155,585.75		
Year 2 Estimated Outcome Amount: $554,519	Year 3 Estimated Outcome Amount: $622,343	Year 4 Estimated Outcome Amount: $673,462	Year 5 Estimated Outcome Amount: $648,385
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundles amounts over DYs 2-5)***:**$2,498,709			

Project Option 2.19 Develop Care Management Function that integrates primary and behavioral health needs of individuals- Integrated Services for the Homeless

Unique Project ID: 0937740-08.2.9 / Pass 2

Performing Provider Name/TPI: Houston Department of Health and Human Services/0937740-08

Project Summary: Provider: The performing provider, Houston Department of Health and Human Services (HDHHS) is the public health authority for Houston, Texas with a population of 2.1 million in 2010. HDHHS has 1,100 employees and a budget of $100,245,403. HDHHS serves the City of Houston through 44 distinct programs. HDHHS provides core public health services to all Houston residents such as air and water quality monitoring and restaurant inspections; birth and death certificates; leadership in emergencies such as hurricanes; operates a comprehensive regional reference laboratory, provides communicable disease prevention and control services and disease surveillance and a variety of health and human services such as the Women, Infants and Children (WIC) nutrition program, senior nutrition services, family planning, oral health services and immunizations via a network of 4 health centers, 14 WIC sites and the Harris County Area Agency on Aging.

Intervention(s): This new Homeless project will serve 200 individuals who are chronically homeless and offer comprehensive service integration intervention. This project will implement its comprehensive five step intervention for the homeless involving 1) permanent housing supportive model 2) program service linkages 3) physical and behavioral health needs 4) financial support 5) other services.

Need for the Project: There is a great need for an integrated system of care for the homeless. There are at least 2000 chronically homeless individuals in Houston according to the last count performed by the Homeless Coalition. People experiencing chronic homelessness have the following characteristics: 1) typically male (79-86%) and middle age (60% are 35-54), 2) 63% unsheltered, 3) almost 100% with presence of disabilities & frequently multiple disabilities at once and 4) frequently use emergency rooms, hospitals, mental health services, veterans' services, substance abuse detoxification and treatment, and criminal justice resources. (Chronic Homelessness Policy Solutions, Chronic Homelessness Brief March 2010, National Alliance to End Homelessness).

Target Population: The project targets individuals with histories of mental illness, addiction, complicated medical problems and meet HUD's definition of chronic homelessness and frequent users of hospitals and crises response systems.

Category 1 or 2 expected patient benefits: Increase patient/target population utilization rates of each aspect of program (Housing, program services, physical and behavioral needs, financial services and other services) by 2% over baseline in DY4 and by 5% over baseline in DY5.

Category 3 outcomes: IT-9.4 Other Outcome Improvement Target - Reduce non emergent ED usage in program participants by 5% over baseline in DY4 and by 10% in DY 5.

Project Option 2.19.2: (Other) Develop Care Management Function that integrates primary and behavioral health needs of individuals- Integrated Services for the Homeless

Unique Project ID: 0937740-08.2.9 / Pass 2
Performing Provider Name/TPI: City of Houston Department of Health and Human Services/0937740-08

Project Description:

HDHHS proposes a comprehensive project to integrate evidence based and best practice models such as Housing First to reduce chronic homelessness and associated health and other public system costs.

The project will strive to create an integrated system of care that will effectively house and provide supportive services to homeless individuals. Evidence based programs and practices (described in program components below) will be implemented and linked with permanent supportive housing in order to permanently house homeless individuals and subsequently engage them in intensive supportive services. Investments in this model of service will ultimately result in reduced health care and other public system costs to the community and increased housing stability. A collaborative partnership will be developed between the Mental Health Mental Retardation Authority in Houston, the City of Houston Housing & Health Departments, and the Houston and Harris County Housing authorities to develop, fund and implement a demonstration project that provides permanent housing and supports to 200 individuals who are chronically homeless. Housing units will be linked to intensive supportive services that are tailored to individual needs of the participants served by the project.

Need for project

Housing and Urban Development's (HUD) definition of chronic homeless is four or more episodes of homelessness within the past three years or one or more current consecutive years of homelessness. In addition, the individual must have a disabling condition which makes daily activities difficult (e.g. medical, psychological, substance abuse). As reported by the Houston Homeless Coalition, over one in three (34.4%) or 1315 individuals of the 3824 unsheltered homeless people who were counted in the Point in Time (PIT) enumeration conducted in Houston in 2012 met HUD's definition of chronic homeless.

Among those in emergency shelters, transitional housing, or safe haven on the night of the PIT count, one in four (25.7%) or 745 individuals of the 2902 sheltered homeless was classified as a chronically homeless individual. Additional data obtained on those staying in shelters that night show that 12.9% had severe mental illness and 21.4% were chronic substance abusers. The PIT count indicates there at least 2000 homeless individuals in Houston/Harris County who meets HUDs definition of chronic homeless.

Research has shown that many chronically homeless people have disabilities such as serious mental illness, chronic substance use disorders, or chronic medical issues and are homeless repeatedly or for long period of time. People experiencing chronic homelessness have the following characteristics: 1) typically male (79-86%) and middle age (60% are 35-54), 2) 63% unsheltered, 3) almost 100% with presence of disabilities & frequently multiple disabilities at once and 4) frequently use emergency rooms, hospitals, mental health services, veterans' services, substance abuse detoxification and treatment, and criminal justice resources. (Chronic Homelessness Policy Solutions, Chronic Homelessness Brief March 2010, National Alliance to End Homelessness). Early engagement in appropriate services to address the multiple conditions for many of these indigent individuals, as well as their needs for housing and social support,

requires both behavioral health case managers and chronic disease care managers working closely to make service settings accessible and to track progress in this target group.

Some of the models that will be adapted for this demonstration project include the Corporation for Supportive Housing Frequent Users Systems Engagement (FUSE) model, Housing First, SOAR and ACT and Integrated Health Care for this project.

The FUSE process (http://www.csh.org/csh-solutions/community-work/systems-change/fuse/) will be utilized to guide the effort toward system integration. FUSE helps communities break the cycle of incarceration and homelessness among individuals with complex behavioral health challenges. The three components of the FUSE model include 1) data-driven problem solving, 2) policy and systems reform and 3) targeted housing and services. Implementation of the model will result in identification and engagement of frequent users of multiple systems (jails, homeless shelters and crisis health services, tracking and measuring of outcomes/impacts and cost-effectiveness, policy & system reforms through the work of an interagency, multi-sector work group and implementation of a Housing model that will lead to increased housing stability and reduced system costs.

Target Population

The project will target individuals with histories of mental illness, addiction, complicated medical problems and meet HUD's definition of chronic homelessness and are frequent users of hospitals and crises response systems.

This integrated program for the homeless individuals will comprise of 1) housing, 2) program services 3) physical and behavioral medical needs 4) financial support and 5) other needs.

1) Housing

The project will use a permanent supportive housing model using the Housing First approach (http://www.seattle.gov/housing/homeless/HousingFirst.htm)as the primary solution. This intervention moves people off the street or out of temporary shelter into stable, affordable housing and combines housing with supportive treatment services in the areas of mental and physical health, substance abuse, education, and employment. Evaluations of permanent supportive housing have demonstrated significant improvements in housing stability, reduction in days of homelessness, and reductions in the utilization and costs of public services such as emergency shelter, hospital emergency room and inpatient care, sobering centers and jails. The Housing First model has been demonstrated to be effective for people with co-occurring psychiatric and substance use disorders who are homeless. The model provides a stable living environment in which various needed psychiatric services and other medical services can be delivered.

2) Program Services

Linking services with the permanent housing model is essential to achieve housing stability and to realize savings in the public systems of care. Behavioral health services will include Assertive Community Treatment services, crisis intervention and other intensive case management services. ACT is a self-contained program that serves as the fixed point of responsibility for providing treatment, rehabilitation and support services to identified consumers with severe and persistent mental illnesses and substance abuse. Using an integrated services approach, an ACT team merges clinical and rehabilitation staff expertise, e.g., psychiatric, substance abuse, employment, and housing within one mobile service delivery system. ACT team members include psychiatrists, licensed mental health professionals, registered nurses, supported employment specialists and supported housing specialists.

3) Physical and Behavioral Health Needs

Program design is inclusive of service coordination, rehabilitative services, psychiatric services, nursing services, medication management, housing support, substance abuse treatment, and vocational services. The ACT team also works with families to provide education and support. Services are need-based vs. time-limited and provided in the consumer's natural environment (i.e. permanent supported housing) the majority of the time. Services provided by an ACT team are focused on reduction of hospitalization and include outreach, engagement and stabilization. The ACT will be responsible for crisis services, hospital admissions and discharge planning.

Programs of Assertive Community Treatment have been around since the early 1970s. The original model developed by Arnold Marx, M.D., Leonard Stein, M.D., and Mary Ann Test, Ph.D., in Madison, Wisconsin, was intended to demonstrate the effectiveness of providing comprehensive services delivered by a multi-disciplinary team to persons who had not responded to traditional mental health service approaches. Assertive Community Treatment (ACT) teams in Texas represent a system wide replication of the National Alliance for the Mentally Ill endorsed Program for Assertive Community Treatment (PACT) model.

The team will implement the Dartmouth or similar model for providing health care through the use of a multi-disciplinary team approach.

4) Financial Support

SOAR is a federal program that helps states and communities increase access to Social Security disability benefits for people who are homeless or at risk of homelessness and who have mental illnesses or other co-occurring disorders. The initiative does this by creating collaborative partnerships between state and federal agencies that allow case managers and clients to more easily navigate the SSI/SDDI application process. Team members who provide case management and navigation support on the care team will be trained in SOAR to increase the number of successful applications for public benefits. Without the assistance of the SOAR program only 10-15% of homeless populations have their disability applications approved. Overall those using the SOAR process have an overall SSI/SSDI application approval rate of 71%.

5) Other services

Other services that will be provided for participants include meetings with extended family, reinforcement of coping skills, assistance in determining appropriate family and community supports, linkage into appropriate ongoing services and alumni groups facilitated by peer navigators. The project will use Certified Peer Specialists to assist homeless individuals in the recovery process. Peer Specialists are individuals who are in recovery from a mental illness and who use their lived experience to assist other individuals in their own recovery. Peer specialists provide a variety of peer support services. Their primary asset is the ability to share their story and inspire hope for recovery. (Via project specific website called “Hope”).

Additionally, the project will work to capitalize on new opportunities afforded in the Affordable Care ACT to maximize access and use of Medicaid benefits to improve access to primary care.

Goals and Relationship to Regional Goals:

The goal of the project is to offer a community based service where homeless individuals that have multiple physical and behavioral comorbidities can receive housing, medical and behavioral care, services and referrals to address their needs without being utilizing the ER.

This project meets the following regional goals:

- Increase access to primary and specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their condition, regardless of where they live or their ability to pay.

Challenges:

Some of the challenges anticipated by the program are location of appropriate housing, with either renovation or new construction, access to housing vouchers or other housing funds, attracting qualified providers in adequate numbers, coordinating services across agencies and engaging chronically homeless individuals to participate in the project. These challenges will be met by collaborating with partner agencies, support of local governmental and non-governmental entities and continual quality improvement built into the program. Extensive training and education of the program staff will be implemented to make the program a success. Resistance to buy in from homeless target population will be overcome by using appropriate strategies such as peer trainers and peer support groups.

5 Year Expected Outcome for Provider and Patient:

It is expected that individuals will decrease admissions to inpatient hospitalizations, Individuals will spend majority of their time stably housed, more than half will accrue supportive services cost significantly lower than were accrued prior to program participation, and most will decrease number of days spent in jail. (SAMHSA, National Registry of Evidence Based Programs and Practices)

Starting Point/ Baseline:

Baseline data will be collected during year 2 and 3 of the project

Rationale:

Research has documented cost savings associated with housing and supportive services. These services when coupled not only achieve housing stability but also improve health outcomes and decreases the use of publicly-funded institutions

The Frequent Users of Health Services Initiative was a five-year, $10 million project jointly funded by The California Endowment and the California HealthCare Foundation. The goal of the initiative was to promote the development and implementation of innovative, integrated approaches to addressing the comprehensive health and social service needs of frequent users of emergency departments Researchers found that homeless clients connected to permanent housing had greater reductions in emergency department use and charges compared to those who remained homeless: 34% fewer emergency department visits, 27% fewer inpatient admissions, and 27% fewer inpatient days.

The Chicago Housing for Health Partnership (CHHP) is a “hospital-to-housing” effort that identifies chronically ill homeless individuals at hospitals, moves them to permanent supportive housing, and provides them with intensive case management services so that they can maintain their health and secure long-term housing stability. The Intervention Group participants had high rates of long-term substance abuse (86 percent), mental illness (46 percent), and medical issues such as HIV/AIDS (34 percent), and hypertension (33 percent), as well as a number of other chronic medical illnesses such as diabetes and cancer. The intervention group had a relative reduction of 29% in hospitalizations, 29% in hospital days, and 24% in emergency department visits.

The Denver Housing First Collaborative (DHFC) The DHFC is designed to provide comprehensive housing and supportive services to chronically homeless individuals with

disabilities. The program uses a housing first strategy combined with assertive community treatment (ACT) services, providing integrated health, mental health, substance treatment and support services. A cost-benefit analysis of the program documented an overall reduction in emergency service costs for the sample group. The total emergency related costs for the sample group declined by 72.95 percent, or nearly $600,000 in the 24 months of participation in the DHFC program compared with the 24 months prior to entry in the program. The total emergency cost savings averaged $31,545 per participant. In addition to saving taxpayers money, the local and national evaluations of the DHFC program document overall improvement in the health status and residential stability of program participants. Fifty percent of participants had documented improvements in their health status, 43 percent had improved mental health status, 15 percent had decreased their substance use, and 64 percent had improved their overall quality of life. Furthermore, the overall quality of life for the community improved as the negative impacts of individuals living and sleeping on the streets were reduced.

Project Components:

This project does not have any specified project components. However, the project will achieve its goals by a comprehensive package consisting of the following, depending on the specific needs of the target population:

- Linking Participants with Housing
- Program Services
- Behavioral and Physical Health Needs
- Financial Services
- Other services

Unique community need identification numbers the project addresses:

The Integrated Mental Health with Housing First initiative also addresses the issues addressed in the following community needs assessments:

- CN.6 Inadequate access to treatment and services designed for special needs populations, including disabled, homeless, children, elderly.[2,3]

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

Although various models exist to meet the needs of an indigent population, this program adopts and adapts critical elements of many of these evidence based programs (described in the narrative) to improve health and social outcomes in the homeless populations enrolled in this program. Additionally, the program is also innovative because it utilizes peer trainers who can provide a unique perspective and help new program enrollees achieve success in program outcomes.

<u>Related Category 3 Outcome Measures:</u>

IT-9.4- Other Outcome Improvement Target

Indigent homeless individuals typically suffer from multiple comorbidities. Along with physical health problems many, if not most also suffer from mental health conditions. These comorbidities and the resulting poor health is compounded by their unstable living conditions. We chose to measure non-emergent inappropriate ED use as our outcome measure. By providing a comprehensive set of services through our program for those enrolled including access to physical (primary care) and behavioral providers and addressing their housing needs, we expect reduced ED use in these individuals.

According to a recent study from 2010, homeless people who seek care in urban EDs come by ambulance, lack medical insurance, and have psychiatric and substance abuse diagnoses

more often than non-homeless people. The high incidence of repeat ED visits and frequent hospital use identifies a pressing need for policy remedies. Compared with others, ED visits by homeless people were four times more likely to occur within three days of a prior ED evaluation, and more than twice as likely to occur within a week of hospitalization. This indicates the need to address the frequent inappropriate ED use by the homeless population at greater numbers than others. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2848264/

Relationship to Other Projects and Other Performing Providers' Projects: The cohabitation of primary care and behavioral health is an important focus of our region in order to treat the patient base with comprehensive physical and behavioral healthcare issues. There are multiple initiatives in our RHP plan that address this need and all can be found on the Region 3 Initiative Grid in the addendums. The outcome measures focused to screening measures and access of the patient base.

Plan for Learning Collaborative: We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system.

Project valuation: HDHHS utilized two categories to calculate value for each DSRIP project. The first category is Prioritization and the second is Public Health Impact (see attachment for HDHHS Valuation Tool). Consistent with other participants in the regional partnership, HDHHS scored the project on a scale of 1 (poor) to 9 (exceptional) for each of the six factors that comprise the Prioritization category. The Prioritization category includes the following factors: 1) Transformational Impact, 2) Population Served / Project Size, 3) Alignment with Community Needs 4)Cost Avoidance 5) Partnership Collaboration and 6)Sustainability. Each factor was then given a weighted score based on the score rated and a pre-determined percentage weight. The six weighted scores were added to get a composite score for the Prioritization category. Public Health includes activities which seek to achieve the highest level of health for the greatest number of people. Public Health also focuses on preventing problems from happening or re-occurring through programs and activities that promote and protect the health of the entire community. As a public health department, HDHHS added an additional valuation category of Public Health Impact that looked at projects through a public health lens. The Public Health Impact category includes the following factors: 1) Alleviate Health Disparity, 2) Control Communicable and Chronic Disease , 3) Prevention Orientation, 4) Population Health Focus, 5) Access and Connection to Health Services and 6) Evidence Based Health Program. HDHHS scored the project on a scale of 1 (poor) to 9 (exceptional) for each of the six factors that comprise the Public Health Impact category. Each factor was then given a weighted score based on the score rated and a pre-determined percentage weight. The six weighted scores were added to get a composite score for the Public Health Impact category.

HDHHS gave the Prioritization score a weight of 25% and the Public Health Impact score a weight of 75% to determine the overall project value for the plan. The Integrated Services for the Homeless Program received a composite Prioritization score of and a Public Health Impact score of 50%.

0937740-08.2.9	2.19.2	N/A	PROJECT TITLE: Integrated Mental Health with Housing First
Performing Provider Name: City of Houston Health and Human Services		TPI – 0937740	
Related Category 3 Outcome Measure(s):	0937740-08.3.14	IT-9.4	Other Outcome Improvement Target

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1 [P- X1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Metric 1 [P-X1.1]: Document plan as described above Goal: Plan all elements of project in order to Milestone 1 Estimated Incentive Payment: $807,160.14 **Milestone 2** [P-2]: Identify community agencies that have the relevant data to identify the service utilization patterns of persons with co-occurring disorders. Metric 1 [P-2.1]: Listing of relevant agencies and the data elements each has available. Goal: Identify partners for data sharing Data Source: Records of lead organization	**Milestone 4** [P- X2]: Develop and test data systems Metric 1 [P-X2.1]: identify, select and test data system Goal: Implement efficient data system for project Data Source: Project documentation Milestone 4 Estimated Incentive Payment: $1,358,827.18 **Milestone 5** [P-X3]: Implement community-based specialized interventions for homeless populations based on evidence based best practice models to include: • Transition assistance – assistance to establish a basic housing and household • Transportation to appointments and community-based activities; • Assertive Community Therapy • Prescription medications; • Certified Peer Specialists support Metric 1 [P-X3.1]: Evidence of	**Milestone 6** [I-X1]: Describe and document Target population (homeless) reached Metric 1 [I-X1.1]: Increase the number of target population reached Baseline: Number of homeless individuals enrolled in data system Data Source: Program data and EHR Milestone 6 Estimated Incentive Payment: $1,470,441 **Milestone 7** [I-X2]: Changes in patient/target population utilization rates of each aspect of program (Housing, program services, physical and behavioral needs, financial services and other services) Metric 1 [I-X2.1]: Document changes in rates of utilization of services Baseline: Establish baseline of average times used for each service Data Source: Program data documentation, EHR	**Milestone 8** [I-X1]: Describe and document Target population (homeless) reached Metric 1 [I-X1.1]: Increase the number of target population reached by 10% Goal: Number of homeless individuals enrolled in data system increased by 10% Data Source: Program data and EHR Milestone 8 Estimated Incentive Payment: $1,415,687.23 **Milestone 9** [I-X2]: Changes in patient/target population utilization rates of each aspect of program (Housing, program services, physical and behavioral needs, financial services and other services) Metric 1 [I-X2.1]: Document changes in rates of utilization of services Goal: Increase by 5% the average times each service is used. Data Source: Program data

Milestone 2 Estimated Incentive Payment: $807,160.14 **Milestone 3** [P-6]: Care coordination protocols are developed. Metric 1 [P-6.1]: Written protocols are easily available to staff. Goal: Systematic protocols for care coordination Data Source: Written protocols; Project documentation Milestone 3 Estimated Incentive Payment: $807,160.14	implementation of project plans which are based on evidence / experience and which address the project goals Metric 2 [P-X3.2]: Intervention implemented with above elements Goal: Implementation of program according to project plan Data Source: Project plan documentation Milestone 5 Estimated Incentive Payment: $1,358,827.18	Milestone 7 Estimated Incentive Payment: $1,470,441	documentation, EHR Milestone 9 Estimated Incentive Payment: $1,415,687.23
Total Estimate Incentive Bundle Payment for Year 2: $2,421,480	Total Estimate Incentive Bundle Payment for Year 3:$2,717,654	Total Estimate Incentive Bundle Payment for Year 4: $2,940,883	Total Estimate Incentive Bundle Payment for Year 5: 2,831,374
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***: $**10,911,392			

City of Houston Department of Health and Human Services

Pass 3

2.12.3: Implement/Expand Care Transitions Programs, "Other" project option to reduce the incidence of hospital readmissions within 30 days of discharge of Medicare Fee For Service and Dual Eligible individuals that are hospitalized resulting from the following chronic diseases; Heart Failure (HF), Acute Myocardial Infarct (AMI) Pneumonia (PNE).

Unique Project ID: 0937740-08.2.1

Performing Provider Name/TPI: City of Houston Department of Health and Human Services/0937740-08

Project Summary: Provider: The performing provider, Houston Department of Health and Human Services (HDHHS) is the public health authority for Houston, Texas, the fourth largest city in the U.S., with a population of 2.1 million in 2010. Established in 1840, HDHHS has grown to a department of 1,100 employees. HDHHS provides core public health services to all Houston residents such as air and water quality monitoring; restaurant inspections; lead paint safety; cancer screening and family planning for the uninsured; communicable disease prevention and control; disease surveillance; birth and death certificates; leadership in emergencies such as hurricanes; services to seniors; WIC programs; immunizations; and others. HDHHS operates 11 multi-service centers, 4 health centers, 14 WIC (Women, Infants and Children nutrition program) sites, the Harris County Area Agency on Aging, a comprehensive regional reference laboratory, and 44 health and human service programs. While HDHHS provides services that benefit all Houston residents, the department also takes additional steps to support those most in need, such as low income mothers and children, the elderly, and minority populations.

Intervention(s): This expansion project, modeled after an existing Coleman Transitions Intervention , utilizes case managers, coaches and navigators to improve transitions of patients from the inpatient hospital setting to other care settings, improve quality of care, reduce avoidable readmissions for high risk heart failure beneficiaries and document measurable savings to the Medicare program.

Need for the Project: Many Medicare patients discharged from an inpatient return to the hospital within 30 days. Nearly one in five Medicare patients discharged from a hospital—approximately 2.6 million seniors—is readmitted within 30 days, at a cost of over $26 billion every year. Many of these hospital readmissions are considered to be avoidable and indicators of poor care or missed opportunities to better coordinate care.

Target Population: The primary target population is at risk patients ages 60 years or older. The majority of clients will be Medicaid or Medicare beneficiaries. This project will expand to additional geographic areas beyond the are covered by the current project.

Category 1 or 2 expected patient benefits: [I-11]: Improve the percentage of patients in defined population receiving standardized care according to the approved clinical protocols and care transitions policies by 5% over baseline in DY4 and by 10% over baseline in DY5.

Category 3 outcomes1 [IT-3.2] Reduce Congestive Heart Failure 30 day readmission rate by 10% over baseline in DY4 and by 25% over baseline in DY5 among individuals that complete the program.

2.12.3: Implement/Expand Care Transitions Programs, "Other" project option to reduce the incidence of hospital readmissions within 30 days of discharge of Medicare Fee For Service and Dual Eligible individuals that are hospitalized resulting from the chronic disease specifically, Congestive Heart Failure (CHF).

Unique Project ID: 0937740-08.2.10 / Pass 3

Performing Provider: City of Houston Department of Health and Human Services/ 0937740-08

Project Description:

The performing provider, Houston Department of Health and Human Services (HDHHS) proposes to implement a program, modeled after Coleman Transitions Intervention to improve transitions of patients from the inpatient hospital setting to other care settings, to improve quality of care, to reduce avoidable readmissions for high risk heart failure beneficiaries, and to document measurable savings to the Medicare program.

Hospitalizations are costly, accounting for approximately 31 percent of total health care expenditures. Many Medicare patients discharged from an inpatient return to the hospital within 30 days. In Medicare, inpatient care accounts for 37 percent of spending, and readmissions contribute significantly to that cost: Nearly one in five Medicare patients discharged from a hospital—approximately 2.6 million seniors—is readmitted within 30 days, at a cost of over $26 billion every year. Some of these readmissions are planned, and others may be part of the natural course of treatment for specific conditions; but, increasingly, some hospital readmissions are considered to be avoidable and indicators of poor care or missed opportunities to better coordinate care.

Hospital readmissions may be prevented. With nearly one in five Medicare patients returning to the hospital within a month of discharge, the government considers readmissions a prime symptom of an overly expensive and uncoordinated health system. Multiple factors contribute to avoidable hospital readmissions: they may result from poor quality care or from poor transitions between different providers and care settings. Likewise, such readmissions may occur if patients are discharged from hospitals or other health care settings prematurely, are discharged to inappropriate settings, or do not receive adequate information or resources to ensure continued progression. A lack of system factors, such as coordinated care and seamless communication and information exchange between inpatient and community-based providers, may also lead to unplanned readmissions. Hospital readmissions may adversely impact payer and provider costs and patient morale. Repeated hospital admissions may also demoralize patients and leave them feeling lost and confused.

CMS has recognized that it is important for the medical community to work collaboratively with community based organizations and other local service providers to address hospital readmissions. This performing provider will expand upon a partnership with The Methodist Hospital part of the Methodist Hospital System (TMHA) to expand a Community Care Transitions Program (CCTP) using the Coleman Care Transitions evidence based model. The will performing provider conducts an existing CCTP project.

Recruitment strategy and program promotion-All hospital staff will receive oral and written communication through hospital leadership such as the Chief Operating Officer and the Chief Nursing Officer regarding the hospital care transitions program. Physicians, nurses, social workers, and other professionals will be encouraged to flag any patient with CHF so that the Transitions Coach can formally invite them to participate in the program. Physicians and staff nurses will be given direction on how to share the program benefits with patients. Program notification and beneficiary communication materials will be posted and distributed throughout the hospital.

Families of admitted patients will receive information about this program as part of the admission process. Visual displays describing the program will be posted in the inpatient areas and Emergency Room so that patients and/or families are prompted to ask questions. A "Fast-Facts" explaining the program will also be sent to physicians with hospital privileges who admit patients from the community, describing the benefits of the program and encouraging their identification of Medicare patients who may be eligible. This communication method will also be used to update physicians regarding the results of the program. When qualified patients are identified as not enrolling in the program, an analysis will be done to identify methods that may be employed in the future to facilitate enrollment. Additionally, hospital staff will receive reminders about the program at regularly scheduled monthly service line staff meetings.

If a patient who is a Medicare and/or Medicaid beneficiary or an at risk 60 year old or older and is admitted to the hospital with an diagnosis of CHF and it is determined by the hospital that the patient is at high risk for readmission, the patient will be asked if they are interested in participating in the Care Transitions Program (CTP). Participants will be placed in a Tier System based on the level of need and physical impairment. Social Workers/Case Managers will be trained to be Coaches in the Care Transitions Intervention to assist patients. A Social Worker/Case Manager team lead will triage Coaches based on the Tier system. Tier 1 will address the most critical needs. This team will consist of Coaches only. Tier 2 will address intermediate needs. This team will consist of a Coach with assistance from a Navigator. Tier 3 will address minimal needs. If necessary, the Navigator will consult with a Coach. Coaches will work with Navigators when necessary based on the Tier system. Navigators will assist with information, referral and assistance and activities of daily living in the home if needed.

Cost savings to the Health Care system and CMS are projected at $864,000, $1,296,000 and $1,728,000, $2,160,000 for years 1,2,3 and 4 respectively.

It is important to note that this cost savings is only derived based on the anticipated reduction in readmissions, and does not include expected savings from other reductions or changes in patient utilization patterns; the performing provider considers this to be a conservative estimate of the real savings and efficiencies the CCTP program will achieve.

The recruitment strategy is as follows:
The case manager/discharge planner in the hospital will assess whether the CHF patient is a good candidate for the program. If the patient is at risk for readmission, a referral will be sent to the Coach by the case manager/discharge planner. The Coach will ask the patient if they want to participate in the program and explain the four pillars of the Coleman Transitions Intervention . If the patient agrees to participate, consent will be obtained.

The hospital case manager/discharge planner will consult with the Coach 48 hours before discharge to ensure a smooth transition from the hospital to the home setting. The Coach will visit the patient to review the four pillars in more depth, arrange a home visit for 48-72 hours post-discharge and a post-discharge follow up doctor's visit will be set. The Coach and hospital case manager/discharge planner will review the patient's discharge plan to determine if any in-home or ancillary services such as home delivered meals, personal care or Benefits Counseling provided by the Harris County Area Agency on Aging (HCAAA) or other organizations are needed. These items will be noted and discussed with the patient prior to discharge. When the caller returns home, the Coach will contact the patient or family member 48-72 hours after discharge to solidify the time of the home visit. During the initial home visit, the Coach will help the patient complete the PHR. The Medication Discrepancies tool will also be completed.

When it is determined that supportive services such as emergency response, in-home respite, medication management, home delivered meals, personal assistance services, transportation and/or longer term Care Management are needed to facilitate patients' compliance with discharge orders and optimize patient recovery, the services will be coordinated and/or provided by the Harris County Area Agency on Aging and the Care Connection Aging and Disability Center. The Coach will make two follow up phone calls on days seven and 14 to reinforce the four pillars of the CTI. On Day 30, the Transitions Coach will administer the Care Transitions and Patient Activation Measures. Follow up will be conducted Days 60, 90 and 180 to ensure ongoing adherence to the four pillars, discharge plan, ensure that the patient has secured a medical home and to determine if the patient has been readmitted to the hospital within the 180 day period after discharge.

Patients with congestive heart failure and with the strongest positive association with readmission were discharged against medical advice and covered by Medicaid had more severe loss of function and certain comorbidities such as drug abuse, renal failure, or psychoses.[1] Additionally, nearly one in five Medicare patients discharged from a hospital—approximately 2.6 million seniors—is readmitted within 30 days, at a cost of over $26 billion every year. CMS sites $9600 as average cost of hospital admission and readmission.

- The performing provider in partnership with TMHS-TMC will enroll 75 patients per month in DY3 with a projected completion rate of 45 per month and a 25% reduction in readmission;
- 100 patients per month will be enrolled in DY4 with a projected completion rate of 60 per month and a 25% reduction in readmission;
- 125 patients per month will be enrolled in DY5 with a projected completion rate of 75 per month and a 25% reduction in readmission;

Goals and Relationship to Regional Goals:

The goals of the project are to expand existing Community Care Transitions project/strategies through partnership with Methodist Hospital and

- reduce 30 day readmissions rates of Medicare FFS and Dual Eligible CHF patients
- maintain or improve quality of care
- document measureable savings to the Medicare program

The CCTP project meets the following regional goal by reducing readmissions: Transform health care delivery from a disease-focused model of episodic care to a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary or duplicative services, and builds on the accomplishments of our existing health care system,

Project Goals:

The goals of the CCTP are to improve transitions of beneficiaries from the inpatient hospital setting to other care settings, to improve quality of care, to reduce readmissions for high risk beneficiaries, and to document measurable savings to the Medicare program

Expected Outcomes:

Implement CCTP strategies to address factors that contribute to avoidable hospital readmissions and will reduce incidence of hospital readmissions of patients with diagnosis of PNE, HF or AMI.

Baseline Data:

Baseline data will be collected from CMS *Hospital Compare* readmission rates. Program baseline will be established in DY 3.

Community Needs Assessment

This project meets the following community needs assessments.

CN.9: High rates of preventable hospital readmissions

CN.7: Insufficient access to care coordination practice management and integrated care treatment programs.

Challenges:

The performing provider anticipates that there will be challenges in buy-in and recruitment from the target population. Other anticipated challenges are patient education for minimally educated and linguistically isolated patients, incentivizing patients to commit to the program in total (as some patients will agree to participate while hospitalized, but due to day to day stressors of this population will not follow through with program post discharge), home based care for patients with limited family support.

By leveraging the performing provider's experience and established networks in serving low income population, this program will benefit from these experiences. Program processes will be refined and improved through a Plan-Do-Check-Act process. The goal of continuous quality improvement is to establish a cyclical, continuous process of planning, assessing, monitoring, analyzing, measuring and evaluating performance to improve desired outcomes. It is expected that revisions to the protocol, training requirements, partnership processes and expectations will need to be clarified on a regular basis. These will be improved through the PDSA process. Initial program enrollment of a small number of target population will help iron out the program weaknesses and allow for a continuous improvement process.

Related Category 3 Outcome Measures:

IT-3.2 Congestive Heart Failure 30 day readmission rate

Reasons/rationale for selecting the outcome measures:

Heart failure is associated with high rehospitalization rates, often due to preventable complications resulting from patients' inability to adequately self-manage the condition and poorly implemented transitions to the next care setting. Programs that provide adequate guidance at discharge, appropriate medication management, and appropriate follow-up with patients during times of transition can reduce readmission rates and improve quality of care. Therefore reduced rehospitalization was chosen as the outcome measure.

(http://www.innovations.ahrq.gov/content.aspx?id=2206).

Relationship to Other Performing Providers' Projects and Plan for Learning Collaborative:

We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system.

Healthcare costs are significantly increased within a patient base with such aggressive chronic conditions that have gone untreated. The initiatives focused to chronic disease management focus to conditions such as asthma, hypertension, and diabetes and are similar in the approach of managing & proactively treating chronic conditions in order to reduce 30-day readmission rates, inappropriate emergency department utilization, and healthcare costs. The Region 3 Initiative grid allows a cross reference of initiatives associated with chronic disease management. (addendum)

Project valuation:

HDHHS utilized two categories to calculate value for each DSRIP project. The first category is Prioritization and the second is Public Health Impact (see attachment for HDHHS Valuation Tool). Consistent with other participants in the regional partnership, HDHHS scored the project on a scale of 1 (poor) to 9 (exceptional) for each of the six factors that comprise the Prioritization category. The Prioritization category includes the following factors: 1) Transformational Impact, 2) Population Served / Project Size, 3) Alignment with Community Needs 4)Cost Avoidance 5) Partnership Collaboration and 6)Sustainability. Each factor was then given a weighted score based on the score rated and a pre-determined percentage weight. The six weighted scores were added to get a composite score for the Prioritization category.

Public Health includes activities which seek to achieve the highest level of health for the greatest number of people. Public Health also focuses on preventing problems from happening or re-occurring through programs and activities that promote and protect the health of the entire community. As a public health department, HDHHS added an additional valuation category of Public Health Impact that looked at projects through a public health lens. The Public Health Impact category includes the following factors: 1) Alleviate Health Disparity, 2) Control Communicable and Chronic Disease , 3) Prevention Orientation, 4) Population Health Focus, 5) Access and Connection to Health Services and 6) Evidence Based Health Program. HDHHS scored the project on a scale of 1 (poor) to 9 (exceptional) for each of the six factors that comprise the Public Health Impact category. Each factor was then given a weighted score based on the score rated and a pre-determined percentage weight. The six weighted scores were added

to get a composite score for the Public Health Impact category. HDHHS gave the Prioritization score a weight of 50% and the Public Health Impact score a weight of 50% to determine the overall project value for the plan. The Integrated Services for the Homeless Program received a composite Prioritization score of and a Public Health Impact score of 50%.

0937740-08.2.10	***2.12.3***	***N/A***	***Project Title: Community Care Transition Project (CCTP)***
Performing Provider Name: City of Houston Department of Health and Human Services			*HDHHS* -0937740-08
Related Category 3 Outcome Measures:	*0937740-08.3.16*	*IT-3.2*	*Congestive Heart Failure 30 day readmission*

Year 2 **(10/1/2012 – 9/30/2013)**	Year 3 **(10/1/2013 – 9/30/2014)**	Year 4 **(10/1/2014 – 9/30/2015)**	Year 5 **(10/1/2015 – 9/30/2016)**
Milestone 1 [P –X1]: Plan scope, range, and current capacity and needed resources for the CCTP. Metric 1: CCTP Program Planning Materials, Meeting minutes, Sign-in sheets, Logic Model, Draft Clinical Protocols, Staff Qualifications, Staffing Plan Goal: Produce a comprehensive document identifying results of planning and including information listed above. Data Source: Report developed by project staff. Milestone 1 Estimate Amount: $487,127 **Milestone 2 [P-X2]:** Develop and test Data systems Metric 1: Select, install and test data system Baseline/Goal: Install an efficient and effective data system to capture outcome and process data Data Source: Documentation of installation of data system	**Milestone 3** [P-4]. Milestone: Conduct an assessment and establish linkages with community-based organizations to create a support network for targeted patients post-discharge P-4.1 Metric: Care transitions assessment a. Submission of care transitions assessment and resource planning documents. Goal: Assess and document available resources. b. Data Source: Care transitions assessment and resource planning documents. Milestone 3 Estimated Amount: $368,672 **Milestone 4[P-2**]. Milestone: Implement standardized care transition processes Metric: Care transitions policies and procedures; Submission of protocols, b. Data Source: Policies and procedures of care transitions program materials Goal: Implement program according	**Milestone 6** [I-11]: Improve the percentage of patients in defined population receiving standardized care according to the approved clinical protocols and care transitions policies I-11.1. Metric: Number over time of those patients in target population receiving standardized, evidence-based interventions per approved clinical protocols and guidelines a. Numerator: Number of at risk CHF patients that receive all recommended education, care and services as dictated by approved and evidence based care guidelines. b. Denominator: Number of patients discharged or eligible for CCTP care transition services Goal: Increase the proportion of people receiving CCTP by 5% over baseline. c. Data Source: Program Registry Milestone 6 Estimated Amount: $1,208,631	**Milestone 7** [I-11]: Improve the percentage of patients in defined population receiving standardized care according to the approved clinical protocols and care transitions policies I-11.1. Metric: Number over time of those patients in target population receiving standardized, evidence-based interventions per approved clinical protocols and guidelines a. Numerator: Number of at risk CHF patients that receive all recommended education, care and services as dictated by approved and evidence based care guidelines. b. Denominator: Number of patients discharged or eligible for CCTP care transition services. Goal: Increase the proportion of people receiving CCTP by 10% over baseline. c. Data Source: Program Registry Milestone 7 Estimated Amount: $1,162,511

0937740-08.2.10	***2.12.3***	***N/A***	***Project Title: Community Care Transition Project (CCTP)***
Performing Provider Name: City of Houston Department of Health and Human Services			*HDHHS* -0937740-08
Related Category 3 Outcome Measures:	*0937740-08.3.16*	*IT-3.2*	*Congestive Heart Failure 30 day readmission*

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 2 Estimate Amount: $487,128	to guidelines Milestone 4 Estimated Amount: $368,672 **Milestone 5 [I-11].** Improve the percentage of patients in defined population (at risk CHF) receiving standardized care according to the approved clinical protocols and care transitions policies I-11.1. Metric: Number of those patients in target population receiving standardized, evidence-based interventions per approved clinical protocols and guidelines Baseline: Establish baseline number of individuals receiving the intervention Numerator: Number of patients that receive all recommended education, care and services as dictated by approved and evidence based care guidelines. Denominator: Number of patients discharged or eligible for CCTP care		

0937740-08.2.10	***2.12.3***	***N/A***	***Project Title: Community Care Transition Project (CCTP)***
Performing Provider Name: City of Houston Department of Health and Human Services			*HDHHS* -0937740-08
Related Category 3 Outcome Measures:	*0937740-08.3.16*	*IT-3.2*	*Congestive Heart Failure 30 day readmission*

Year 2 **(10/1/2012 – 9/30/2013)**	Year 3 **(10/1/2013 – 9/30/2014)**	Year 4 **(10/1/2014 – 9/30/2015)**	Year 5 **(10/1/2015 – 9/30/2016)**
	transition services c. Data Source: Registry Data Source: Registry or EHR report/analysis Milestone 5 Estimated Amount: $368,673		
Year 2 Estimated Milestone Bundle Amount: $974,257	Year 3 Estimated Milestone Bundle Amount: $1,106,017	Year 4 Estimated Milestone Bundle Amount: $1,208,631	Year 5 Estimated Milestone Bundle Amount: $1,162,511
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5):$4,451,417			

El Campo Memorial Hospital

Pass 1

Project Option 2.4.1 – Develop and implement a structured patient experience training program: Improving the Patient Experience – The AIDET Project.

Unique RHP Project ID: 131045004.2.1.
Performing Provider Name/TPI: El Campo Memorial Hospital / 131045004

Project Summary:

Provider:
El Campo Memorial Hospital is a 30-bed rural hospital located in Wharton County. It is comprised of a rural health clinic and a home health agency. El Campo Memorial Hospital provided approximately $2 million in charity care revenue in FY 2012.

Volume Statistics - FY2012	Patient Payor Mix	Patient Demographics
Hospital admissions- 533 Swingbed days- 706 Emergency visits- 5,626 Outpatient visits- 11,568 Rural health clinic visits- 35,124 Home health visits- 1,604	Self-Pay- 15% Medicaid and CHIP- 7% Medicare- 46% Other Funding- 4% Commercial Insurance- 28%	Hispanic- 37% African American- 10% Caucasian- 31% Asian- 0.08% Other- 21.92%

Intervention(s):
The AIDET Project is a patient experience training program which was developed by the Studer Group. It is a powerful communication tool.

Need for the project:
The purpose of the project is to improve communication between patients and healthcare providers by enabling our employees with formal training of how to interact with patients to gain their trust which is essential for obtaining patient compliance and improving clinical outcomes.

Target Population:
All patients within the system with may benefit from this project (Medicaid and CHIP-7% / Self-Pay- 15%).

Category 1 or 2 expected patient benefits:
By the end of DY3, our goal is for 90% of employees to have participated in the patient experience training. Our DY4 goal is to develop a display of patient experience data to share internally with employees the efforts we have undertaken to improve the experience of our patients and their families. Our DY5 goal is to share this patient experience data externally to our community.

Category 3 outcomes:
OD-6: Our goal is to increase patient satisfaction scores "To Be Determined" in DY4 and in DY5.

Project Option 2.4.1 – Develop and implement a structured patient experience training program: Improving the Patient Experience – The AIDET Project.

Unique RHP Project Identification Number: 131045004.2.1.
Performing Provider Name/TPI: El Campo Memorial Hospital / 131045004

Project Description:
El Campo Memorial Hospital will develop and implement a structured patient experience training program: Improving the Patient Experience – The AIDET Project.

El Campo Memorial Hospital is a 30-bed rural hospital located in Wharton County. The population of Wharton County is 41,280 per the 2010 Census. The community of El Campo has a population of 11,602 per the 2010 Census. El Campo Memorial Hospital is one of three top employers in El Campo who provide 200 jobs or more. El Campo Memorial Hospital is an acute hospital. We provide basic services including Emergency Room, Radiology, Laboratory, Rehabilitation, Swing Bed, Home Health and Hospice services. We also operate a hospital-based rural health clinic.

El Campo Memorial Hospital plans to roll out The AIDET Project to all new and existing full-time and part-time employees. The AIDET program was developed by the Studer Group. It is a powerful communication tool. AIDET is an acronym for Acknowledge, Introduce, Duration, Explanation and Thank You. When interacting with patients, gaining trust is essential for obtaining patient compliance and improving clinical outcomes. The project goal is to reduce patient anxiety and increase patient satisfaction which will result in positive outcomes for the patient.

We expect to incur scheduling difficulties amongst the targeted population; however, in addition to the live training program that will be conducted, we will also implement a self-study web-based program, so we can accommodate various schedules. By the end of the waiver, our expected outcome is to have 100% of our full-time and part-time employees trained on the patient experience training program, and for the employees and public to be educated on our efforts of improving patient satisfaction for our patients and their families. This project helps achieve the overall goals of the region by promoting positive healthcare experiences throughout the region which will ultimately improve the health of patients and decrease healthcare costs.

Starting Point/Baseline:
The starting point/baseline for this project will be the number of new full-time and part-time employees and the number of existing full-time and part-time employees. As of October 1, 2012, we are expecting to train 134 full-time employees and 4 part-time employees. The number of new full-time and part-time employees is unknown at this time. The time period for this baseline is one year from October 1, 2012 – September 30, 2013; however, we will continue to provide patient experience training even after this date in order to continue our quality improvement process.

Rationale:
Our rationale for selecting project option 2.4.1 Implement processes to measure and improve patient experience was a result of the need for improved communication between patients and healthcare providers. We believe if we can increase patient satisfaction, it has the

potential to increase the level of care integration and coordination of the patient/doctor relationship and lead to better health and better patient experience of care.

Project Components:
All core components will be addressed in this project:

a) Organizational integration and prioritization of patient experience;
b) Data and performance measurement will be collected by utilizing patient experience of care measures from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) in addition to CAHPS and/or other systems and methodologies to measure patient experience;
c) Implementing processes to improve patient's experience in getting through to the clinical practice; and
d) Develop a process to certify independent survey vendors that will be capable of administering the patient experience of care survey in accordance with the standardized sampling and survey administration procedures,

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
We believe the need for this project could fall under several of the needs reported in the RHP #3 Community Needs Assessment list, but it best is categorized under CN.23 Lack of patient navigation, patient and family education and information programs. If a patient has a good experience, we believe they will continue to actively engage themselves in their future health related care which will ultimately lead to positive outcomes and lower overall healthcare costs. We are not aware of any related activities to this project that are funded by the US. Department of Health and Human Services currently ongoing or coming up in the future.

Related Category 3 Outcome Measure(s):
OD-6 Percent improvement over baseline of patient satisfaction scores.

- IT-6.1 Percent Improvement Over Baseline Of Patient Satisfaction Scores

Reasons/rationale for selecting the outcome measures:

We believe if we can decrease patient anxiety and improve patient satisfaction in the rural setting when the patient is referred to the urban setting for extended/expanded healthcare that they will be more receptive and compliant to their healthcare needs which will ultimately lead to positive outcomes, improved patient satisfaction and ultimately lower healthcare costs. When patients perceive healthcare as a positive process, they will practice healthy lifestyles which results in lower healthcare costs.

We will focus on the stand-alone measure that will monitor an increase in patient satisfaction scores for the measure - patient is getting timely care, appointments, and information. We believe this measure is very important to the overall patient experience. These outcomes are important to our hospital because we believe if patients felt comfortable with the timeliness of their care, they would be less anxious about healthcare processes and more open to working with the healthcare providers. We believe by improving the patient experience through our Category 2 project – developing and implementing a structured patient experience training program, the patient will feel optimistic about their healthcare experience and take care of themselves. Again, we believe by focusing on patient satisfaction for every patient, it will improve the health of low-income population as well as the total population.

Relationship to other Projects: N/A

Relationship to Other Performing Providers' Projects in the RHP:
Healthcare treatment cannot focus to only the acute or chronic encounter and properly treat the patient. It is critical that our region focuses to patient education and community education to ensure a proactive and responsive approach to healthcare needs. The education models represented in the Region 3 RHP plan can be identified in the Initiative Grid (addendum) and all focus to outcome measures such as appropriate utilization, patient satisfaction scores, and standalone chronic condition scores such as diabetes and asthma.

Plan for Learning Collaborative: We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our region's healthcare system.

Project Valuation: We valued the project based on cost and benefits to our organization. We believe if we can reduce patient anxiety through education, the patient will have positive experiences and positive outcomes which will make them to want to take care of themselves by leading healthier lives, obtaining preventative healthcare and seeking medical help at appropriate times.

131045004.2.1	2.4.1	2.4.1 (A-D)	IMPROVING THE PATIENT EXPERIENCE - THE AIDET PROJECT
El Campo Memorial Hospital			131045004
Related Category 3 Outcome Measure(s):	131045004.3.1	IT-6.1(1)	Percent improvement over baseline of patient satisfaction scores.

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1 [P-1]: Appoint an executive accountable for experience performance and create a percentage of time in existing executive positions for experience performance. Metric 1 [P-1.1]: Documentation of an executive assigned responsibility experience performance. Goal: Appoint executive and dedicate time for existing positions Data Source: Job description Milestone 1 Estimated Incentive Payment (*maximum amount*): $44,857 **Milestone 2** [P-15]: Develop a training program on patient experience. Metric 1 [P-15.1]: Submission of training program materials. Goal: Develop training program Milestone 2 Estimated Incentive Payment: $44,858 **Milestone 3** [P-4]: Integrate patient experience training into new employee orientation training. Metric 1 [P-4.1]: Percent of new full-time and part-time employees who received patient experience training as	**Milestone 5** [P-4]: Integrate patient experience training into new full-time and part-time employee orientation training. Metric 1 [P-4.1]: Percent of new full-time and part-time employees who received patient experience training as part of their new employee orientation. Baseline/Goal: Baseline = number of new full-time and part-time employees & Goal = 90% of new full-time and part-time employees receive patient experience training. Data Source: Human Resource Records Milestone 5 Estimated Incentive Payment (*maximum amount*): $65,250 **Milestone 6** [P-4} Integrate patient experience training into existing full-time and part-time employee training. Metric 1 [P-4.1]: Percent of existing full-time and part-time employees who received patient experience training. Baseline/Goal: Baseline = number of existing full-time and part-time employees & Goal = 90% of existing full-time and part-time employees receive patient	**Milestone 8** [P-6]: Include specific patient and/or employee experience objectives into employee job descriptions and work plans. Hold employees accountable for meeting them. Metric 1 [P-6.1]: Percent of employees who have specific patient and/or employee experience objectives in their job description and/or work plan. Baseline/Goal: Baseline = number of employees & Goal = 100% employees to have specific patient and/or employee experience objectives in their job description and/or work plan. Data Source: Job descriptions Milestone 8 Estimated Incentive Payment: $98,160 **Milestone 9** [I-18]: Develop regular organizational display(s) of patient experience data (e.g., via a dashboard on the internal web) and provide updates to the employees on the efforts the organization is undertaking to improve the experience of it patients and their families. Metric 1 [I-18.1]: Number of organization-wide displays (can be	**Milestone 10** [I-19]: Make patient experience data available externally (e.g., via a dashboard on the external website) and provide updates to the general public on the efforts the organization is undertaking to improve the experience of it patients and their families. Metric 1 [I-19.1]: Number of external communications aimed at the general public's understanding of the organization's results and improvement efforts in the area of patient experience. Goal: TBD Data Source: External Communication Milestone 10 Estimated Incentive Payment: $162,177

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131045004.2.1	*2.4.1*	*2.4.1 (A-D)*	*IMPROVING THE PATIENT EXPERIENCE - THE AIDET PROJECT*
El Campo Memorial Hospital			*131045004*
Related Category 3 Outcome Measure(s):	*131045004.3.1*	*IT-6.1(1)*	*Percent improvement over baseline of patient satisfaction scores.*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
part of their new employee orientation. Baseline/Goal: Baseline = number of new full-time and part-time employees & Goal = 75% of new full-time and part-time employees receive patient experience training. Data Source: Human Resource Records Milestone 3 Estimated Incentive Payment (*maximum amount*): $44,858 **Milestone 4** [P-4} Integrate patient experience training into existing full-time and part-time employee training. <u>Metric 1</u> [P-4.1]: Percent of existing full-time and part-time employees who received patient experience training. Baseline/Goal: Baseline = number of existing full-time and part-time employees & Goal = 50% of existing of full-time and part-time employees receive patient experience training. Data Source: Human Resource Records Milestone 4 Estimated Incentive Payment: $44,858	experience training. Data Source: Human Resource Records Milestone6 Estimated Incentive Payment: $65,250 **Milestone 7** [P-6]: Include specific patient and/or employee experience objectives into employee job descriptions and work plans. Hold employees accountable for meeting them. <u>Metric 1</u> [P-6.1]: Percent of employees who have specific patient and/or employee experience objectives in their job description and/or work plan. Baseline/Goal: Baseline = number of employees & Goal = 100% of employees to have specific patient and/or employee experience objectives in their job description and/or work plan. Data Source: Job descriptions Milestone 7 Estimated Incentive Payment: $65,250	physical or virtual) about the organization’s performance in the area of patient/family experience per year; and at least one example of internal CEO communication on the experience improvement work. Goal: TBD Data Source: Display and Internal Communication Milestone 9 Estimated Incentive Payment: $98,159	

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131045004.2.1	***2.4.1***	***2.4.1** (A-D)*	***IMPROVING THE PATIENT EXPERIENCE - THE AIDET PROJECT***
El Campo Memorial Hospital			***131045004***
Related Category 3 Outcome Measure(s):	*131045004.3.1*	*IT-6.1(1)*	*Percent improvement over baseline of patient satisfaction scores.*
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Year 2 Estimated Milestone Bundle Amount: $179,431	Year 3 Estimated Milestone Bundle Amount: $195,750	Year 4 Estimated Milestone Bundle Amount: $196,319	Year 5 Estimated Milestone Bundle Amount: $162,177
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over DYs 2-5)**:*** $733,677			

Fort Bend County Clinical Health Services

Pass 1

Project Summary - Fort Bend County 2967606-01 2.1
Establish/Expand and Patient Care Navigation Program – Care Coordination Program
Provider: Fort Bend County Clinical Health Services is a division of the Fort Bend County Health & Human Services Department (FBCHHS), the local health department for the County. Fort Bend County is located in the Houston metropolitan area of southeast Texas. It encompasses a total of 875.0 square miles (562,560 acres). The current population is estimated at almost 607,000. FBCHHS services include: Animal Services, Clinical Health Services, EMS, Environmental Health, Social Services, Veterans Services and Public Health Preparedness. Fort Bend County also has a Behavioral Health Services Program.
Intervention: This project will expand patient navigation services to a subset of the uninsured and underinsured population in the county which uses EMS and ED services inappropriately for non-emergent conditions and has no means to pay for the services. Identified patients will be referred into the navigation system to promote a medical home and provide primary care, prevention services and chronic condition management. In addition, linkages to social service agencies to resolve other issues will be provided. Navigation will include follow up for appointment and medication compliance.
Need for the project: While the county population as a whole is wealthy, 8% of the population (48,560) live below the federal poverty level and 19% of the population has no health insurance coverage (>115,000). In one of the county census divisions, more than 17% of the population lives below the federal poverty level. The county has no hospital district and the only health care payment available to the population that does not qualify for Medicaid/Medicare is the Indigent Health Care program which covers only those with an existing medical condition who have an income of less than 21% of the federal poverty level. The program covers up to $30,000 of eligible medical care per year for individuals who qualify for the program, approximately 1,000 per year. In some areas and some populations in the county, when no primary care is available or affordable, the EMS and ED are by default the primary care providers.
Target Population: Uninsured, underinsured and Medicaid covered individuals who do not access primary care and use emergency services in lieu of a medical home. Patients will receive the benefit of ongoing assistance with medical care for primary care, prevention and chronic conditions as well as being linked to needed social services and transportation. Overall health will improve as well as some of the conditions leading to less than optimum health.
Category 2 patient benefit milestones: The program targets a minimum of 95 individuals diverted from high cost EMS transportation and ED visits to the patient navigation system in the FQHC medical home.
Category 3 outcome measures: IT 1.10 – 10% (DY4) and 20% (DY5) reduction in HbA1c poor control (>9%) in the target population. IT 9.2 - 25% (DY4) and 30% (DY5) reduction in ED use in the target population. IT 9.4 - 15% (DY4) and 20% (DY5) reduction in EMS transport use in the target population.

Project Option 2.9.1 - Establish/expand a Patient Care Navigation Program: Care Coordination Program
Unique RHP Project Identification Number: 2967606-01 2.1
Performing Provider Name /TPI: Fort Bend County Clinical Health Services / 2967606-01

Project Description:

Fort Bend County proposes a project where Indigent Health Care, Medicaid and uninsured patients who are frequent or inappropriate users of the County Emergency Medical Service (EMS) and hospital Emergency Departments (EDs) or who have repeat admissions to the hospital would be referred into a care management system based in the local Federally Qualified Health Center.

Care management would include:

- Assistance with making and keeping outpatient appointments
- Assistance with medication needs and medication compliance
- Appropriate case management of chronic conditions
- Dietary and exercise education
- Transportation if needed
- Connection to Social Service agencies for other needs
- A call line to assist clients with determining whether they need EMS, ED or an appointment scheduled at the clinic.

The Care Management Program would be housed within the local Federally Qualified Health Center (FQHC), Fort Bend Family Health Center. This FQHC has in place the protocol to manage patients at the level of preventive care, for management of chronic conditions and outpatient acute illnesses. This project would enhance the capacity, the partnerships and the community connection to the protocol that has been developed. The FQHC would become the medical home for patients referred to and cared for at the facility.

A partnership of the local de facto indigent care hospital, the Federally Qualified Health Center, the Health Department, Emergency Medical Service, and additional community partners would collaborate on a systematic method of identifying frequent users of the high end medical resources who are covered by Medicaid, Medicare, or the County Indigent Health Care program or who are self-pay.

The identified clients would be referred into a care management program at the FQHC led by Community Health Workers. Fort Bend County Health & Human Services will subcontract with the FQHC to provide payment for clients referred by the program whose care is not covered by an insurance program and who cannot afford care. Community Health Workers will assume responsibility for contacting the referred individuals to establish a relationship, set appointments, and assist with medication compliance and encouragement for follow up visits to establish the FQHC as the medical home.

In addition to the Care Management program at the FQHC, Fort Bend County proposes to establish within the EMS department, an Advanced Practice Paramedic (APP) program that will allow for treatment at the home or scene of patients who are calling the 9-1-1 response service for non-emergent health needs. This program will be modeled after successful community primary care APP programs in the United Kingdom, Australia, Wake County, North Carolina and Tarrant County, Texas.

The aim is to provide necessary primary care on scene, avoid an expensive EMS transport and ED visit and also be the link in to the Care Management system at the Federally Qualified Health Center.

Target Zip codes for the program are:

77053	77406	77407	77417	77441	77444
77451	77459	77461	77464	77469	77471
77476	77477	77478	77479	77481	77487
77489	77494	77496	77497	77498	77545

Goals and Relationship to Regional Goals:

The goal of this project is to provide a coordinated program of referrals, care management, patient centered needs resolution, community to medical home connection, and evaluation of program success in a rapid cycle improvement method. The proposed project will add community health worker capacity to the local FQHC and provide payment for services provided to those without means or coverage to pay. The goals include:

- Reduction in use of high end medical resources such as EMS and EDs
- Increase in the number of medically indigent, uninsured, and Medicaid eligible clients who have a medical home, prevention services and chronic disease management
- Improve clinical markers in the individuals served by the project.

The project meets the following regional goals:

- Increase access to primary and specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their condition, regardless of where they live or their ability to pay.
- Transform health care delivery from a disease-focused model of episodic care to a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary or duplicative services, and builds on the accomplishments of our existing health care system.

Challenges:

The populations that this project seeks to serve have established patterns of behavior that are not conducive to improved health or to cost effective use of existing medical resources. As with any intervention that seeks to change current behavior, the project will need to be patient centered and be flexible to encourage the change in behavior that is desired. Data collection for baseline and rapid cycle evaluation will need to come from a variety of providers and agencies and will need a systematic collection methodology.

5-year Expected Outcome for Provider and Patients:

Fort Bend County expects to see decreases in use of the ED and EMS for non-urgent conditions, to see improvements in health status of the targeted population in terms of clinical markers, follow up with appointments and medications or other interventions and an improvement in recognition of available community resources and the concept of a medical home for all.

Starting Point/Baseline:

Baseline data is not established, although each individual system has some data points as background rationale for the project. Data will be gathered on past and current users of the EMS system, hospital EDs and the Fort Bend County Indigent Care program for non-emergent and for frequent users of the high-end resources to establish the starting point for the proposed program.

In the first six months of the program, data gathering systems will be put in place to monitor the successful referral, engagement and outcomes for the patients who are referred in, using a rapid cycle improvement method.

Rationale:

Fort Bend County does not have a hospital district structure for indigent healthcare or for the uninsured and underinsured population of the County. The County participates in the state mandated Indigent Health Care Program which provides care for qualifying individuals whose income is below 22% of the Federal Poverty Level. With a population estimate of 606,000, there are more than 48,500 (8%) individuals living below the Federal Poverty Level and up to 145,000 uninsured at this time in the County[1]. For these individuals, medical care is often beyond their economic reach. Cash payment options and even sliding scale fees take lower priority than housing payments and food. One of the ways that the indigent population of the County avoids payment up front is to utilize the EMS 9-1-1 response system to obtain a "free" ride to the hospital, to receive priority care in the Emergency Department because of EMS transport and to not have a co-pay on site at the hospital.

Data from the local hospital handling the majority of indigent or uninsured/ underinsured clients in the county, shows that more than two thirds of the ED visits in 2011 were not of an emergent nature. In addition, of the approximately 10,000 patients seen in the first half of this year, 20% were Medicare enrollees, 37% Medicare and Medicaid managed care, and 1% county indigent health care. The remaining 42% are self-pay of which the majority have no means to pay for their health care.

Along with the use of expensive EMS and ED services for non-emergent illnesses, is the use of these same resources for chronic conditions which could better be managed and controlled in an outpatient setting using a medical home approach. Barriers to patients voluntarily seeking this option include lack of knowledge and understanding of their own medical conditions and of the resources available, lack of transportation, inability to pay fees and available hours for care.

The County Indigent Health Care program currently focuses on the need for care once an illness has developed and does not include a preventive or chronic care model.

When a patient is provided stabilization care by the County EMS department and then refuses transportation to the hospital, valuable continuing care coordination and follow-up is lost. A study of frequent users of the County EMS service showed 15,000 patients with more than three uses of the EMS service in a span of 18 months. The highest number was 20 calls in 18 months. The highest number of calls for one individual in the calendar year 2011 was 16 calls, but one individual has already reached 18 calls in the first 8 months of 2012.

Project Components:

Required core project components: 2.9.1

a) Identify frequent ED users and use navigators as part of a preventable ED reduction program. Train health care navigators in cultural competency.

b) Deploy innovative health care personnel, such as case managers/workers, community health workers and other types of health professionals as patient navigators.

c) Connect patients to primary and preventive care.

d) Increase access to care management and/or chronic care management, including education in chronic disease self-management.

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

Other project components: 2.9.2
a) Development of an Advanced Practice Paramedic program to provide primary care in the community when individuals are attempting to use EMS and ED resources for non-emergent conditions and chronic condition stabilization.
b) Expand the available call line to allow all identified target population patients to access a community health worker and/or medical professional to assist with determining the level of care needed for a particular complaint – for example EMS and ED vs appointment at the medical home.

Milestones and Metrics:
Process Milestones and Metrics
P-1. Milestone: Conduct a needs assessment to identify the patient population(s) to be targeted with the Patient Navigator program. (Metric P-1.1)
P-3. Milestone: Provide care management/navigation services to targeted patients. (Metric P-3.1)
P-5. Milestone: Provide reports on the types of navigation services provided to patients using the ED as high users or for episodic care. (Metric P-5.1)
P-8. Milestone: Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. (Metric P-8.1)
P-X. Provide primary care to individuals with non emergent needs who call the 9-1-1 EMS for non-emergent conditions or chronic condition stabilization. (Metric P-X.1. Number served, P-X.2. Number referred to the Care Coordination Program)

Improvement Milestones and Metrics
I-7. Milestone: Reduce number of ED visits and/or avoidable hospitalizations for patients enrolled in the navigator program (Metric I-7.1)
I-8. Milestone: Reduction in ED use by identified ED frequent users receiving navigation services. (Metric I-8.1)
I-9. Additional outcome metrics (Metric I-9.1, I-9.2)
I-X. Milestone: Reduce number of EMS transports for patients enrolled in the patient navigator program (Metric I-X.1)
Unique community need identification number the project addresses:
CN.7 Insufficient access to care coordination practice management and integrated care treatment programs.
CN.8 High rates of inappropriate emergency department utilization
CN.9 High rates of preventable hospital admissions
CN.11 High rates of chronic disease and inadequate access to treatment programs and services for illnesses associated with chronic disease

How the project represents a new initiative for the Performing Provider or significantly enhances an existing delivery system reform initiative.
This project uses the care coordination protocol already in existence within the local FQHC and expands the scope of the protocol to include identified frequent or inappropriate users of the high cost resources of EMS transport services and ED visits. It additionally provides access to the care coordination protocol for those traditionally not involved in coordinated care systems which

can lead to improved health outcomes and reduction in disease driven encounters with EMS and the ED.

Related Category 3 Outcome Measures:

OD-1 Primary and Chronic Disease Management (IT 1.10 – Diabetes Care)
OD-9 Right Care, Right Setting (IT 9.2 – ED Appropriate Utilization / Reduce ED use in target population referred to Care Coordination Program)
OD-9 Right Care, Right Setting (IT 9.4 – Other Outcome Improvement Target / Reduce EMS transport use in target population referred to Care Coordination Program)

Reasons/Rationale for selecting the outcome measures:

One population that could benefit from the proposed care coordination project is the indigent or uninsured population with a chronic health condition. This subset of the target population can indicate whether the chronic health condition is improved by coordination of care, management of medications, education, and having other needs met. For a chronic condition such as diabetes, the chosen improvement target is an easily recorded measure of the effectiveness of the program.

A determined need is to reduce the use of high cost medical resources such as ED and EMS for non-urgent and chronic conditions. The two additional outcome measures seek to determine whether the project is reaching this goal in the targeted population.

Relationship to other Projects: This project supports the Chronic Disease registry and interventions project proposed by our partners, the local hospital authority, and the FQHC. The intention of both projects is to decrease the burden of care on the EMS and emergency departments as well as to establish an improved coordination of care model for chronic and non-emergent conditions that will improve the health of the individuals involved, resulting in improved clinical outcomes and reduce the cost of care.

Relationship to Other Performing Providers' Projects in the RHP:

The ability to properly identify and monitor specific patients with chronic conditions or frequent emergency department utilization trends will allow the region to accurately mange the very large patient base. Patient navigation includes a comprehensive list of tasks as well as unique provider types based on the focus of the initiative and will help the focus of cost containment, emergency department utilization, and chronic disease management. The Region 3 Initiative Grid in the addendum allows for a cross reference of all initiatives proposed within this concept.

Plan for Learning Collaborative: We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system.

Project Valuation:

This project addresses the top priority identified by the FBC 1115 Access to Care planning group – a system of Care Coordination for community residents who are medically indigent, uninsured or underinsured. The project aims to reduce EMS and ED use in this population, thereby improving the health of the targeted population by access to ongoing preventive and chronic disease care in a patient centered program as opposed to episodic disease care in high cost resource settings.

Valuation is based on cost avoidance, projecting savings associated with reducing unnecessary EMS and ED use by patients in the target population. Fort Bend County has analyzed cost data

for patients in its indigent health care program. For this population, the cost of ED treatment averaged $3,000 for each of the 129 patients in one year. With a projected 25% reduction in ED visits the anticipated cost savings in one year is $96,750. Using the data for inpatient stays reduced by the project, the cost savings of 25% of the historic 295 inpatient hospital days ($1,400 per day) is $103,250. Adding to this is an anticipated 16.5% avoidance of EMS transports of the 4,161 medically unnecessary responses per year. At $800 cost per call, the yield is an anticipated $549,320 in savings. The total savings anticipated is $749,320 per year of the project.

References:

2. http://www.rgkcenter.org/sites/default/files/file/research/FB%20Report_for_posting.pdf

2967606-01 2.1	2.9.1	2.9.1(A-E)	ESTABLISH/EXPAND A PATIENT NAVIGATION SYSTEM (CARE COORDINATION PROGRAM)
Fort Bend County			2967606-01
Related Category 3 Outcome Measure(s):	3.2 3.3 3.4	IT 1.10 IT 9.2 IT 9.4	Diabetes Care: HbA1c Poor Control (>9.0%) ED Appropriate Utilization Other Outcome Improvement Target (Reduce EMS use)

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1 [P-1]: Conduct a Needs Assessment to identify the patient population(s) to be targeted with the Patient Navigator program. Metric 1 [P-1.1]: Provide report identifying the following: Targeted patient population characteristics (e.g., patients with no PCP or medical home, frequent ED utilization, homelessness, insurance status, low health literacy). • Gaps in services and service needs. • How program will identify, triage and manage target population (i.e. Policies and procedures, referral and navigation protocols/ algorithms, service maps or flowcharts). • Ideal number of patients targeted for enrollment in the patient navigation program • Number of Patient Navigators needed to be hired • Available site, state, county and clinical data including flow patients, cases in a given year by race and ethnicity, number of cases lost to follow-up that required medical treatment, percentage of	**Milestone 2** [P-3]:Provide care management/navigation services to targeted patients Metric 1 [P-3.1]: Increase in the number or percent of targeted patients enrolled in the program Baseline: TBD Goal: Successfully refer 50 patients (targeted population) from the ED or EMS to the Care Coordination program. Data Source: Referral and enrollment reports Milestone 2 Estimated Incentive Payment: $156,129 **Milestone 3** [P-X]: Provide primary care to individuals with non emergent needs who call the 9-1-1 EMS for non-emergent needs or chronic disease stabilization using an Advanced Practice Paramedic program based in the EMS program. Metric 1 [P-X.1]: Number of patients referred to the Care Coordination program after receiving care Baseline: TBD Goal: - Treat and refer 25 patients to the Care Coordination program	**Milestone 6** [P-3]:Provide care management/navigation services to targeted patients Metric 1 [P-3.1]: Increase in the number or percent of targeted patients enrolled in the program Baseline: (DY3 data) targeted patients referred in to system in DY3 Goal: increase the successfully referred patients (targeted population) by 50% over DY3 data from the ER or EMS to the Care Coordination program. Data Source: Referral and enrollment reports Milestone 6 Estimated Incentive Payment: $173,350 **Milestone 7** [P-X]: Provide primary care to individuals with non emergent needs who call the 9-1-1 EMS for non-emergent needs or chronic disease stabilization using an Advanced Practice Paramedic program based in the EMS program. Metric 1 [P-X.1]: Number of patients referred to the Care Coordination	**Milestone 10** [P-3]:Provide care management/navigation services to targeted patients Metric 1 [P-3.1]: Increase in the number or percent of targeted patients enrolled in the program Baseline: (DY4 data) targeted patients referred in to system in DY3 Goal: increase the successfully referred patients (targeted population) by 25%over DY4 data from the ED or EMS to the Care Coordination program. Data Source: Referral and enrollment reports Milestone 10 Estimated Incentive Payment: $133,752 **Milestone 11** [P-X]: Provide Primary care to individuals with non emergent needs who call the 9-1-1 EMS for non-emergent needs or chronic disease stabilization using an Advanced Practice Paramedic program based in the EMS program. Metric 1 [P-X.1]: Number of patients referred to the Care Coordination program after receiving care

2967606-01 2.1		*2.9.1*	*2.9.1(A-E)*	*ESTABLISH/EXPAND A PATIENT NAVIGATION SYSTEM (CARE COORDINATION PROGRAM)*
Fort Bend County				*2967606-01*
Related Category 3 Outcome Measure(s):	*3.2* *3.3* *3.4*	*IT 1.10* *IT 9.2* *IT 9.4*	*Diabetes Care: HbA1c Poor Control (>9.0%)* *ED Appropriate Utilization* *Other Outcome Improvement Target (Reduce EMS use)*	

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
monolingual patients Goal: To produce a report including the above data for program planning and implementation Data Source: Program documentation, EHR, claims, needs assessment survey, partner organization data Milestone 1 Estimated Incentive Payment: $609,295	in DY3 Data Source: EMS APP program ePCR referral documentation Milestone 3 Estimated Incentive Payment $156,128 **Milestone 4:** [P-5] Provide Reports on the types of navigation services provided to patients using the ED or EMS as high users or for episodic care Metric 1 [P-5.1] Collect and report on all the types of patient navigator services provided. Baseline: Navigation Services not provided to this targeted and referred population in DY2 Goal: Comprehensive report on services provided Data Source: Care Coordination CHW reports on referred patients Milestone 4 Estimated incentive Payment $156,128 **Milestone 5:** [P-8] Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around	program after receiving care Baseline: No patients treated and referred by APP program in DY2 Goal: - Treat and refer 50 patients to the Care Coordination program in DY3 Data Source: EMS APP program ePCR referral documentation Milestone 7 Estimated Incentive Payment: $173,349 **Milestone 8:** [P-5] Provide Reports on the types of navigation services provided to patients using the ED or EMS as high users or for episodic care Metric 1 [P-5.1]: Collect and report on all the types of patient navigator services provided. Baseline: Navigation Services not provided to this targeted and referred population in DY2 Goal: Comprehensive report on services provided Data Source: Care Coordination CHW reports on referred patients Milestone 8 Estimated incentive Payment $173,349 **Milestone 9:** [P-8] Participate in face-	Baseline: No patients treated and referred by APP program in DY2 Goal: - Treat and refer 75 patients to the Care Coordination program in DY3 Data Source: EMS APP program ePCR referral documentation Milestone 11 Estimated Incentive Payment: $133,753 **Milestone 12:** [P-5] Provide Reports on the types of navigation services provided to patients using the ED or EMS as high users or for episodic care Metric 1 [P-5.1]: Collect and report on all the types of patient navigator services provided. Baseline: Navigation Services not provided to this targeted and referred population in DY2 Goal: Comprehensive report on services provided Data Source: Care Coordination CHW reports on referred patients Milestone 12 Estimated incentive Payment $133,753 **Milestone 13:** [P-8] Participate in

2967606-01 2.1	*2.9.1*	*2.9.1(A-E)*	*ESTABLISH/EXPAND A PATIENT NAVIGATION SYSTEM (CARE COORDINATION PROGRAM)*
Fort Bend County			***2967606-01***
Related Category 3 Outcome Measure(s):	*3.2* *3.3* *3.4*	*IT 1.10* *IT 9.2* *IT 9.4*	*Diabetes Care: HbA1c Poor Control (>9.0%)* *ED Appropriate Utilization* *Other Outcome Improvement Target (Reduce EMS use)*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	shared or similar projects Metric 1 [P-8.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: Participate in all RHP organized meetings/seminars Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes Milestone 5 Estimated incentive Payment $156,128	to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects Metric 1 [P-8.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: Participate in all RHP organized meetings/seminars Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes Milestone 9 Estimated incentive Payment $173,349	face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects Metric 1 [P-8.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: Participate in all RHP organized meetings/seminars Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes Milestone 13 Estimated incentive Payment $133,753 **Milestone 14** [I-9]: Additional Outcome Metrics (improved diabetes control) Metric 1 [I-9.1]: Improved Clinical outcome of target population (diabetes control HbA1c<9.0%). Baseline: TBD determined for DY4 Goal: 10% improvement in diabetes control in population referred to care coordination.

2967606-01 2.1		***2.9.1***	***2.9.1(A-E)***	***ESTABLISH/EXPAND A PATIENT NAVIGATION SYSTEM (CARE COORDINATION PROGRAM)***
Fort Bend County				***2967606-01***
Related Category 3 Outcome Measure(s):	*3.2* *3.3* *3.4*	*IT 1.10* *IT 9.2* *IT 9.4*	*Diabetes Care: HbA1c Poor Control (>9.0%)* *ED Appropriate Utilization* *Other Outcome Improvement Target (Reduce EMS use)*	

Year 2 (10/1/2012 – 9/30/2013)	**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 14 Estimated incentive Payment $133,753
Year 2 Estimated Milestone Bundle Amount: $609,295	Year 3 Estimated Milestone Bundle Amount: $624,513	Year 4 Estimated Milestone Bundle Amount: $693,397	Year 5 Estimated Milestone Bundle Amount: $668,764
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over DYs 2-5)*: $2,595,969			

Fort Bend County Clinical Health Services

Pass 2

Project Option: 2.13.1 – Design, implement and evaluate research supported and evidence based interventions tailored towards individuals in the target population- Fort Bend County Behavioral Health Juvenile Diversion Project

RHP Project Identification Number: 2967606-01 2.2 / Pass 2
Performing Provider: Fort Bend County / 296706-01

Project Summary:
Provider: Fort Bend County (FBC) Clinical Health Services is a division of the Fort Bend County Health & Human Services Department (FBCHHS), the local health department for the County. Fort Bend County is located in the Houston metropolitan area of southeast Texas. It encompasses a total of 875.0 square miles (562,560 acres). The current population is estimated at almost 607,000. FBCHHS services include: Animal Services, Clinical Health Services, EMS, Environmental Health, Social Services, Veterans Services and Public Health Preparedness. Fort Bend County also has a Behavioral Health Services program.

Intervention: FBC will design, implement and evaluate a program that diverts youth with complex behavioral health needs such as serious mental illness or a combination of mental illness and intellectual developmental disabilities, substance abuse and physical health issues from initial or further involvement with juvenile. Services are individualized and community based and include assessment, multi-disciplinary treatment planning, crisis stabilization services, family supports, respite, specialized therapies (trauma focused interventions, cognitive behavioral interventions), medication management, case management and wraparound supports.

Need for the project: In the juvenile justice system the number of youth diagnosed with mental illness is significantly greater than that in the general population. Over the past decade, FBC Juvenile Probation Department has experienced a significant increase in the number of youth with mental health issues. The most recent data indicated that 40% to 45% of the youth in detention are on psychotropic medications. In 2011, FBJPD completed 543 intakes/bookings on youth. It is estimated that approximately 40% of these youth had a mental illness.

Target population: The target population is youth with complex behavioral health needs such as serious mental illness or a combination of mental illness and intellectual developmental disabilities, substance abuse and physical health issues that are at risk of incarceration. The priority population will be the uninsured and Medicaid population.

Category 2 expected patient benefits: FBC expects to reduce the percentage of youth with complex behavioral health needs that are incarcerated. The FBC project also expects improve the functioning of youth served by the FBC BHJD program. The FBC project will serve 10 youth in DY3, 20 in DY4 and 25 in DY5. It is expected that at least 25% of individuals receiving specialized interventions will demonstrate improved functional status on standardized instruments in DY4 and DY5.

Category 3 outcomes: IT 9.1 Reduce % (TBD) of admissions to juvenile detention for youth with complex behavioral health needs.

Project Title: **Fort Bend County Behavioral Health Juvenile Diversion Project**

RHP Project Identification Number: 2967606-01 2.2
Performing Provider Center: Fort Bend County / 296706-01
Project area: 2.13 - Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specific setting: juvenile justice system

Project Option: 2.13.1 – Design, implement and evaluate research supported and evidence based interventions tailored towards individuals in the target population: youth with complex behavioral health needs involved or at risk of involvement in the juvenile justice system.

Project Description: 2.13.1
Fort Bend County (FBC) proposes to develop a program that diverts youth with complex behavioral health needs such as serious mental illness or a combination of mental illness and intellectual developmental disabilities, substance abuse and physical health issues from initial or further involvement with juvenile and to support them in their communities. Services are individualized and community based and include assessment, multi disciplinary treatment planning, crisis stabilization services, family supports, respite, specialized therapies (trauma focused interventions, cognitive behavioral interventions), medication management, case management and wraparound supports.

In the juvenile justice system the number of youth diagnosed with mental illness is significantly greater than that in the general population. It is estimated that up to 70% of the youth in the juvenile justice system have at least one mental health disorder and approximately 20% have a serious mental illness[219]. There is agreement among both mental health and correction systems that many of these youth would be better served in community based programs with clinically appropriate interventions and supports.[220] Youth with mental illness end up on the doorstep of juvenile justice system through a variety of different paths and the juvenile justice system, much like the criminal justice system, has become the default mental health treatment for youth.

In Fort Bend County, the lack of comprehensive and coordinated services for youth with serious mental illness has resulted in the juvenile probation department (including the detention facility) becoming the assessment, stabilization and even treatment center for many of these youth. The most recent Needs Assessment of FBC conducted by the Lyndon Baines Johnson School of Public Affairs in the summer of 2011 states that the lack of services for the mentally ill has resulted in "mental health becoming a law enforcement issue."[221] The same study also indicated the scarcity of mental health services especially for the poor as a priority need for the county. Approximately, 9,000 persons are eligible for CHIP or Medicaid but not enrolled. Mental health services for youth, especially those with no insurance or on Medicaid, and with complex behavioral health needs is a significant need in Fort Bend County.

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[219] 1. Joseph J. Cocozza and Kathleen R. Skowyra, "Youth with Mental Health Disorders: Issues and Emerging Responses," *Juvenile Justice*, 7 (April 2000): 6; available at www.ncmhjj.com/pdfs/publications/Youth_with_Mental_Health_Disorders.pdf.
[220] National Health Policy Forum: Mental Health and Juvenile Justice: Moving Toward More effective Systems of Care ; available at http://www.nhpf.org/library/issue-briefs/IB805_JuvJustice_07-22-05.pdf

[221] http://www.rgkcenter.org/sites/default/files/file/research/FB%20Report_for_posting.pdf

Over the past decade, Fort Bend County Probation Department has experienced a significant increase in the number of youth with mental health issues. Although the total number of juvenile cases has slightly decreased over the last several years, it is estimated that the number of cases involving mental health disorders, has nearly doubled. A study completed by the Fort Bend Juvenile Probation Department (FBJPD) found that 18% to 20% of the youth in juvenile detention (between 2005 and 2009) were on psychotropic medication. The most recent data obtained from FBJPD indicated that 40% to 45% of the youth in detention are on psychotropic medications. This increase is a direct result of a decrease in treatment services for youth at the community level, a decrease in inpatient treatment services, and the closing of several residential treatment centers in the Houston Metropolitan Area. Consequently, the juvenile justice system has become the default system for providing mental health services to youth. Unfortunately, this is often the start of a cycle with the criminal justice system leading into adulthood.

In 2011, Fort Bend Juvenile Probation Department completed 543 intakes/bookings on youth. It is estimated that approximately 40% of these youth have a mental illness. Many have co-occurring disorders of substance abuse. Furthermore, many struggle with learning disabilities, developmental disabilities, abuse and neglect, and poverty. These vulnerabilities coupled with family problems and legal involvement increase the odds for negative health outcomes.

The Fort Bend County (FBC) Behavioral Health Juvenile Diversion (BHJD) program will focus on the development of specialized interventions and a service delivery system to better identify youth with mental illness and divert them to the appropriate services. This project will interface other FBC proposed DSRIP projects including the Behavioral Health Crisis and Response system. The FBC BHJD program will enhance the safety net, provide necessary interventions, increase the array of services including diversion services, and as a result reduce incarceration of youth with serious mental illness and other complex behavioral health needs as well as improve the functional outcomes for these youth (as measured by the Child and Adolescents Needs and Strengths). The FBC BHJD will include cross systems training and development of data tracking systems to ensure the appropriate response to mental health needs of youth and to monitor outcomes.

The FBC BHJD program will provide intensive care coordination and assessment services at the first point of contact with law enforcement or other intercept point (e.g., schools, hospitals) to identify, triage, and divert youth to appropriate clinical services. The FB BHJD program will also provide intensive care coordination to ensure that youth and their families are connected with the most appropriate level of clinical services in a timely manner. The FB BHJD will work collaboratively with treatment providers to develop individualized treatment plans that address the complex behavioral health needs of the youth and monitor treatment progress. Interventions such as Functional Family Therapy (FFT), Aggressive Replacement Training, Cognitive behavioral Therapy (CBT), respite, crisis stabilization services, and mentoring, wraparound supports may be part of the individualized treatment plans. Follow-up and aftercare services will be essential. As a result, the FBC BHJD program will work collaboratively with public and private behavioral health providers, FBC’s Health and Human Services, physical health providers, Mental Health America (MHA), National Alliance on Mental Illness (NAMI), and behavioral health providers and organizations in the community to provide the necessary array of

services to divert youth from the incarceration and provide the necessary array of services to improve functional outcomes.

The unique community need this project addresses is CN.2 – Insufficient access to behavioral healthcare services, resulting in lack of care or delay of care, delivery of inappropriate and insufficient care, unnecessary and preventable complications, and increased demand on the criminal justice system.

Goals and Relationship to Regional Goals:

Project Goals

FBC expects to see a reduction in the percentage of youth with complex behavioral health needs that are incarcerated. The FBC project also expects to see an improvement in functioning of youth served by the FBC BHJD program.

The FBC BHJD project presents a major opportunity to enhance the service delivery system for a complex behavioral health population (youth with serious mental illness at risk of involvement or further involvement with the legal system). The project also presents the opportunity for development of necessary infrastructure to facilitate communication, access, coordination, evaluation of services and systems transformation. The FBC project is the result of collaboration and commitment among county officials, law enforcement, health and human services, behavioral health (including the Mental Health Authority of Fort Bend County), courts, and community organizations to redesign current county operations to effectively respond to the behavioral health needs in the community.

This project meets the following Region 3 goals:

- Develop a regional approach to health care delivery that leverages and improves on existing programs and infrastructure that is responsive to patient needs throughout the entire region, and improves health care outcomes and patient satisfaction;
- Increase access to primary and specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their condition, regardless of where they live or their ability to pay; and,
- Develop a culture of ongoing transformation and innovation that maximizes the use of technology and best-practices, facilitates regional collaboration and sharing, and engages patients, providers, and other stakeholders in the planning, implementation, and evaluation processes.

The FBC BHJD Program builds on the success of the FBC Juvenile Probation Department in providing an array of mental health services to youth involved in the juvenile system. The FB BHJD transforms the current service delivery system by expanding the array of services available, implementing and evaluating evidence based interventions, developing data tracking across systems, information sharing, and monitoring outcomes for a targeted population of youth with complex behavioral health needs at risk of involvement or further involvement in the juvenile justice system.

Challenges:

Access to appropriate levels of care will be a challenge. There are limited resources for stabilizing and supporting youth with behavioral health disorders in the community. The FBC

project will address this by engaging with public and private providers of behavioral health services, community organizations, and volunteer groups. For example, FBC will work with MHA of FBC to develop an on-line resource directory with special attention to high risk populations (e.g., youth with complex behavioral health needs). This project will also focus on the expansion of wraparound supports and patient/ family education necessary for keeping youth in the community and development of strength/ protective factors.

The integration of data systems will also be a challenge**.** FBC has well developed data tracking systems but this need to be integrated to facilitate communication regarding patients' needs, linking them to appropriate services and tracking outcomes. The availability of integrated data tracking systems will allow us to continuously identify unmet needs and new resources. The project will work with various partners in the region as well as the county's Information Technology department to develop the most efficient data tracking system. These data elements will be used as part of the project's quality improvement process.

5-year Expected Outcome for Provider and Patients:
FBC expects to see a reduction in the percentage of youth with behavioral health needs that are incarcerated and improved functional status. The project will be county wide and include the following zip codes:

77053	77406	77407	77417	77441	77444
77451	77459	77461	77464	77469	77471
77476	77477	77478	77479	77481	77487
77489	77494	77496	77497	77498	77545

Starting Point/Baseline:
This is a new program; therefore, the baseline for all metrics and milestones will be established after the project is implemented.

Rationale:
Reasons for selecting the project option: 2.13.1 – Design, implement and evaluate research supported and evidence based interventions tailored towards individuals in the target population: youth with complex behavioral health needs involved or at risk of involvement in the juvenile justice system.

Project Components:
Through the FBC BHJD Program, we propose to meet all the required project components below and the selected milestones and metrics that relate to the project components:

a. Assess size, characteristics and needs of target population

FBC BHJD project will expand the assessment of the needs of youth with severe mental illness as well as the factors leading to their involvement with law enforcement.

b. Review literature/ experiences with populations similar to the target population to determine community based interventions that are effective at diverting youth from the incarceration

FBC BHJD project will continue to review literature and evaluate ongoing experiences with youth with complex behavioral health needs that are effective at reducing negative

outcomes, such as incarceration, decreased mental and physical functional status and promoting positive health, social and quality of life outcomes.

c. Develop project evaluation plan using qualitative and quantitative metrics to determine outcomes

FBC BHJD project will develop a project evaluation plan that includes qualitative and quantitative measures to determine project outcomes.

d. Design models which include an appropriate range of community based and residential supports

FBC BHJD project will work with public and private behavioral health providers, community organizations, and others stakeholders to develop an array of community based services for youth with complex behavioral health

e. Assess the impact of the interventions based on standardized quantitative measures and qualitative analysis relevant to the target population

FBC BHJD will develop measurement processes that are based on standardized tools relevant to the target population including the use of the Child and Adolescent Needs and Strengths (CANS).

Milestones & Metrics:

FBC has selected the following process milestones and metrics. These were chosen to ensure core components, some of which have already been fulfilled, are completed and documented appropriately.

- P-1 – Conduct needs assessments of youth with complex behavioral health needs
- P-2 - Design community based specialized interventions for youth to prevent incarceration or re-incarceration and improve functional status
- P-3- Enroll and serve individuals
- P-4 – Evaluate and continuously improve interventions
- P-7– 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 similar or shared projects.

Since this is a start-up project and these services are not available, all of these milestones/metrics are necessary for a successful project.

The following improvement milestone and metrics were chosen.

1-5.1 : 25% of individuals receiving specialized interventions, through the FB BHJD project, will demonstrate improved functional status on standardized instruments (e.g., CANS) in DY4 and DY5

The Child and Adolescent Needs and Strengths Assessment (CANS) will be used to guide service planning and to evaluate functional status. The CANS will be completed at intake and at regular intervals throughout the project to guide service planning. The CANS post intervention data will be used as an improvement outcome.

How the project represents a new initiative for the Performing Provider or significantly enhances an existing service delivery reform initiative:

This is a new initiative for FBC and will improve response to youth with complex behavioral health needs that are involved with juvenile probation department and / or at risk of involvement.

In addition, this initiative will further the development of needed infrastructures and partnerships to leverage existing resources, develop additional resources based on identified needs, and improve access to care in the community.

Related Category 3 Outcome Measure(s):
The Category 3 Outcome Measure chosen falls within OD-9-Right Care, Right Setting.
Reasons/rationale for selecting the outcome measure(s):
The goal of the FBC project is to divert youth with complex behavioral health needs from incarceration. The Fort Bend County (FBC) Behavioral Health Juvenile Diversion (BHJD) program will focus on the development of specialized interventions and a service delivery system to better identify youth with mental illness and divert them to the appropriate services. This project will interface other FBC proposed DSRIP projects including the Behavioral Health Crisis and Response system. The FBC BHJD program will provide necessary interventions, increase the array of services including diversion services, and as a result reduce incarceration of youth with serious mental illness and other complex behavioral health needs as well as improve the functional outcomes for these youth.

Relationship to Other Projects:
This project will interface with the Behavioral Health Crisis Response and Intervention project proposed by FBC. The project will also interface with the FBC Primary Care Coordination and Primary Care Expansion projects to facilitate access to essential primary care often overlooked for youth with behavioral health disorders.

Relationship to Other Performing Providers' Projects in the RHP: The FBC project will interface with other Performing Provider's (PP's) in the region to ensure access to necessary behavioral health services to prevent juvenile justice involvement and improve functional status of youth with complex behavioral health needs.

Plan for Learning Collaborative:
We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system.

Project Valuation:
Valuation is based on cost avoidance, projecting savings associated with reducing use of Juvenile Detention to manage the target population with regard to mental and behavioral health needs. During DY 4 and DY 5 Fort Bend County will avoid an average of 41 days annually in detention for an average of 23 youth per year. At $400 per day, this will produce a total savings of $754,400.

2967606-01 2.2		2.13.1	**Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specific setting: juvenile justice system**
Fort Bend County			**29606-01**
Related Category 3 Outcome Measures	**3.5**	*IT-9-1*	
Starting Point/Baseline:	*TBD*		

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
P- 1 Conduct needs assessment Metric 1 (P-1.1): Numbers of individuals, demographics, location, diagnoses, educational needs, family, natural supports, functional issues, juvenile justice and psychiatric needs Data Source: Project documentation; law enforcement records; public psychiatric facility records; survey of stakeholders (e.g., inpatient providers, mental health providers, social services, family, and forensics) **Process Milestone Estimated Incentive Payment: $146,751**	**P- 2** Design community-based specialized interventions to prevent incarceration and improve functional status Metric 2 (P-2.1): Project plans will be based on empirically based treatment approaches such as those offered by SAMSHA Data Source: Written Plan Goal: Complete project plan **Process Milestone Estimated Incentive Payment: $82,351** **P- 3** Enroll and Serve individuals Metric 2 (P-3.1): Number of targeted individuals enrolled Data Source: Project reports Goal: Enroll and serve **10** youth **Process Milestone Estimated Incentive Payment: $82,350**	**P- 3** Enroll and Serve individuals Metric 2 (P-3.1): Number of targeted individuals enrolled Data Source: Project reports Goal: Enroll and serve **20** youth **Process Milestone Estimated Incentive Payment: $59,410** **P-9** – Participate in face-to-face learning at least twice per year with other providers and the RHP to promote collaborative learning around similar or shared projects. Metric(P-9.1): Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Baseline/Goal (P-9.1): Promote continuous learning and best practices in twice-yearly meetings. Data Source (P-9.1): Documentation of semiannual face-to-face meetings including meeting agendas, slides from presentations, and/or meeting notes. **Process Milestone Estimated Incentive Payment: $59,410** **Improvement Milestone:**	**P- 3** Enroll and Serve individuals Metric 8 (P-3.1): Number of targeted individuals enrolled Data Source: Project reports Goal: Enroll and serve **25** youth **Process Milestone Estimated Incentive Payment: $57,198** **P-9** – Participate in face-to-face learning at least twice per year with other providers and the RHP to promote collaborative learning around similar or shared projects. Metric(P-9.1): Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Baseline/Goal (P-9.1): Promote continuous learning and best practices in twice-yearly meetings. Data Source (P-9.1): Documentation of semiannual face-to-face meetings including meeting agendas, slides from presentations, and/or meeting notes. **Process Milestone Estimated Incentive Payment: $57,198**

2967606-01 2.2		2.13.1	**Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specific setting: juvenile justice system**
Fort Bend County			**29606-01**
Related Category 3 Outcome Measures	**3.5**	*IT-9-1*	
Starting Point/Baseline:	*TBD*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
		Milestone: Functional Status 1-5.1. Metric: 25% percent of individuals receiving specialized interventions demonstrate improved functional status on standardized instruments (e.g., CANS, etc.) Data Source: standardized instruments (e.g. CANS, etc.) **Outcome Improvement Target Estimated Incentive: $59,409**	**Improvement Milestone:** Milestone: Functional Status 1-5.1. Metric: 25% percent of individuals receiving specialized interventions demonstrate improved functional status on standardized instruments (e.g., CANS, etc.) Data Source: standardized instruments (e.g. CANS, etc.) **Outcome Improvement Target Estimated Incentive: $57,197**
Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone): $146,751	**Year 3 Estimated Milestone Bundle Amount: $164,701**	**Year 4 Estimated Milestone Bundle Amount: $178,229**	**Year 5 Estimated Milestone Bundle Amount: $171,593**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over DYs 2-5)*: $661,274			

Project Option 2.3.2: "Other" project option: Implement other evidence-based project to redesign primary- Community Paramedic Program

Unique RHP Project Identification Number: 2967606-01 2.3 / Pass 2

Performing Provider Name /TPI: Fort Bend County Clinical Health Services / 2967606-01

Project Summary:

Provider: Fort Bend County Clinical Health Services is a division of the Fort Bend County Health & Human Services Department (FBCHHS), the local health department for the County. Fort Bend County is located in the Houston metropolitan area of southeast Texas. It encompasses a total of 875.0 square miles (562,560 acres). The current population is estimated at almost 607,000. FBCHHS services include: Animal Services, Clinical Health Services, EMS, Environmental Health, Social Services, Veterans Services and Public Health Preparedness. Fort Bend County also has a Behavioral Health Services program.

Intervention: This project will provide primary care to individuals who call 9-1-1 service for non-emergent conditions. Advanced Practice Paramedics will assess the individuals, provide necessary care and also connect them to the local Federally Qualified Health Center (FWHC) and the patient navigation program proposed in our project 2967606-01 2.1. The project will promote the medical home and serve as a community based navigation system.

Need for the project: While the county population as a whole is wealthy, 8% of the population (48,560) live below the federal poverty level and 19% of the population has no health insurance coverage (>115,000). In one of the county census divisions, more than 17% of the population lives below the federal poverty level. The county has no hospital district and the only health care payment available to the population that does not qualify for Medicaid/Medicare is the Indigent Health Care program which covers only those with an existing medical condition who have an income of less than 21% of the federal poverty level. The program covers up to $30,000 of eligible medical care per year for individuals who qualify for the program, approximately 1,000 per year. In some areas and some populations in the county, when no primary care is available or affordable, the EMS and ED are by default the primary care providers.

Target Population: Uninsured, underinsured or Medicaid covered individuals who do not access primary care and use emergency services in lieu of a medical home.

Patients will receive primary or acute care in their home setting and will then receive the benefit of ongoing assistance with medical care for primary prevention and chronic conditions as well as being linked to needed social services and transportation. Overall health will improve as well as some of the conditions leading to less than optimum health.

Category 2 patient benefit milestones: The program targets a minimum of 225 individuals diverted from high cost EMS transportation and ED visits to the FQHC medical home.

Category 3 outcome measures: IT 9.2 – 25% reduction in ED use in DY 4 and 30% reduction in DY5 in the target population. IT 9.4 - 25% reduction in EMS transport use in DY 4 and 30% reduction in DY5 in the target population.

Project Option 2.3.2: "Other" project option: Implement other evidence-based project to redesign primary- Community Paramedic Program

Unique RHP Project Identification Number: 2967606-01 2.3 / Pass 2

Performing Provider Name /TPI: Fort Bend County Clinical Health Services / 2967606-01

Project Description:

Fort Bend County proposes a project which would identify Indigent Health Care, Medicaid and uninsured patients who are frequent or inappropriate users of the County Emergency Medical Service (EMS) and hospital Emergency Departments (EDs) to provide appropriate care in their home setting using Advanced Practice Paramedics / Community Paramedics. The project will have the following components:

- EMS Dispatch trained to determine nature of call as non-emergent
- Trained Advanced Practice Paramedics / Community Paramedics
- Response vehicles with equipment for treatment at home, but not ALS transport
- Treatment of minor or chronic illness in the home setting
- Transportation to a medical facility if determined necessary
- Coordination with the established medical home for the target population, the FQHC for ongoing management of chronic conditions, primary care, prevention services
- Connection to Social Service agencies for other needs
- Information provide on the call line to assist clients with determining whether they need EMS, ED or an appointment scheduled at the FQHC clinic.

The Community Paramedic Program would be housed with the Fort Bend County EMS department, which is part of Fort Bend County Health & Human Services. The program would be conducted in coordination with the local Federally Qualified Health Center (FQHC), AccessHealth. The FQHC would become the medical home for patients referred after treatment by the Community Paramedic Program.

A partnership of the local de facto indigent care hospital, the Federally Qualified Health Center, the Health Department, Emergency Medical Service, and additional community partners would collaborate on a systematic method of identifying frequent users of the high end medical resources who are covered by Medicaid, Medicare, or the County Indigent Health Care program or who are self-pay. These patients would be eligible for management through the Community Paramedic Program. This program will be modeled after successful community primary care APP programs in the United Kingdom[2], Australia[3], Wake County, North Carolina[4] and Tarrant County, Texas[5].

The aim is to provide necessary primary care on scene, avoid an expensive EMS transport and ED visit and also be the link in to the Care Management system at the Federally Qualified Health Center. As reported by other programs established in communities, the program can

reduce the probability of providing acute emergency medical care for at risk patients and the medically underserved, thereby reducing unnecessary health care expenditures, and increase the outreach activity and education components of EMS.

Target Zip codes for the program are:

77053	77406	77407	77417	77441	77444
77451	77459	77461	77464	77469	77471
77476	77477	77478	77479	77481	77487
77489	77494	77496	77497	77498	77545

Goals and Relationship to Regional Goals:

The goal of this project is to provide a coordinated program of patient centered needs resolution, community to medical home connection, and evaluation of program success in a rapid cycle improvement method. The proposed project will add Advanced Practice Paramedics to the local EMS. The goals include:

- Reduction in use of high end medical resources such as EMS and EDs
- Increase in the number of medically indigent, uninsured, and Medicaid eligible clients who have access to primary care and a medical home, prevention services and chronic disease management
- Improvement in health for those patients who are identified as frequent users of high end resources for non-emergent care.

The project meets the following regional goals:

- Increase access to primary and specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their condition, regardless of where they live or their ability to pay.
- Transform health care delivery from a disease-focused model of episodic care to a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary or duplicative services, and builds on the accomplishments of our existing health care system.

Challenges:

The populations that this project seeks to serve have established patterns of behavior that are not conducive to improved health or to cost effective use of existing medical resources. As with any intervention that seeks to change current behavior, the project will need to be patient centered and be flexible to encourage the change in behavior that is desired. Data collection for baseline and rapid cycle evaluation will need to come from a variety of providers and agencies and will need a systematic collection methodology.

5-year Expected Outcome for Provider and Patients:

Fort Bend County expects to see decreases in use of the ED and EMS for non-urgent conditions, to see improvements in health status of the targeted population in terms of clinical markers, follow up with appointments and medications or other interventions and an improvement in recognition of available community resources and the concept of a medical home for all.

Starting Point/Baseline:

Baseline data is not established, although the EMS and EDs have some data points as background rationale for the project. Data will be gathered on past and current users of the EMS system, hospital EDs and the Fort Bend County Indigent Care program for non-emergent and for frequent users of the high-end resources to establish the starting point for the proposed program. In the first six months of the program, data gathering systems will be put in place to monitor the successful treatment, referral, engagement and outcomes for the patients who are referred in, using a rapid cycle improvement method.

Rationale:

Reasons for selecting the project option:

Fort Bend County does not have a hospital district structure for indigent healthcare or for the uninsured and underinsured population of the County. The County participates in the state mandated Indigent Health Care Program which provides care for qualifying individuals whose income is below 22% of the Federal Poverty Level. With a population estimate of 606,000, there are more than 48,500 (8%) individuals living below the Federal Poverty Level and up to 115,140 uninsured at this time in the County[1]. For these individuals, medical care is often beyond their economic reach. Cash payment options and even sliding scale fees take lower priority than housing payments and food. One of the ways that the indigent population of the County avoids payment up front is to utilize the EMS 9-1-1 response system to obtain a "free" ride to the hospital, to receive priority care in the Emergency Department because of EMS transport and to not have a co-pay on site at the hospital.

Data from the local hospital handling the majority of indigent or uninsured/ underinsured clients in the county, shows that more than two thirds of the ED visits in 2011 were not of an emergent nature. In addition, of the approximately 10,000 patients seen in the first half of this year, 20% were Medicare enrollees, 37% Medicare and Medicaid managed care, and 1% county indigent health care. The remaining 42% are self-pay of which the majority have no means to pay for their health care.

Along with the use of expensive EMS and ED services for non-emergent illnesses, is the use of these same resources for chronic conditions which could better be managed and controlled in an outpatient setting and using a medical home approach. Barriers to patients voluntarily seeking this option include lack of knowledge and understanding of their own medical conditions

and of the resources available, lack of transportation, inability to pay fees and available hours for care.

The County Indigent Health Care program currently focuses on the need for care once an illness has developed and does not include a preventive or chronic care model.

When a patient is provided stabilization care by the County EMS department and then refuses transportation to the hospital, valuable continuing care coordination and follow-up is lost. A study of frequent users of the County EMS service showed 15,000 patients with more than three uses of the EMS service in a span of 18 months. The highest number was 20 calls in 18 months. The highest number of calls for one individual in the calendar year 2011 was 16 calls, but one individual has already reached 18 calls in the first 8 months of 2012.

Project Components:

Project option 2.3.2 does not have required components. Other project components:

- Development of an Advanced Practice Paramedic/Community Paramedic program to provide primary care in the community when individuals are attempting to use EMS and ED resources for non-emergent conditions and chronic condition stabilization.
- Ensure coordination of the Community Paramedic Program with the FQHC and Social Service agencies within the community to allow for ongoing coordination of care and resolution of other needs.

Milestones and Metrics:

Process Milestones and Metrics

P-X. Milestone: Conduct a needs assessment to identify the patient population(s) to be

targeted with the Patient Navigator program. (Metric P-X.1)

P-XX. Milestone: Provide primary care to individuals with non emergent needs who call the 9-1-1 EMS for non-emergent conditions or chronic condition stabilization, and referral services to the targeted patients. (Metric P-XX.1)

P-XXX. Milestone: Provide reports on the types of care provided to patients using the Community Paramedic Program. (Metric P-XXX.1)

P-12. Milestone: Participate in face-to-face learning (i.e. meetings or seminars) at least twice

per year with other providers and the RHP to promote collaborative learning around

shared or similar projects. (Metric P-12.1)

Improvement Milestones and Metrics

I-X. Milestone: Reduce number of EMS transports for patients managed by the Community Paramedic Program (Metric I-X.1

I-XX. Milestone: Reduce the number of inappropriate ED visits for patients managed by the Community Paramedic Program. (Metric I-XX.1)

Unique community need identification number the project addresses:

- CN.8 High rates of inappropriate emergency department utilization
- CN.9 High rates of preventable hospital admissions
- CN.11 High rates of chronic disease and inadequate access to treatment programs and services for illnesses associated with chronic disease
- CN.21 Inadequate transportation options for individuals in rural areas and for indigent/low income populations

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

This project uses a proven community paramedic program concept to reduce the burden on over utilized high end resources such as EMS transport and ED care, while offering primary and chronic care management in the home setting. The project also brings patients into a care coordination system and medical home for ongoing management which can lead to improved health outcomes and reduction in episodic and disease driven encounters with EMS and the ED.

Related Category 3 Outcome Measures:

OD-9 Right Care, Right Setting (IT 9.2 – ED Appropriate Utilization / Reduce ED use in target population managed by the Community Paramedic Program)

OD-9 Right Care, Right Setting (IT 9.4 – Other Outcome Improvement Target / Reduce EMS transport use in target population managed by the Community Paramedic Program)

Reasons/Rationale for selecting the outcome measures:

The population that will benefit from the proposed Community Paramedic Program is the indigent or uninsured population with episodic or chronic health conditions. A determined need is to reduce the use of high cost medical resources such as ED and EMS for non-urgent and chronic conditions. The two outcome measures seek to determine whether the project is reaching this goal in the targeted population.

Relationship to other Projects: This project supports the Chronic Disease registry ED diversion projects proposed by our partners, the local hospital authority, and the FQHC. In addition, it will support the Care Coordination project proposed in the Pass One submission by Fort Bend County. The intention of each of these projects is to decrease the burden of care on

the EMS and emergency departments as well as to establish an improved coordination of care model for chronic and non-emergent conditions that will improve the health of the individuals involved, resulting in improved clinical outcomes and reduce the cost of care.

Relationship to Other Performing Providers' Projects in the RHP:

Primary Care/Ambulatory Care clinics are a top priority to Region 3 due to the acuity of the regional patient mix, population concentration, and lack of primary care access points for our patient base. The regional approach of collaboration as well as existing patient referral pattern relationships allowed our team to properly identify the community needs based on the necessity of population, uninsured, and medically underserved patient bases. This program is consistent with our region and similar to numerous initiatives in our RHP plan sharing both concepts as well as outcome measures focused to percent improvement over baseline of patient satisfaction scores, reduction of inappropriate ED utilization, and third next available appointment status. The Region 3 Initiative Grid attached as a RHP Plan addendum reflects a grid of relationship for all initiatives.

Plan for Learning Collaborative: We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system.

Project Valuation:

This project addresses the top priority identified by the FBC 1115 Access to Care planning group – a system of care for community residents who are medically indigent, uninsured or underinsured. The project aims to reduce EMS and ED use in this population, thereby improving the health of the targeted population by access to ongoing preventive and chronic disease care in a patient centered program as opposed to episodic disease care in high cost resource settings.

Valuation is based on cost avoidance, projecting savings associated with reducing unnecessary EMS and ED use by patients in the target population. Fort Bend County will reduce EMS and emergency room usage during DY 4 and DY 5 by an estimated $1.5 million.

References:

3. http://www.rgkcenter.org/sites/default/files/file/research/FB%20Report_for_posting.pdf
4. BMJ 207; 335 dol: 10.1136/bmj.39356.700139.BE (Published 1 November 2007)
5. http://www.rrh.org.au.Engaging rural communities in through a paramedic expanded scope of practice. *Rural and Remote Health* 7:839. (online), 2007
6. http://www.wakegov.com/ems/about/staff/Pages/advancedpracticeparamedics.aspx
7. http://www.medstar911.org/community-health-program

2967606-01 2.3	*2.3.2*	*N/A*	*REDESIGN PRIMARY CARE* *ESTABLISH A COMMUNITY PARAMEDIC PROGRAM*
Fort Bend County			**2967606-01**
Related Category 3 Outcome Measure(s):	*2967606-01 3.6* *2967606-01 3.7*	*IT I.X* *IT I.XX*	*REDUCE NUMBER OF INAPPROPRIATE EMS TRANSPORTS* *REDUCE THE NUMBER OF INAPPROPRIATE ED VISITS*
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Milestone 1 [P-X]: Conduct a Needs Assessment to identify the patient population(s) to be targeted with the Community Paramedic Program. Metric 1 [P-1.1]: Provide report identifying the following: □Targeted patient population characteristics (e.g., patients with frequent ED utilization, insurance status, low health literacy). • Gaps in services and service needs. • How program will identify, triage and manage target population (i.e. Policies and procedures, referral protocols/ algorithms, service maps or flowcharts). • Ideal number of patients targeted • Number of APP needed Goal: To produce a report including the above data for program planning and implementation Data Source: Program	**Milestone 2** [P-XX]:Provide care through a Community Paramedic Program to targeted patients Metric 1 [P-XX.1]: Increase in the number of targeted patients served by the program in the program Baseline: TBD Goal: Successfully treat 50 patients (targeted population) using a community paramedic program. Data Source: Usage and Care reports Milestone 2 Estimated Incentive Payment: $54,901 **Milestone 3** [P-XXX]: Provide Reports on the types of care and referrals provided to patients using the Community Paramedic Program	**Milestone 5** [P-XX]:Provide care through a Community Paramedic Program to targeted patients Metric 1 [P-XX.1]: Increase in the number of targeted patients served by the program in the program Baseline: DY3 Goal: Successfully treat 75 patients (targeted population) using a community paramedic program. Data Source: Usage and Care reports Milestone 5 Estimated Incentive Payment: $59,410 **Milestone 6** [P-XXX]: Provide Reports on the types of care and referrals provided to patients using the Community Paramedic Program	**Milestone 8** [P-XX]:Provide care through a Community Paramedic Program to targeted patients Metric 1 [P-XX.1]: Increase in the number of targeted patients served by the program in the program Baseline: DY3 Goal: Successfully treat 100 patients (targeted population) using a community paramedic program. Data Source: Usage and Care reports Milestone 8 Estimated Incentive Payment: $42,898 **Milestone 9** [P-XXX]: Provide Reports on the types of care and referrals provided to patients using the Community Paramedic Program

2967606-01 2.3	*2.3.2*	*N/A*	*REDESIGN PRIMARY CARE* *ESTABLISH A COMMUNITY PARAMEDIC PROGRAM*
Fort Bend County			**2967606-01**
Related Category 3 Outcome Measure(s):	*2967606-01 3.6* *2967606-01 3.7*	*IT I.X* *IT I.XX*	*REDUCE NUMBER OF INAPPROPRIATE EMS TRANSPORTS* *REDUCE THE NUMBER OF INAPPROPRIATE ED VISITS*

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
documentation, ePCR, EHR, claims, needs assessment survey, partner organization data Milestone 1 Estimated Incentive Payment: $146,751	Metric 1 [P-XXX.1]: Collect and report on all the patients encountered by the Community Paramedic Program. Baseline: TBD from DY3 data Goal: Comprehensive report on services provided Data Source: ePCR, EHR, dispatch reports Milestone 3 Estimated incentive Payment $54,900 **Milestone 4** [P-12]: Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects Metric 1 [P-12.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP.	Metric 1 [P-XXX.1]: Collect and report on all the patients encountered by the Community Paramedic Program. Baseline: TBD from DY3 data Goal: Comprehensive report on services provided Data Source: ePCR, EHR, dispatch reports Milestone 6 Estimated incentive Payment $59,410 **Milestone 7** [P-12]: Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects	Metric 1 [P-XXX.1]: Collect and report on all the patients encountered by the Community Paramedic Program. Baseline: TBD from DY3 data Goal: Comprehensive report on services provided Data Source: ePCR, EHR, dispatch reports Milestone 9 Estimated incentive Payment $42,898 **Milestone 10** [P-12]: 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

2967606-01 2.3	*2.3.2*	*N/A*	*REDESIGN PRIMARY CARE* *ESTABLISH A COMMUNITY PARAMEDIC PROGRAM*
Fort Bend County			**2967606-01**
Related Category 3 Outcome Measure(s):	*2967606-01 3.6* *2967606-01 3.7*	*IT I.X* *IT I.XX*	*REDUCE NUMBER OF INAPPROPRIATE EMS TRANSPORTS* *REDUCE THE NUMBER OF INAPPROPRIATE ED VISITS*

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
	Goal: Participate in all RHP organized meetings/seminars Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes Milestone 4 Estimated incentive Payment $54,900	Metric 1 [P-12.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: Participate in all RHP organized meetings/seminars Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes Milestone 7 Estimated incentive Payment $59,409	Metric 1 [P-12.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: Participate in all RHP organized meetings/seminars Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes Milestone 10 Estimated incentive Payment $42,898 **Milestone 12** [I-X]: Successful primary care/episodic care given to target population with reduction in EMS/ED use. Metric 1 [I-X.1]: Care given to Target Population Baseline: TBD determined in DY3 Goal: 25% fewer EMS transports for non-urgent situations after

2967606-01 2.3	***2.3.2***	***N/A***		***REDESIGN PRIMARY CARE*** ***ESTABLISH A COMMUNITY PARAMEDIC PROGRAM***
Fort Bend County				**2967606-01**
Related Category 3 Outcome Measure(s):	*2967606-01 3.6* *2967606-01 3.7*	*IT I.X* *IT I.XX*		*REDUCE NUMBER OF INAPPROPRIATE EMS TRANSPORTS* *REDUCE THE NUMBER OF INAPPROPRIATE ED VISITS*
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**		**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
				treatment by Community Paramedic Program. Milestone 12 Estimated incentive Payment $42,898
Year 2 Estimated Milestone Bundle Amount: $146,751	Year 3 Estimated Milestone Bundle Amount: $164,701		Year 4 Estimated Milestone Bundle Amount: $178,229	Year 5 Estimated Milestone Bundle Amount: $171,593
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over DYs 2-5)***:** $661,274				

Project Option 2.7.1: Implement innovative evidence-based strategies to increase appropriate use of technology and testing for targeted populations– Colonoscopy Screening

Unique RHP Project ID: 2967606-01 2.4 / Pass 2

Performing Provider Name /TPI: Fort Bend County Clinical Health Services/2967606-01

Project Summary:

Provider: Fort Bend County Clinical Health Services is a division of the Fort Bend County Health & Human Services Department (FBCHHS), the local health department for the County. Fort Bend County is located in the Houston metropolitan area of southeast Texas. It encompasses a total of 875.0 square miles (562,560 acres). The current population is estimated at almost 607,000. FBCHHS services include: Animal Services, Clinical Health Services, EMS, Environmental Health, Social Services, Veterans Services and Public Health Preparedness. Fort Bend County also has a Behavioral Health Services program.

Intervention: Through a cooperative project with local health care providers, this project will provide colonoscopy screening to uninsured and underinsured populations who meet the criteria for this procedure. In addition, for those identified with colorectal cancer through this project, the appropriate continuum of care will be provided through cooperative agreements.

Need for the project: While the county population as a whole is wealthy, 8% of the population (48,560) live below the federal poverty level and 19% of the population has no health insurance coverage (>115,000). In one of the county census divisions, more than 17% of the population lives below the federal poverty level. The county has no hospital district and the only health care payment available to the population that does not qualify for Medicaid/Medicare is the Indigent Health Care program which covers only those with an existing medical condition who have an income of less than 21% of the federal poverty level. The program will cover up to $30,000 of eligible medical care per year for individuals who qualify for the program, approximately 1,000 per year. Neither the Indigent Health Care program, nor the Federally Qualified Health Center can provide screening colonoscopies at this time.

Target Population: Uninsured, underinsured and Medicaid covered individuals who meet the criteria for screening for colorectal cancer by colonoscopy. Patients will receive screening colonoscopies and may have cancer prevented by the removal of pre-cancerous lesions. If diagnosed with cancer they will be provided appropriate treatment.

Category 2 patient benefit milestones: The program targets a minimum of 200 individuals who meet the criteria for colorectal screening by colonoscopy but who have no means to cover this procedure. Of this group, some will receive polypectomies for pre-cancerous polyps, thus preventing cancer. Some may be diagnosed and treated for cancer.

Category 3 outcome measures: IT-6.1: 40% increase in patient satisfaction in regards to their access to a medical specialist and in shared decision making. IT 12.3: 100% increase in the number of screening colonoscopies performed in the target population.

Project Option 2.7.1: Implement innovative evidence-based strategies to increase appropriate use of technology and testing for targeted populations– Colonoscopy Screening

Unique RHP Project ID: 2967606-01 2.4 / Pass 2

Performing Provider Name /TPI: Fort Bend County Clinical Health Services/2967606-01

Project Description:

Fort Bend County proposes a project where Indigent Health Care, Medicaid and uninsured patients who meet guidelines for screening or diagnostic colonoscopies are referred to a local medical provider for this procedure. Under contract with Fort Bend County Clinical Health Services, the local medical provider (negotiations underway) would provide the following:

- Instructions on preparation for the procedure, including prescriptions if needed
- Appointment scheduling for the procedure
- Coverage of the anesthesia, colonoscopy procedure and pathology, if required
- Acceptance for cancer surgery, radiation and/or chemotherapy for a patient diagnosed with colon/rectal cancer at a contracted rate.

The population of uninsured and underinsured individuals in Fort Bend County does not currently have access to low cost or no cost colonoscopies. The Federally Qualified Health Center (AccessHealth) can only provide Fecal Occult Blood (FOBT) testing and has no referral source for colonoscopies for those without insurance coverage or without means to pay. The County Indigent Health Care Program can only provide payment for services to those who are below 21% of the federal poverty level and who already have a health condition such as a positive FOBT or other medical indication of need. Preventive screening is not covered.

The project will include education to the target population through AccessHealth and other points of contact with this population about colorectal cancer, the importance and benefits of screening and the availability of the new project to make this available.

Target Zip codes for the program are:

77053	77406	77407	77417	77441	77444
77451	77459	77461	77464	77469	77471
77476	77477	77478	77479	77481	77487
77489	77494	77496	77497	77498	77545

Goals and Relationship to Regional Goals:

The goal of this project is to provide evidence-based prevention for colon and rectal cancers in the uninsured and underinsured population of Fort Bend County. The expected outcomes include:

- prevention of colorectal cancers by the removal of precancerous polyps
- reduction in cost and increase in cures by early detection of colorectal cancer.

The project meets the following regional goal:

- Increase access to primary and specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their condition, regardless of where they live or their ability to pay.

Challenges:

The populations targeted by this program currently have no available low cost or no cost option for screening or diagnostic colonoscopies. One challenge will be the education of the population that this service is now available to them and why it is important. A second major challenge will be if the percentage of the patients who are screened and are diagnosed with cancer is higher than anticipated. This will place a higher burden on the contracted entity than planned based on current population estimates of colorectal cancers.

5-year Expected Outcome for Provider and Patients:

Fort Bend County expects to see increases in the number of uninsured and underinsured who are able to take advantage of the screening recommendations for colorectal cancer. In addition, any patient whose screening results in a need for further medical treatment will be able to complete the needed treatment under contractual agreement between the performing provider and a local medical provider.

Starting Point/Baseline:

Baseline data is limited to the Texas Department of State Health Services surveillance for colorectal cancer morbidity and mortality, as noted below. During the planning stage of the program, local data from health care providers will be gathered to enhance the state provided data. In the first six months of the program, data gathering systems will be put in place to monitor the successful referral, engagement and outcomes for the patients who are referred in, using a rapid cycle improvement method.

Rationale:

Reasons for selecting the project option:

Fort Bend County does not have a hospital district structure for indigent healthcare or for the uninsured and underinsured population of the County. The County participates in the state mandated Indigent Health Care Program which provides care for qualifying individuals whose income is below 22% of the Federal Poverty Level. With a population estimate of 606,000, there

are more than 48,500 (8%) individuals living below the Federal Poverty Level and up to 115,140 uninsured at this time in the County[1]. For these individuals, medical care is often beyond their economic reach. Cash payment options and even sliding scale fees take lower priority than housing payments and food. Expensive screening and diagnostic colonoscopies are beyond the reach of the majority of these individuals.

Data shows that the current incidence rate for Colon and Rectal cancer in Fort Bend County is 38.6 per 100,000 population, and the death rate is 15.5 per 100,000[2]. Even without assuming that the incidence and death rate is higher in the uninsured and underinsured (therefore unscreened) population, these rates would result in 44 cases of colorectal cancer and 18 deaths due to this cancer in the uninsured population of Fort Bend County.

Project Components:

Project Option: 2.7.1 does not have required components.

Milestones and Metrics:

Process Milestones and Metrics

P-1. Milestone: Development of innovative evidence-based project for targeted population.

Metric P1.1: Document Innovational Strategy and Plan

a. Data Source: Documentation of meetings and discussion leading to contract for colonoscopy services.
b. Rationale/Evidence: Meeting minutes, preliminary program designs, contract for services

P-2. Milestone: Implement evidence-based innovational project for targeted population.

Metric P2.1: Document implementation strategy and testing outcomes

a. Data Source: Program protocols and procedures, Numbers of colonoscopies performed and outcomes
b. Rationale/Evidence: To identify, develop and test new models of healthcare delivery and disease management lays the groundwork for widespread adoption of innovative care that can lead to a system that delivers better health, better care at reduced costs.

P-7. Milestone: Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. (Metric P-8.1)

Improvement Milestones and Metrics

I-7. Milestone: Increase access to disease prevention programs using innovative project option

Metric 1.7.1: Increase percentage of the target population reached

a. Numerator: Number of individuals of target population reached
b. Denominator: Number of individuals in the target population
c. Data Source: documentation of outreach, education and referrals in the target population
d. Rationale/Evidence: Success/failure of outreach, education, adoption of screening program

Unique community need identification number the project addresses:

- CN.1 Inadequate access to primary care
- CN.2 Inadequate access to specialty care

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

This project is based in the evidence of cancer prevention and successful treatment resulting from appropriate and early screening for colorectal cancers, which is currently not available to the uninsured and underinsured population in our County. At this time, there is no referral available for screening and very limited availability of treatment resource or payment options for diagnosed colorectal cancer.

Related Category 3 Outcome Measures:

OD-6 Patient Satisfaction (IT-6.1 – Patient Access to Specialist, Shared Decision Making)

OD-12 Primary Care and Primary Prevention (IT-12.3 – Colorectal Cancer Screening)

Reasons/Rationale for selecting the outcome measures:

The target population has limited access to specialist care and valuable data can be gathered from the survey regarding their satisfaction with and experience with the specialist and also as to whether they feel a part of the process in deciding what will happen in their health care plan as they access resources not previously available to them. The measurement of the numbers of colonoscopies performed per targeted population will measure the success of the project in reaching and engaging the target population in prevention of a serious health issue.

Relationship to other Projects: This project supports and enhances the Expand a Patient Navigation system project that is proposed in the Fort Bend County pass one project. The medical home and patient navigation system will now have a resource to refer patients to for primary prevention and treatment of a curable cancer.

Relationship to Other Performing Providers' Projects in the RHP: The increase of primary care and specialty care will naturally result in additional ambulatory care encounters for our region patient base. The ambulatory initiatives cover items such as laboratory, PT/OT, social work, etc. and are a necessity of our patients to ensure a comprehensive treatment for access as

well as cost avoidance. The Region 3 initiative grid in the addendum reflects all ambulatory operations initiatives.

Plan for Learning Collaborative: We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system.

Project Valuation:

Valuation is based on cost avoidance, projecting savings associated with prevention of a life threatening disease and potentially detecting the cancer early enough from rapid and successful treatment. At an average annual cost of $3,000 for co-morbidity treatment. The cost savings of early detection and treatment over five years is estimated at $600,000.

References:

8. http://www.rgkcenter.org/sites/default/files/file/research/FB%20Report_for_posting.pdf
9. http://www.dshs.state.tx.us/tcr

2967606-01 2.4	*2.7.1*	*N/A*	*IMPLEMENT EVIDENCE-BASED DISEASE PREVENTION PROGRAMS (COLONOSCOPY SCREENING PROGRAM)*	
Fort Bend County				**2967606-01**
Related Category 3 Outcome Measure(s):	*2967606-01 3.8* *2967606-01 3.9*	*IT-6.1* *IT-12.3*	*Patient Satisfaction – Access to Specialist/Shared Decision Making* *Primary Care and Primary Prevention – Colorectal Cancer Screening*	

Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Milestone 1 [P-1]: Development of an innovative evidence-based project for targeted population <u>Metric 1</u> [P-1.1]: Document Innovational Strategy and Plan: • Description of target population ○ Level of colonoscopy adoption ○ Gatekeepers ○ education providers • Best practices research • program models. • Data Source: Documentation of meetings, research and discussions leading to development of a contract for colonoscopy services and an outreach program Milestone 1 Estimated Incentive Payment: $105,475	**Milestone 2** [P-2]:Implement evidence-based innovational project for targeted population <u>Metric 1</u> [P-2.1]: Document implementation strategy and testing outcomes Goal: Refer 50 patients for colonoscopy screening: Data Source: Documentation of education, outreach and referrals. Appointment and outcome reports Milestone 2 Estimated Incentive Payment: $59,187 **Milestone 3** [P-7]: 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 <u>Metric 1</u> [P-8.1]: Participate in semi-annual face-to-face meetings or	**Milestone 4** [P-2]: Implement evidence-based innovational project for targeted population <u>Metric 1</u> [P-2.1]: Document implementation strategy and testing outcomes Goal: Refer 75 patients for colonoscopy screening: Data Source: Documentation of education, outreach and referrals. Appointment and outcome reports Milestone 4 Estimated Incentive Payment: $65,049 **Milestone 5** [P-7] 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 <u>Metric 1</u> [P-8.1]: Participate in semi-annual face-to-face meetings or	**Milestone 6** [P-2]: Implement evidence-based innovational project for targeted population <u>Metric 1</u> [P-2.1]: Document implementation strategy and testing outcomes Goal: Refer 75 patients for colonoscopy screening: Data Source: Documentation of education, outreach and referrals. Appointment and outcome reports Milestone 6 Estimated Incentive Payment: $41,110 **Milestone 7:** [P-7] 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 <u>Metric 1</u> [P-8.1]: Participate in semi-

2967606-01 2.4	*2.7.1*	*N/A*	*IMPLEMENT EVIDENCE-BASED DISEASE PREVENTION PROGRAMS (COLONOSCOPY SCREENING PROGRAM)*
Fort Bend County			**2967606-01**
Related Category 3 Outcome Measure(s):	*2967606-01 3.8* *2967606-01 3.9*	*IT-6.1* *IT-12.3*	*Patient Satisfaction – Access to Specialist/Shared Decision Making* *Primary Care and Primary Prevention – Colorectal Cancer Screening*

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
	seminars organized by the RHP. Goal: Participate in all RHP organized meetings/seminars Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes Milestone 3 Estimated incentive Payment $59,187	seminars organized by the RHP. Goal: Participate in all RHP organized meetings/seminars Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes Milestone 5 Estimated incentive Payment $64,050	annual face-to-face meetings or seminars organized by the RHP. Goal: Participate in all RHP organized meetings/seminars Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes Milestone 7 Estimated incentive Payment $41,109 **Milestone 8** [I-7]: Increase access to disease prevention programs using innovative project option. Metric 1 [I-7.2]: Increased number of colonoscopies. Baseline: TBD in Year 2 Goal: 100% increase in number of colonoscopies performed in the target population.

2967606-01 2.4	***2.7.1***	***N/A***	***IMPLEMENT EVIDENCE-BASED DISEASE PREVENTION PROGRAMS (COLONOSCOPY SCREENING PROGRAM)***
Fort Bend County			**2967606-01**
Related Category 3 Outcome Measure(s):	*2967606-01 3.8* *2967606-01 3.9*	*IT-6.1* *IT-12.3*	*Patient Satisfaction – Access to Specialist/Shared Decision Making* *Primary Care and Primary Prevention – Colorectal Cancer Screening*

Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
			Data Source: EHRs, program referrals, appointments Milestone 8 Estimated incentive Payment $41,109
Year 2 Estimated Milestone Bundle Amount: $105,475	Year 3 Estimated Milestone Bundle Amount: $118,374	Year 4 Estimated Milestone Bundle Amount: $128,099	Year 5 Estimated Milestone Bundle Amount: $123,328
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over DYs 2-5)**:*** $475,276			

Gulf Bend

Pass 2

Project Option2.15.1-Integrate Primary and Behavioral Health Care Services: Person-Centered Behavioral Health Medical Home

Unique RHP Project Identification Number: 1352544-07.2.1/Pass 2
Performing Provider Name/TPI: Gulf Bend Center / 1352544-07

Project Summary:
Provider - Gulf Bend Center is the Community Mental Health Center located in Victoria, Texas. Gulf Bend Center provides services to individuals in the following seven county area: DeWitt, Lavaca, Jackson, Goliad, Victoria, Calhoun, and Refugio. Gulf Bend Center's Local Service Area has a population of approximately 200,000. Today, Gulf Bend Center is funded to serve an average 608 unduplicated adults per year. The Center currently reaches 1,800 adults a year with the help of local contributions, foundation grants and other forms of resource leveraging.
Intervention: Develop and implement a Person-Centered Behavioral Health Medical Home in Port Lavaca, TX. The center will target at risk populations with co-morbid diseases of mental illness and chronic disease who currently go untreated or under treated and who routinely access more intensive and costly services. The person-centered behavioral health medical home will offer behavioral health services, primary care services, health behavior education & training programs, long & short term care for those with mental illness and co-occurring chronic disease and case management services to help patients navigate the services in the same location.
Need for project: The need for this project was based upon data for Victoria County from the Texas Department of State Health Services for preventable hospitalizations from diabetes, asthma, and COPD with a coexisting behavioral/mental health disorder. The data showed:

- Between 2005 and 2010, there were 48 hospitalizations for diabetes complications that totaled $2,170,723 in charges. Using national statistics, we can conclude that of those 48 hospitalizations, that 15 had a co-occurring mental illness. If those 15 patients had access to integrated care, it would have lead to a cost savings of $678,345[222]
- Further data from Memorial Medical Center shows that 231 individuals were seen in the Emergency Department in 2011 with a primary behavioral health diagnosis. Using national statistics, of those 231 individuals, 157 had a co-occurring chronic disease.

Target population: The target population are the at risk populations with co-morbid diseases of mental illness and chronic disease.
Category 1 expected benefits: The project seeks to decrease inpatient and ED admissions for co-occurring mental illness and chronic diseases, lower the costs of providing care, and providing greater access to primary care for those with co-occurring mental illness and chronic diseases.
Category 3 outcomes: IT-2.4: Behavioral Health/Substance Abuse Admission Rate

- One for BH/SA as the principal diagnosis
- A secondary category in which a significant BH/SA secondary diagnosis is present (i.e. reduction in admission rate with a primary diagnosis of diabetes/COPD with a secondary diagnosis of mood/affective disorders.)
  Gulf Bend will attempt to decrease admissions due to diabetes and COPD with an underlying or co-existing mental health disorder by 0% by the end of DY 5.

[222] Per DSHS, the average hospital charge for a diabetes admission in Calhoun County from 2005 to 2010 was $45,223

Project Option2.15.1-Integrate Primary and Behavioral Health Care Services: Person-Centered Behavioral Health Medical Home

Unique RHP Project Identification Number:1352544-07.2.1/Pass 2
Performing Provider Name/TPI: Gulf Bend Center / 1352544-07

Project Description:
This project will integrate behavioral health and primary care services in a clinic operated by Gulf Bend Center in Calhoun County, Texas where access to these services is limited by geographical and socioeconomic barriers.

The goal of this project is to develop and implement a Person-Centered Behavioral Health Medical Home, targeting at risk populations with co-morbid diseases of mental illness and chronic disease who currently go untreated or under treated and who routinely access more intensive and costly services, such as emergency departments or jails.
This project proposes a solution by offering a site that will integrate primary care into the behavioral health services that Gulf Bend already provides in its service region, which includes the counties of DeWitt, Lavaca, Jackson, Goliad, Victoria, Calhoun, and Refugio. The person-centered behavioral health medical home will offer the following services in the same location:

1. Behavioral Health Services
2. Primary care services
3. Health behavior education and training programs
4. Long and short term care for those with mental illness and co-occurring chronic disease
5. Case Management services to help patient navigate the services provided in the community.

Clients will receive proactive, ongoing behavioral health services that keep them healthy and empower them to self-manage their conditions in order to avoid their health worsening and needing ED or inpatient care.

Goals and Relationship to Regional Goals:
The goals for this project include:

- Increase in access to primary care
- Increase in access to behavioral health care services
- Reduction in inpatient psychiatric hospitalizations
- Implement the IMPACT model of integrated collaborative care
- Increase in patient satisfaction
- Reduction in Emergency Department visits
- Chance to develop and change health behaviors
- Reduction in preventable behavioral health and chronic disease hospitalizations

This project meets the followingregional goal(s):
Improving the health of our region by expanding and coordinating access to patient-centered primary care and behavioral health care services that includes health promotion and disease prevention.

Challenges:
Gulf Bend will face several challenges in opening and operating a satellite behavioral health clinic in Calhoun County. The first challenge will be determining the best location within Calhoun County to provide these services. To meet this challenge, Gulf Bend will engage city and community official and stakeholder input as to the best location for the new clinic. The second challenge will be determining the correct staff and staffing ration to be efficient in delivering behavioral health services at the satellite clinic. Gulf Bend feels that this challenge can be overcome by researching and engaging other community health centers for a solution to this challenge. The third, and final, challenge will be operating a clinic that will be located 45 minutes away. Gulf Bend will meet this challenge by hiring a clinic manager, who will be responsible for the day to day operations of the clinic.

5-Year Expected Outcome for Provider and Patients:
The five year expected outcome through the development and implementation of the Person-Centered Behavioral Health Medical Home project is to provide critical services to the targeted population with co-morbid diseases of mental illness and chronic disease that currently go untreated or under treated. Through the delivery of integrated medical and behavioral health care we expect to see individuals with a treatment plan developed and implemented with delivery provided by those with primary care and behavioral health expertise. We also expect to see an overall reduction in costs and an increase in the overall satisfaction and health and well-being of this population.

Starting Point/Baseline:
Gulf Bend Center currently provides behavioral health services for primarily indigent or Medicaid-eligible clients who have schizophrenia, bipolar disorder, and major depression in its Victoria County location. Gulf Bend Center's Local Service Area has a population of approximately 200,000. Using national statistics we can conclude approximately 50,000 individuals have some form of mental illness of which 34,000 likely have a medical and/or chronic disease. Today, Gulf Bend Center is funded to serve an average 608 unduplicated adults per year. The Center currently reaches 1,800 adults a year with the help of local contributions, foundation grants and other forms of resource leveraging. Currently, 10% of Gulf Bend clients reside in Calhoun County. Of the 97 clients, 78 are adult and the remaining 19 are children/adolescents.

Rationale:
Gulf Bend selected this project because of the critical need for these services, which was based upon national and local data. Co-occurring mental and physical health issues are common in the general population but are significant for persons with serious mental illness. National statistics demonstrate on average more than 68% of adults with a mental disorder had at least one medical condition, and 29% of those with a medical disorder also had a mental health condition. People with schizophrenia and bipolar disorder are up to three times more likely to have three or more chronic conditions compared to people without these disorders. Research has shown that those patients affected by mental illness and suffering from chronic disease are dying 25 years earlier than the rest of the population[223].

[223] Freeman, E, Yoe, J. The Poor health status of consumers of mental healthcare: Behavioraldisorders and chronic disease, Presentation to NASMHPD Medical Directors Work Group,May 2006.

There is a demonstrated community need in Calhoun County for this project. Texas Department of State Health Services data showed alarming rates of chronic disease and preventable hospitalizations based upon data from 2005 to 2010. Between 2005 and 2010, there were 48 hospitalizations for diabetes complications that totaled $2,170,723 in charges. Using national statistics above, we can conclude that of those 48 hospitalizations, that 15 had a co-occurring mental illness. If those 15 patients had access to integrated care, it would have lead to a cost savings of $678,345[224]. Further data from Memorial Medical Center shows that 231 individuals were seen in the Emergency Department in 2011 with a primary behavioral health diagnosis. Using national statistics, of those 231 individuals, 157 had a co-occurring chronic disease. Research has shown that patient centered medical homes that use the IMPACT model of collaborative care have lead to improved outcomes in physical health, benefited various populations and have provided a lower cost of long term health care services[225]. Druss and colleagues conducted a randomized trial of patients within the Veterans Administration system in 2001. In the study, individuals living with serious mental illnesses were to receive primary care in an integrated behavioral health-primary care patient focused model of care. The study showed that individuals were significantly more likely to have made a primary care visit, had a greater mean number of primary care visits, were more likely to have received 15 of 17 preventive measures, and had a significantly greater improvement in their health[226]. Research has shown that the integration of primary care and behavioral health services in the same service location has increased outcomes for those suffering from mental illness and co-occurring chronic disease. A reason for these improved outcomes is due to the fact that integrated care offers "one-stop shopping" for its patients. Data from the Bureau of Primary Care shows that only 1 in 4 patients referred for mental health or chronic disease management make the first appointment. The same research further showed that co-location of integrated primary care services and behavioral health services resulted in improved behavioral health and chronic disease outcomes and proved to provide cost savings.

Several studies have shown the effectiveness of integrated patient centered homes for those suffering from co-occurring co-morbid diseases. On study performed in Texas showed that using an integrated collaborative care site using the IMPACT model of care enhanced access to mental health services, improved quality of life, reduced the occurrence of depression and anxiety, decrease in the utilization of unnecessary emergency department services, and a reduction in overall health care costs[227]. In the study, researchers found that anxiety scores fell by 50%, emergency department use decreased by 50%, and the average health care cost per enrolled decreased by 17% in the second year and 56% in the third year of the program. This data is significant because the targeted patient population size is similar in the Gulf Bend area. There is another benefit to an integrated collaborative care site. The other benefit of an integrated approach that will help reduce the number of admissions is long-term compliance. In 2000, researchers found that patients that receive care in an integrated care site show a higher level of adherence and retention in treatment. This translates into an overall decrease in hospital

[224] Per DSHS, the average hospital charge for a diabetes admission in Calhoun County from 2005 to 2010 was $45,223

[225] http://www.impact-uw.org/about/research.html

[226] Druss, B et al. Integrated medical care for patients with serious psychiatric illness. *Archives of General Psychiatry*, Vol 58, September 2001

[227] Watt T. A Process and Outcome Evaluation of Two Integrated Behavioral Health Care Models: People's Community Clinic and Lone Star Circle of Care. Year-Three Final Report.Texas State University. Fall 2009

admissions. This is because the patient only has to travel to one location for their behavioral and physical health services and has increased access to those services.
The research and data shown above provides evidence that Gulf Bends Category 2 project will have a significant impact and help achieve its selected Category 3 outcome measure. Gulf Bend will be integrating primary care into its existing behavioral health services and will therefore be able to reduce admissions of those affected with co-occurring co-morbid disease.

Project Components: We propose to meet all of the required core project components as follows:

a) Identify sites for integrated care projects, which would have the potential to benefit a significant number of patients in the community. This will be accomplished through community stakeholder meetings. A site will be chosen that will increase access to the integrated services based upon community need and resources, as well as the needed space requirements. Gulf Bend will secure a long term lease to meet this goal.

b) Develop provider agreements whereby co-scheduling and information sharing between physical health and behavioral health providers could be facilitated through stakeholder meetings on a weekly or monthly basis.

c) Establish protocols and processes for communication, data-sharing, and referral between behavioral and physical health providers based upon evidence based best practice models, such as the IMPACT model of collaborative care.

d) Recruit a number of specialty providers (physical health, mental health, substance abuse, etc) to provide services in the specified locations based upon community and clinic needs, as well as analysis of unduplicated patient visits. Gulf Bend will use provider recruiting and staffing agencies, postings on national association websites, and journals to recruit the needed providers.

e) Train physical and behavioral health providers in protocols, effective communication and team approach. Build a shared culture of treatment to include specific protocols and methods of information sharing that include:
    - 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.

This will be accomplished by holding weekly or semi-weekly meetings between providers and support staff to make sure that collaborative care is used.

f) Acquire data reporting, communication and collection tools (equipment) to be used in the integrated setting, which may include an integrated electronic health record system or participation in a health information exchange – depending on the size and scope of the local project. Gulf Bend will pursue the implementation of an EHR that will allow ease of use when sharing a patient’s health information and medical records among providers.

g) Explore the need for and develop any necessary legal agreements that may be needed in a collaborative practice through the advice and use of Gulf Bend's legal counsel.

h) Arrange for utilities and building services for these settings by calling the utility company within Port Lavaca.

i) Develop and implement data collection and reporting mechanisms and standards to track the utilization of integrated services as well as the health care outcomes of individual

treated in these integrated service settings. The collection methods and reporting mechanisms will be based upon a best practice model from an organization that has already implemented integrated health care.

j) Conduct quality improvement for project using methods such as rapid cycle improvement. Gulf Bend currently has a Quality Improvement board made up of several members of the executive management team and quality management staff. The QI board will develop and implement quality practices for the integrated care based upon evidence based best practice *methods.*

Unique community need identification numbers the project addresses:
The primary care/behavioral health integration proposed in this plan relates to community needs CN.1,CN.3, CN.5, CN.6, CN.7, CN.8, CN.9, CN.10, CN.11, CN.18, CN.20, CN.23,

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative: In Gulf Bend's service region, integrated care sites do not exist. This integrated medical home presents a new, more efficient, project that will begin to treat the person as a whole. The behavioral health and primary care system in the region currently operate in silos with lack of care coordination and communication among behavioral health and primary care providers. This results in less than favorable health outcomes for those with co-occurring chronic disease and mental illness. The integrated care site operated by Gulf Bend will be the first of its kind and will have a positive impact upon the residents of Calhoun County.

Related Category 3 Outcome Measure(s):OD-2 Potentially Preventable Admissions - IT-2.4 Behavioral Health/Substance Abuse Admission Rate

1. One for BH/SA as the principal diagnosis
2. A secondary category in which a significant BH/SA secondary diagnosis is present (i.e. reduction in admission rate with a primary diagnosis of asthma/diabetes/COPD with a secondary diagnosis of mood/affective disorders.)

Gulf Bend will attempt to decrease admissions due to diabetes and COPD with an underlying or co-existing mental health disorder by 10% by the end of DY 5.

Reason/rationale for selecting the outcome measure: Using the above statistics from national, state, and local data sources, there is a community need to prevent admissions in hospitals in Calhoun County for co-occurring co-morbid diseases. The integrated delivery of care will help prevent these admissions and help reduce the overall cost of providing health care to these patients.

Relationship to Other Projects: This project is related to all initiatives designed to support Primary and Behavioral Health Services redesign for improved patient satisfaction and access to care. Its focus and emphasis on improving patient experience, outcomes, coordination of care and access to specialty services will enhance and support many projects within the region, particularly those projects designed to improve access to care and reduce inappropriate ED utilization, including the following: 020973601.1.4 – Expand the number of community based settings where behavioral health services may be delivered in underserved areas; 1352544-07.1.1 (RHP 4 project) – Development of behavioral health crisis stabilization services as alternatives to hospitalization; 121775403.1.6 – Development of a crisis stabilization/urgent care

center to provide screening and assessments to determine the appropriate level of care, and 121990904.2.1 – Integrate primary and behavioral health care services. Related category 4 measures include potentially preventable admissions measures in RD-1.3, and Patient Satisfaction in RD-4.1, and Potentially Preventable Readmissions in RD -2.

Relationship to Other Performing Providers' Projects in the RHP: The cohabitation of primary care and behavioral health is an important focus of our region in order to treat the patient base with comprehensive physical and behavioral healthcare issues. There are multiple initiatives in our RHP plan that address this need and all can be found on the Region 3 Initiative Grid in the addendums. The outcome measures focused to screening measures and access of the patient base. This project will provide coordination of efforts with LMHAs that will result in great learning opportunities. Through the learning collaborative, we will work with other community entities to discuss challenges, lessons learned and obstacles to delivery. The collaborative will provide an ideal learning opportunity and sharing of ideas. Other providers with similar projects with whom we will collaborate and share information include Corpus Christi Medical Center, Bluebonnet Trails Community Mental Health Center, Coastal Plains Community Center and DeTar Healthcare System

Plan for Learning Collaborative: We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our region's healthcare system.

Project Valuation:

Gulf Bend considered several factors in valuing this project including reductions in costs associated with emergency room visits and hospitalizations for diseases and illnesses. Improving the physical health of behavioral health clients should reduce the number of ED visits and the occurrences of hospitalizations. The average cost of an ED visit in Gulf Bend's area is $1,265; average cost of a cardiology-related hospital stay is about $16,000.

The decrease in costs due to a decrease in hospital admissions is not the only costs determining factor used in this valuation. One valuation was the affect on the patient themselves. Due to these services, Gulf Bend feels that healthier individuals will have a longer and more productive life span. Those persons with mental illness and co-occurring chronic disease have a lifespan of 25 years less than those who do not have a co-occurring mental illness. Since patients will receive the needed primary care services and studies have shown that compliance is increased, Gulf Bend expects these patients to be able to be more productive and help contribute to the overall benefit of society. Studies have shown that depression is the leading cause of a decrease in productivity in the work place. If the integration of services were to help increase the productivity of patients suffering from a mood disorder and co-occurring chronic disease then the community will benefit as a whole.

1352544-07.2.1	2.15.2	*A-J*	**Integrate Primary and Behavioral Health Care Services**
Gulf Bend Center			**1352544-07**
Related Category 3 Outcome Measure(s):	*096166602.3.1*	*OD-6 IT-6.1 (1)*	*Percent improvement over baseline of patient satisfaction scores-Patients are getting timely care, appointments, and information*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-2]:Identify existing clinics or other community-based settings where integration could be supported. It is expected that physical health practitioners will share space in existing behavioral health settings, but it may also be possible to include both in new settings or for physicians to share their office space with behavioral health practitioners **Metric 1** [P-2.1]: Discussions/Interviews with community healthcare providers (physical and behavioral), city and county governments, charities, faith-based organizations and other community based helping organizations. **Baseline/Goal**: 0 **Data Source**: Information from persons interviewed Milestone2 Estimated Incentive Payment: $316,667 **Milestone 2** [P-4]:Assess ease of access to potential locations for	**Milestone 4** [P-3]: Develop and implement a set of standards to be used for integrated services to ensure effective information sharing, proper handling of referrals of behavioral health clients to physical health providers and vice versa. **Metric 1** [P-3.1]: Number and types of referrals that are made between providers at the location **Baseline/Goal: 0** **Data Sources:** Surveys of providers to determine the degree and quality of information sharing; Review of referral data and survey results Milestone 4 Estimated Incentive Payment: $225,000 **Milestone 5** [P-X2]: Recruit and hire needed primary and behavioral health staff based upon needs assessment **Metric 1** **[**P-X2.1]: Needed employees hired by start date **Baseline/Goal: 3** **Data Source:** Employee roster	**Milestone 8** [P-7]: Evaluate and continuously improve integration of primary and behavioral health services. **Metric 1** [P-7.1]: Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles **Data Source**: Project reports include examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement (e.g. how the project continuously uses data such as weekly run charts or monthly dashboards to drive improvement) Milestone 8 Estimated Incentive Payment (maximum amount): $300,000 **Milestone 9** [I-9]: Coordination of Care **Metric 1** [I-9.1]: 35% of individuals with a treatment plan developed and implemented with primary care and behavioral health expertise	**Milestone 11** [I-11]: Health Metrics **Metric 1** [I-11.1]: 20% Increase in positive results of standardized health metrics which may include objective health indicators such as body mass index, glycated hemoglobin (A1c), blood pressure; behavioral health instruments such as Quality of Life (QOL) Questionnaire, Adult Needs and Strengths Assessment (ANSA) **Goal:** 20% increase from baseline in positive results of standardized health metrics **Data Source**:Project Data; Medical Records; Claims and Encounter Data Milestone 11 Estimated Incentive Payment: $160,000 **Milestone 12** [I-12]: Improved consumer satisfaction with integrated services **Metric 1** [I-12.1]: 45% of People report satisfaction with integrated services **Goal**: 45% improvement above baseline

1352544-07.2.1	2.15.2	*A-J*	**Integrate Primary and Behavioral Health Care Services**
Gulf Bend Center			**1352544-07**
Related Category 3 Outcome Measure(s):	*096166602.3.1*	*OD-6 IT-6.1 (1)*	*Percent improvement over baseline of patient satisfaction scores-Patients are getting timely care, appointments, and information*

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
project implementation **Metric 1** [P-4.1]: Access to major roadways, bus routes, or proximity to a large number of individuals who may benefit from services. Baseline/Goal: 0 **Data Source**: City/County data, maps, demographic data relating to prevalence of health conditions Milestone 2 Estimated Incentive Payment: $316,667 **Milestone 3**[P-X1] Develop and create policies, procedures, and treatment plans for the delivery of integrated care **Metric 1** [P-X1.1]: Policy and procedure manual **Baseline/Goal: 0** **Data Source**: Gulf Bend Policy and Procedure Manual Milestone 3 Estimated Incentive Payment: $316,666	Milestone 5 Estimated Incentive Payment: $225,000 **Milestone 6** [P-5]: Develop integrated sites reflected in the number of locations and providers participating in the integration project: **Metric 1** [P-5.2]: Number of primary care providers newly located in behavioral health settings. **Baseline/Goal: 1** **Data Source**: Project data Milestone 6 Estimated Incentive Payment: $225,000 **Milestone 7** [P-6]: Develop integrated behavioral health and primary care services within co-located sites. **Metric 1** [P-6.1]: Number of providers achieving Level 4 of interaction (close collaboration in a partially integrated system). **Baseline/Goal:** **Data Source**: Project data	Goal: 35% above baseline **Data Source**: Project data; claims and encounter data; medical records Milestone 9 Estimated Incentive Payment: $300,000 **Milestone 10** [I-10]:No-Show Appointments **Metric 1** [I-10.1]: 10% decrease the "no shows" for behavioral and physical health appointments **Goal:** 10% decrease from baseline **Data Source**: Project Data; Clinic Registry Data; Claims and Encounter Data Milestone 10 Estimated Incentive Payment: $300,000	**Data Source**: Completed consumer satisfaction surveys Milestone 12 Estimated Incentive Payment: $160,000 **Milestone 13** [I-8]: Integrated Services **Metric 1** [I-8.1]: 25% of Individuals receiving both physical and behavioral health care at the established locations **Goal:** 25% improvement above baseline **Data Source**:Project data; claims and encounter data; medical records Milestone 13 Estimated Incentive Payment: $160,000 **Milestone 14** [I-9]: Coordination of Care **Metric 1** [I-9.1]: 45% of individuals with a treatment plan developed and implemented with primary care and behavioral health expertise **Goal:** 45% improvement above

1352544-07.2.1	2.15.2	*A-J*	**Integrate Primary and Behavioral Health Care Services**
Gulf Bend Center			**1352544-07**
Related Category 3 Outcome Measure(s):	*096166602.3.1*	*OD-6 IT-6.1 (1)*	*Percent improvement over baseline of patient satisfaction scores-Patients are getting timely care, appointments, and information*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	Milestone 7 Estimated Incentive Payment :$225,000		baseline **Data Source**: Project data; claims and encounter data; medical records Milestone 14 Estimated Incentive Payment: $160,000 **Milestone 15** [I-10]:No-Show Appointments **Metric 1** [I-10.1]: 20% decrease the "no shows" for behavioral and physical health appointments **Goal:**20% decrease from baseline **Data Source**: Project Data; Clinic Registry Data; Claims and Encounter Data Milestone 15 Estimated Incentive Payment: $160,000
Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone): $950,000	Year 3 Estimated Milestone Bundle Amount: $900,000	Year 4 Estimated Milestone Bundle Amount: $900,000	Year 5 Estimated Milestone Bundle Amount: $800,000
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:**$3,550,000			

Harris County Hospital District Ben Taub General Hospital

Pass 1

Project Option 2.5.4- "Other" project option: Implement other evidence-based project that will impact cost efficiency in an innovative manner: Ambulatory Care Central Fill Pharmacy

Unique RHP Project ID: 133355104.2.1 / Pass 1

Performing Provider Name/TPI: Harris Health / 133355104

Project Summary:

Provider: Harris Health System is comprised of 16 community health centers, seven school-based clinics, a dental center, dialysis center, five mobile health units, one outpatient specialty services clinic, and three hospitals. With a tax base of $511.6 million, Harris Health System was able to provide more than $1.254 billion in charity care during FY 2012.

Volume Statistics - FY2012	Patient Payor Mix	Patient Demographics
Hospital admissions- 35,343 Births (babies delivered)- 6,643 Emergency visits- 173,263 Outpatient clinic visits- 1,054,770	Self-Pay- 62.6% Medicaid and CHIP- 23.4% Medicare- 8.6% Other Funding- 3.6% Commercial Insurance- 1.8%	Hispanic- 57.4% African American- 26.3% Caucasian- 9.2% Asian- 4.8% Other- 2.2% American Indian- 0.2%

This project will create an automated ambulatory central fill pharmacy to facilitate dispensing up to 10,000 prescriptions per shift with a 24 hour turnaround time and mail order capability.

Need for the project:

Currently, Harris Health System has no automated prescription counting technology. Annually, 2.5M prescriptions are counted manually, using only a counting tray and spatula. A Central Fill facility will provide efficiencies in conjunction with the existing ePrescribing system to improve the patient's pharmaceutical experience by improving safety, wait times, turnaround times, access, and convenience.

Target Population:

All patients with prescription medications within the system with may benefit from this project (Medicaid and CHIP-23.4% / Self-Pay- 62.6%).

Category 1 or 2 expected patient benefits:

Our goal is to increase to 50% of total monthly prescription volume from established baseline of 0% prescriptions filled at central fill facility (based on 2.5M annual prescription volume) in DY4 and increase to 60% (1.5M annual) in DY5.

Category 3 outcomes:

IT-5.1: Our goal is to decrease the average labor cost per prescription 7% from established baseline in DY3 (based on 2.5M annual prescription volume), 19% in DY4, and 31% in DY5.

Project Option 2.5.4- “Other” project option: Implement other evidence-based project that will impact cost efficiency in an innovative manner: Ambulatory Care Central Fill Pharmacy

Unique RHP Project ID: 133355104.2.1 / Pass 1
Performing Provider Name/TPI: Harris Health / 133355104
Project Description:

Harris Health proposes to create an automated ambulatory central fill pharmacy to facilitate dispensing up to 10,000 prescriptions per shift with a 24 hour turnaround time and mail order capability.

Currently, Harris Health System has no automated prescription counting technology. Annually, 2.5M prescriptions are counted manually, using only a counting tray and spatula. Central Fill automation will include robotics which will count and dispense the pills into a prescription container, label and cap the prescription container, and sort and package the prescriptions for delivery to the patient or local pharmacy. A Central Fill facility will provide efficiencies in conjunction with the existing ePrescribing system to improve the patient’s pharmaceutical experience by improving safety, wait times, turnaround times, access, and convenience. Central Fill automation will provide 99.99% prescription dispensing accuracy for improved medication safety. Prescription mail order will provide increased access, convenience, and satisfaction because many of our patients have problems with transportation and job related time constraints. Wait times at the on-site pharmacies will be improved by processing the majority of refill prescriptions with a 24 hour turnaround time at Central Fill. The Harris Health Planning Department is currently searching for a suitable location on our existing property. Lease space has also been given consideration. Project managers will consist of an interdisciplinary team of pharmacy, IT, and planning representatives. Future expansion of the Central Fill model is possible at negligible cost due to the efficiencies gained by automation.

Goals and Relationship to Regional Goals:
Project Goals:

- Develop an in-house central fill facility that can process up to 10,000 prescriptions per day with the capability of increasing volume at a negligible cost.
- Increasing the percentage of prescriptions filled by the central fill facility annually.
- Decreasing the average labor cost per prescription from baseline.
- Engineering pharmacy operations to develop a patient centered delivery model ensuring comprehensive medication management for optimal outcomes.
- Enhancing patient satisfaction by decreasing pharmacy wait times and increasing pharmacy access.
- To become a provider of choice for our patients and for the medically underserved individuals and families of Harris County.

- To offer pharmaceutical services to Regional Healthcare Partners as collaborative agreements are formed.

<u>This project meets the following regional goals:</u>

The central fill project will provide the ability for Harris Health to offer pharmacy services to external Federally Qualified Health Centers (FQHC) and/or other regional healthcare partners as collaborative agreements are formed. The project will also provide increased access and patient satisfaction.

- Develop a regional approach to health care delivery that leverages and improves on existing programs and infrastructure, is responsive to patient needs throughout the entire region, and improves health care outcomes and patient satisfaction. The Harris Health Central Fill will improve efficiency in the pharmacy and improve patient satisfaction with improved wait times and patient adherence.
- Transform health care delivery from a disease-focused model of episodic care to a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary or duplicative services, and builds on the accomplishments of our existing health care system. The Harris Health Central Fill project will allow on site pharmacists to focus on clinical patient centered activities such as Medication Therapy Management, Refill Clinics and lab monitoring. These programs promote patient adherence and wellness as well as decrease emergency room visits for refills.
- Develop a culture of ongoing transformation and innovation that maximizes the use of technology and best-practices, facilitates regional collaboration and sharing, and engages patients, providers, and other stakeholders in the planning, implementation, and evaluation processes. Automation technology represents best practices currently in use by the Veterans Administration, the United States Armed Services, as well as other public hospitals and retail pharmacy services. Regional collaboration could include Harris Health acting as a contract pharmacy for our regional healthcare partners.

Challenges:

- Funding – this is addressed by the DSRIP project.
- Site location - the site location will be determined by a committee consisting of pharmacy, planning and security representatives. The site will optimally be on Harris Health property or leased if necessary. The Harris Health Planning Department is actively looking for internal space but has also identified potential external lease space.
- Software operating system - the pharmacy software operating system will be transitioned to Epic by mid DY2 which supports central fill.
- Project development – Due to the large scale nature of the project, the central fill DSRIP project will be supported by a multidisciplinary team including; an Information Technology (IT) project manager, Planning project manager and Pharmacy project manager.

5 -Year expected outcome for Provider and Patients:

Through the Central Fill project, Harris Health plans to provide increased efficiency and safety in delivery of pharmaceutical services along with increased access to such services for our patients and regional healthcare partners. Net cost savings are approximately $6.6M through use of automation as compared to the current manual prescription processing. This estimate is based on the current 2.5M prescription volume and will be greater if volume increases with proposed clinic expansions.

Starting Point/Baseline:

Currently, all prescriptions (approximately 2.5M annually) at Harris Health System are manually filled on site by frontline pharmacy staff with no available automation. Patients either wait for their prescriptions or come back at a later date. Efficiency, safety and access would be greatly enhanced with the creation of a central fill facility with mail order capability.

Rationale:

Project option 2.5.4, "Other"project option: Implement other evidence-based project that will impact cost efficiency in an innovative manner, was chosen to justify the pharmacy prescription processing redesign for cost containment. The Harris Health System Department of Pharmacy is committed to providing high quality pharmacy services in the most cost effective and efficient manner through implementation of an in-house central fill facility. The Harris Health System serves approximately 330,000 unduplicated lives, and the Department of Pharmacy currently fills approximately 2.5M prescriptions per year at 16 ambulatory pharmacies located throughout Harris County. Two of the outpatient pharmacies are located within hospitals, and the remaining 14 pharmacies are located within ambulatory clinics. Pharmaceutical services at Harris Health are currently 100% manual. It is expected that approximately 60% of the total Harris Health prescription volume could be efficiently processed by an in-house central fill facility. These medications would consist primarily of maintenance medications for chronic disease conditions. The remaining 40% prescription volume would continue to be filled at the clinic sites and would consist of immediate need medications such as antibiotics, pain medication, antipsychotics, blood pressure and diabetic medications. The in-house central fill processing would afford time for the on-site clinical pharmacists to provide expanded clinical services as physician extenders, such as Medication Therapy Management (MTM), Refill Clinics, and basic lab monitoring. These clinical value added benefits enhance the efficiency and significance of the redesign. Furthermore, the Harris Health System Central Fill Project can easily expand at negligible labor cost to offer pharmaceutical services to our Regional Healthcare Partners as collaborative agreements are formed.

Project Components:

This project does not have required components.

We will improve efficiencies by increasing the percentage of prescriptions filled at the central fill facility.

- There is currently no automation at Harris Health ambulatory pharmacies, therefore the baseline percentage of prescriptions filled at the central fill facility is 0%
- The first partial year consisting of 6 months central fill processing, ending in DY3, is expected to meet a goal of filling 40% of the total monthly ambulatory prescription volume at the facility. This percentage was chosen based on prior Rx.com central fill reports demonstrating a 36% fill rate at the central fill facility. Additional support is based on the fact that the central fill formulary consists primarily of medications used to treat chronic diseases. Approximately 50% of the total ambulatory prescription volume is for refills, and the majority is chronic disease medications.
- In DY4, the percent of prescriptions filled at central fill will increase by 10% to a goal of 50% over baseline. This will be possible by increasing the central fill formulary, centralizing drug replacement program medications and promoting a central fill awareness campaign.
- In DY5, the percent of prescriptions filled at central fill will increase by 10% to a goal of 60% over baseline. Again, this will be possible by increasing the central fill formulary and increasing central fill awareness.

Milestones & Metrics:

- Process Milestones and Metrics: P-X1, P-X1.1; P-7, P-7.1; P-X2, P-X2.1
- Improvement Milestones and Metrics: I-X1, I-X1.1

Unique Community need identification numbers the project addresses:
CN.11 High rates of chronic disease and inadequate access to treatment programs and services for illnesses associated with chronic disease, including cancer, diabetes, obesity, cardiovascular disease, asthma and AIDS/HIV. The prescriptions filled at the central fill facility are primarily refills for chronic disease conditions. The efficiencies gained with this project will allow pharmacists on site, in the clinics and hospitals, to focus on urgent need prescriptions, e.g. antibiotics, pain, seizure medications. On site clinical pharmacists will also have more time to focus on clinical functions such as Medication Therapy Management (MTM), Refill Clinics and basic lab monitoring.

- CN.21 Inadequate transportation options for individuals in rural areas and for indigent/low income populations. The Central Fill project will provide the option for mail order prescriptions. Mail order delivery will enhance access and compliance for our low income patients by relieving transportation, parking and job related issues.
  RHP priority and starting point

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

- An in-house central fill facility is a new initiative for Harris Health System. From August 2008 through December 2011 Harris Health participated in an Alternative Method Demonstration Project (AMDP) approved by Health Resources Services Administration (HRSA) to outsource the filling of prescriptions at a central fill in Fort Worth, Texas. Due to software limitations, the AMDP was discontinued and currently all prescriptions are filled on site. The 2 years with the contracted central fill pharmacy has allowed Harris Health to understand the central fill process in regards to formulary management, workflow, regulatory compliance, reports, record keeping, software and hardware requirements. The lessons learned from outsourcing to a central fill facility will ensure a successful creation of an in house central fill facility.
- The robotics in the central fill facility fill approximately 240 prescriptions per hour as compared to 22 prescriptions per hour filled manually on site. Ten thousand prescriptions may be filled per day at the central fill facility with the option to increase capacity at negligible cost.

Related Category 3 Outcome Measure(s):

OD-5 Cost of Care

IT-5.1 Improved cost savings: Demonstrate cost savings in care delivery

The central fill redesign for pharmacy services at Harris Health will result in cost savings through increased efficiencies in the delivery of pharmaceutical services at Harris Healthy System. Automation will help keep labor costs in check while our frontline staff can focus on clinical efforts for our patients. Pharmacists will be readily available for counseling patients on medication adherence. Offering a mail order delivery option will enhance access and compliance for our low income patients by relieving transportation and parking issues.

We will utilize the Cost Benefit Analysis to demonstrate costs and outcomes in monetary units. We propose incremental cost savings as the project goes from zero automation at baseline in DY2 to 60% automation by the end of DY5. We expect to decrease the average labor cost per prescription by 7% by the end of the initial DY3 implementation year. In DY4, we expect a 19% decrease from baseline in the average labor cost per prescription. In DY5, we expect a 31% decrease from baseline in the average labor cost per prescription. We will use a report to be generated from the new software operating system to determine the percentage of prescriptions filled at the central fill facility. The monthly operating statements will be used to show comparative cost savings in total salaries and benefits and the total number of prescriptions filled at Harris Health. Projected cost savings are based on current 2.5M annual prescription volume.

Relationship to other Projects:

The increase of primary care and specialty care will naturally result in additional ambulatory care encounters for our region patient base. The ambulatory initiatives cover items such as laboratory, PT/OT, social work, etc. and are a necessity of our patients to ensure a comprehensive treatment for access as well as cost avoidance. The Region 3 initiative grid in the addendum reflects all ambulatory operations initiatives.

Plan for Learning Collaborative: We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system.

Project Valuation:

This project is a supporting pillar for one of the main objectives of the 1115 Waiver; increasing access to primary care for the underserved population in Harris County. The value of the project is based on cost avoidance, projecting savings associated with reducing the costs incurred in filling 2.5 million current patient prescriptions on an annual basis. Based on the increase in primary care volumes addressed in several other Harris Health System Waiver projects, further growth in volume to over 3.0 million prescriptions is projected. Despite this increase in prescription volume, processing costs are projected to decrease in total with the addition of the central fill function. The prompt availability of needed prescriptions for our underserved patients, particularly those with chronic disease that can be managed effectively with appropriate pharmaceuticals, will result in fewer emergency room visits for public and private hospitals located in the service area, and will also help to prevent future downstream inpatient admissions.

133355104.2.1	2.5.4	N/A	"Other" project option: AMBULATORY CARE CENTRAL FILL PHARMACY
HARRIS HEALTH SYSTEM			133355104
Related Category 3 Outcome Measure(s):	133355104.3.15	IT-5.1	Improved cost savings: Demonstrate cost savings in care delivery

Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Milestone 1 [P-X1]: Establish a baseline for percentage of prescriptions processed at central fill facility Metric 1 [P-X1.1]: Baseline is 0% since there is no current automation) Goal: Provide documentation of 0% baseline (current state) Data Source: software operating system reports TBD Milestone 1 Estimated Incentive Payment (*maximum amount*): $3,428,658 **Milestone 2** [P-X2]: Complete a planning process and submit a plan Metric 1 [P-X2.1]: Implementation of Central Fill	**Milestone 3** [P-X2]: Complete a planning process and submit a plan Metric 1 [P-X2.1]: Implementation of Central Fill Goals: • Complete pharmacy operating system transition to Epic Willow Ambulatory • Complete central fill facility build out • Go-live at central fill facility Data Source: project coordinators Milestone 3 Estimated Incentive Payment: $2,493,654.33 **Milestone 4** [I-X1]: Increase number of prescriptions filled at central fill Metric 1 [I-X1.1]: Percent increase of prescriptions filled at central fill	**Milestone 6** [I-X1]: Increase number of prescriptions filled at central fill Metric 1 [I-X1.1]: Percent increase of prescriptions filled at central fill facility Goal: Increase to 50% of total monthly prescription volume from established baseline of 0% prescriptions filled at central fill facility (based on 2.5M annual prescription volume) Data source: Software operating system reports TBD Improvement Milestone 6 Estimated Incentive Payment: $3,751,355 **Milestone 7** [P-7]: Participate in at least biweekly interactions with other providers and the RHP to promote collaborative learning around	**Milestone 8** [I-X1]: Increase number of prescriptions filled at central fill Metric 1 [I-X1.1]: Percent increase of prescriptions filled at central fill facility Goal: Increase to 60% of total monthly prescription volume from established baseline of 0% prescriptions filled at central fill facility (based on 2.5M annual prescription volume) Data source: Software operating system reports TBD Improvement Milestone 8 Estimated Incentive Payment: $3,098,945.50 **Milestone 9** [P-7]: Participate in at least biweekly interactions with other providers and the RHP to promote collaborative learning around

133355104.2.1	*2.5.4*	*N/A*	***"Other" project option:*** ***AMBULATORY CARE CENTRAL FILL PHARMACY***
HARRIS HEALTH SYSTEM			*133355104*
Related Category 3 Outcome Measure(s):	*133355104.3.15*	*IT-5.1*	*Improved cost savings: Demonstrate cost savings in care delivery*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3** (10/1/2013 – 9/30/2014)	**Year 4** (10/1/2014 – 9/30/2015)	**Year 5** (10/1/2015 – 9/30/2016)
Goals: • Complete RFP & award contract to vendor • Determine site location • Begin pharmacy operating system transition to Epic Willow Ambulatory • Begin central fill facility build out Data Source: project coordinators Milestone 2 Estimated Incentive Payment: $3,428,658	facility Goal: Increase 40% of total monthly prescription volume from established baseline of 0% prescriptions filled at central fill facility (based on 2.5M annual prescription volume) Data source: software operating system reports TBD Milestone 4 Estimated Incentive Payment: $2,493,654.33 **Milestone 5** [P-7]: Participate in at least biweekly interactions with other providers and the RHP to promote collaborative learning around solutions or similar projects. This will include 1) sharing challenges and solutions 2) sharing results and quantitative progress on new improvements and 3) identifying new improvements and publicly committing to testing in the week to	solutions or similar projects. This will include 1) sharing challenges and solutions 2) sharing results and quantitative progress on new improvements and 3) identifying new improvements and publicly committing to testing in the week to come. Metric 1 [P-7.1]: Participate in one biweekly meeting, conference call or webinar organized by the RHP Goal: Bi-weekly meetings Data Source: Minutes Milestone 7 Estimated Incentive Payment: $3,751,355	solutions or similar projects. This will include 1) sharing challenges and solutions 2) sharing results and quantitative progress on new improvements and 3) identifying new improvements and publicly committing to testing in the week to come. Metric 1 [P-7.1]: Participate in one biweekly meeting, conference call or webinar organized by the RHP Goal: Bi-weekly meetings Data Source: Minutes Milestone 9 Estimated Incentive Payment: $3,098,945.50

133355104.2.1	***2.5.4***	***N/A***	***"Other" project option:* AMBULATORY CARE CENTRAL FILL PHARMACY**
HARRIS HEALTH SYSTEM			*133355104*
Related Category 3 Outcome Measure(s):	*133355104.3.15*	*IT-5.1*	*Improved cost savings: Demonstrate cost savings in care delivery*

Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
	come. <u>Metric 1</u> [P-7.1]: Participate in one biweekly meeting, conference call or webinar organized by the RHP Goal: Bi-weekly meetings Data Source: Minutes Milestone 5 Estimated Incentive Payment: $2,493,654.33		
Year 2 Estimated Milestone Bundle Amount: $6,857,316	Year 3 Estimated Milestone Bundle Amount: $7,480,963	Year 4 Estimated Milestone Bundle Amount: $7,502,710	Year 5 Estimated Milestone Bundle Amount: $6,197,891
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over DYs 2-5)****:*** $28,038,880			

Project Option 2.9.1- Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care: Reduce ER Utilization for Top Frequenters

Unique RHP Project ID: 133355104.2.2 / Pass 1
Performing Provider Name/TPI: Harris Health System / 133355104

Project Summary:

Provider:
Harris Health System is comprised of 16 community health centers, seven school-based clinics, a dental center, dialysis center, five mobile health units, one outpatient specialty services clinic, and three hospitals. With a tax base of $511.6 million, Harris Health System was able to provide more than $1.254 billion in charity care during FY 2012.

Volume Statistics - FY2012	Patient Payor Mix	Patient Demographics
Hospital admissions- 35,343 Births (babies delivered)- 6,643 Emergency visits- 173,263 Outpatient clinic visits- 1,054,770	Self-Pay- 62.6% Medicaid and CHIP- 23.4% Medicare- 8.6% Other Funding- 3.6% Commercial Insurance- 1.8%	Hispanic- 57.4% African American- 26.3% Caucasian- 9.2% Asian- 4.8% Other- 2.2% American Indian- 0.2%

Intervention(s):
This project will target top EC frequenters and ensure they are managed appropriately to receive the right care in the right setting through a navigation program.

Need for the project:
In 2010, more than 40% of Harris County ER visits by Harris County residents were primary care related, these include visits for conditions that are non-urgent, primary care treatable, and primary care preventable.

Target Population:
Any patient seeking care in the EC for primary care-treatable conditions may benefit from this project (Overall Payor Mix: Medicaid and CHIP-23.4% / Self-Pay- 62.6%).

Category 1 or 2 expected patient benefits:
Our goals are to increase the percent of patients without a PCP who receive an appointment from the EC and increase the percent of patients with a PCP who receive an appointment from the EC by 10% in DY4 and 20% in DY5. The program will target the top 100 most frequent ER utilizers by DY5.

Category 3 outcomes:
IT-9.4: Our goal is to reduce ER utilization rate for frequent user cohort by 10% in DY4 and 20% in DY5.

Project Option 2.9.1- Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care: Reduce ER Utilization for Top Frequenters

Unique RHP Project ID: 133355104.2.2 / Pass 1
Performing Provider Name/TPI: Harris Health System / 133355104

Project Description:
Harris Health System proposes a project that will target top EC frequenters and ensure they are managed appropriately to receive the right care in the right setting.

Harris Health aims to ensure patients receive appropriate care in the appropriate setting by identifying the cohort of highest EC frequenters at Ben Taub Hospital and Lyndon B. Johnson Hospital. This will allow targeted implementation of personalized management plan for more appropriate utilization of medical services and has been demonstrated to provide significant cost savings. A social worker and nurse will establish a baseline assessment of each patient identified in the cohort. The social worker will contact the patient by telephone. If the attempts are unsuccessful, the patient will be met at the next emergency center visit. During the initial contact the social worker, nurse and patient will create a plan to improve the patient's access to care and disease management. The social worker will contact the patient at mutually agreed upon intervals to monitor the patient's progress.

4.0 full-time equivalent (FTE) social workers will be required to initiate the program, which will expand to 8.0 FTE by DY5. 2.0 FTE nurses will be required to initiate the program. This will expand to 4.0 FTEs by DY5. These FTEs will be divided between Ben Taub Hospital and Lyndon B Johnson Hospital. Some physician oversight will be required. 0.5 physician FTEs, to be divided among Emergency Medicine at each hospital and Family Medicine, will be required to initiate the program. This will grow to 1.5 FTE by DY5.

Goals and Relationship to Regional Goals:
Project Goals:
The goal of this project is to identify the top ER Frequenter cohort and implement personalized management plans in order to decrease annual rate of ER usage for these patients. This project supports the region's goal to ensure patients receive the most appropriate care for their conditions.

This project addresses the following regional goals:

- Develop a regional approach to health care delivery that leverages and improves on existing programs and infrastructure, is responsive to patient needs throughout the entire region, and improves health care outcomes and patient satisfaction.

- Transform health care delivery from a disease-focused model of episodic care to a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary or duplicative services, and builds on the accomplishments of our existing health care system

Challenges:
Top ER users suffer high rates of social dysfunction, substance abuse, and psychiatric dysfunction, creating disease management challenges. Barriers to managing a chronic disease include: access to a primary care physician, transportation to routine health care visits, homelessness, lack of personal Identification, health care literacy, and medication side effects.

5-Year Expected Outcomes:
Marked decrease in ER usage for the patient cohort is expected. Additionally, Harris Health expects to realize significant cost savings and improved clinical outcomes.

Baseline:
The navigation program does not yet exist; baseline data will be identified in DY2 and DY3 as appropriate.

Rationale:
ER usage by top frequenters represents a markedly disproportionate percent of ER and hospitalization costs. Careful navigation services that establish patient trust in the healthcare system can reduce utilization of emergency services and reduce costs significantly.[228] In 2010, over 40% of Harris County ER visits by Harris County residents were primary care related, these include visits for conditions that are non-urgent, primary care treatable, and primary care preventable. The average cost to treat these patients in the ER at Harris Health System versus a primary care setting was approximately $800 per visit for all age groups. The proposed navigation program will help patients access ongoing chronic care in appropriate settings, which can significantly decrease the cost of care for those patients.

Project Components:
Harris Health will meet the required project components:

a) Identify frequent ED users and use navigators as part of a preventable ED reduction program. Train health care navigators in cultural competency. A needs assessment will be conducted in DY1 to determine the appropriate structure of the program (P-1). Navigators will be trained in DY2. Training will include cultural competency components (P-2).

[228] Gawande A. The Hot Spotters: Can we lower medical costs by giving the neediest patients better care? *The New Yorker.* 2011. http://www.newyorker.com/reporting/2011/01/24/110124fa_fact_gawande. Accessed October 25, 2012.

b) Deploy innovative health care personnel, such as case managers/workers, community health workers and other types of health professionals as patient navigators. Case managers will be trained and deployed in DY2 (P-2).
c) Connect patients to primary and preventive care. As one of the core components of the program, case managers will help patients obtain primary care appointments (I-6).
d) Increase access to care management and/or chronic care management, including education in chronic disease self-management. This will be completed as part of the development of the patient's individualized care plan.
e) Conduct quality improvement for the project, including identifying project impacts, identifying "lessons learned," opportunities to scale all or part of the project to a broader patient population, and identifying key challenges associated with expansion of the project, including special considerations for safety-net populations. A follow-up needs assessment will be completed in DY4 to determine if the program is meeting the patients' needs. Improvements identified through the needs assessment will be implemented by DY5 (P-1).

Milestones and Metrics:
The following milestones and metrics have been selected based on the population needs:
- Process Milestones and Metrics: P-1 (P-1.1), P-2 (P-2.1)
- Improvement Milestones and Metrics: I-6 (I-6.4, I-6.5)

Unique Community Needs Identification Number:
This project addresses the following community needs as identified by the region:
- CN4 – Absence of care coordination for chronic conditions
- CN12 – Improved access to patient education and information
- CN13 – Improved services and access to care for the homeless population
- CN14 – Reduction in inappropriate emergency department utilization

How the project represents a new initiative for the Performing Provider:
Patient navigation services do not currently exist for frequent ER users. This initiative will improve access to coordinated care for patients who most need it.

Related Category 3 Outcome Measure:
OD-9 Right Care, Right Setting
IT-9.4 Other Outcome Improvement Target – ED Appropriate Utilization
Reasons/rationale for selecting the outcome measures:
In 2010, over 40% of Harris County ER visits by Harris County residents were primary care related, these include visits for conditions that are non-urgent, primary care treatable, and primary care preventable. The average cost to treat these patients in the ER versus a primary care setting was approximately $800 per visit for all age groups. Connecting patients who frequent the ER with consistent, coordinated primary and specialty care access will improve clinical outcomes, which will decrease the need to access emergent services.

Relationship to Other Projects:
A primary focus of the waiver as well as our region is ensuring appropriate emergency department utilization for our patient base. The lack of primary care, specialty care, and

behavioral health treatment currently creates congestion in the emergency departments thus increasing cost and comprehensive treatment of patients with chronic conditions. The ED initiatives focus to outcomes of readmission rates, appropriate ED utilization, and patient satisfaction and all initiative relationships can be found on the Region 3 initiative grid in the addendum.

Plan for Learning Collaborative:
We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system.

Project Valuation:
This project will identify the highest utilizers of emergency room services in the Harris health System, and implement personalized navigation and management plans in order to decrease the annual rate of usage for these patients. The value of the project is based on cost savings associated with a substantial reduction in the utilization of emergency services, as well as helping to prevent future downstream inpatient admissions that frequently occur in this population. While the initial focus will begin with the top 100 patients, as the program expands we will drill further into the emergency room population and enroll more patients, as appropriate.

133355104.2.2	*2.9.1*	*(A-D)*	*PROVIDE NAVIGATION SERVICES TO TARGETED PATIENTS WHO ARE AT HIGH RISK OF DISCONNECT FROM INSTITUTIONALIZED HEALTH CARE: REDUCE ER UTILIZATION FOR TOP FREQUENTERS*
Harris Health System			*133355104*
Related Category 3 Outcome Measure:	*133355104.3.16*	*IT-9.4*	*Reduce ER Visits for Frequent User Cohort*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-1]: Conduct needs assessment Metric 1 [P-1.1]: Provide needs assessment Goal: Submission of report Data Source: Performing provider report Milestone 1 Estimated Incentive Payment: $3,130,732	**Milestone 2** [P-2]: Establish navigation program Metric 1 [P-2.1]: Number of people trained as navigators Goal: Train 2 navigators Data Source: Workforce development plans Milestone 2 Estimated Incentive Payment: $1,707,730 **Milestone 3** [I-6]: Percent of patients who are given a scheduled PCP appointment Metric 1 [I-6.4]: Percent of patients without a PCP who receive an appointment Goal: Establish baseline Data Source: Administrative and scheduling data Metric 2 [I-6.5]: Percent of patients with a PCP who receive an appointment Goal: Establish baseline Data Source: Administrative and scheduling data	**Milestone 4** [P-1]: Conduct follow-up needs assessment Metric 1 [P-1.1]: Provide ongoing needs assessment Goal: Submission of report Data Source: Performing provider report Milestone 4 Estimated Incentive Payment: $114,796.33 **Milestone 5** [P-2]: Expand navigation program Metric 1 [P-2.1]: Number of people trained as navigators Goal: Train 2 additional navigators Data Source: Workforce development plans Milestone 5 Estimated Incentive Payment: $114,796.33 **Milestone 6** [I-6]: Percent of patients who are given a scheduled PCP appointment Metric 1 [I-6.4]: Percent of patients	**Milestone 7** [I-6]: Percent of patients who are given a scheduled PCP appointment Metric 1 [I-6.4]: Percent of patients without a PCP who receive an appointment Goal: Increase by 20% over baseline Data Source: Administrative and scheduling data Metric 2 [I-6.5]: Percent of patients with a PCP who receive an appointment Goal: Increase by 20% over baseline Data Source: Administrative and scheduling data Milestone 7 Estimated Incentive Payment: $2,829,669

133355104.2.2	***2.9.1***	***(A-D)***	***PROVIDE NAVIGATION SERVICES TO TARGETED PATIENTS WHO ARE AT HIGH RISK OF DISCONNECT FROM INSTITUTIONALIZED HEALTH CARE: REDUCE ER UTILIZATION FOR TOP FREQUENTERS***
Harris Health System			*133355104*
Related Category 3 Outcome Measure:	*133355104.3.16*	*IT-9.4*	*Reduce ER Visits for Frequent User Cohort*
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	Milestone 3 Estimated Incentive Payment: $1,707,730	without a PCP who receive an appointment Goal: Increase by 10% over baseline Data Source: Administrative and scheduling data <u>Metric 2</u> [I-6.5]: Percent of patients with a PCP who receive an appointment Goal: Increase by 10% over baseline Data Source: Administrative and scheduling data Milestone 6 Estimated Incentive Payment: $114,796.33	
Year 2 Estimated Milestone Bundle Amount: $3,130,732	Year 3 Estimated Milestone Bundle Amount: $3,415,460	Year 4 Estimated Milestone Bundle Amount: $3,425,389	Year 5 Estimated Milestone Bundle Amount: $2,829,669
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over DYs 2-5)***:** $12,801,250			

Project Option 2.8.6- Reduce Inappropriate ED Use: Emergency Center Advanced Triage Care

Unique RHP Project Identification Number: 133355104.2.3 / Pass 1
Performing Provider Name/TPI: Harris Health System / 133355104

Project Summary:

Provider:
Harris Health System is comprised of 16 community health centers, seven school-based clinics, a dental center, dialysis center, five mobile health units, one outpatient specialty services clinic, and three hospitals. With a tax base of $511.6 million, Harris Health System was able to provide more than $1.254 billion in charity care during FY 2012.

Volume Statistics - FY2012	Patient Payor Mix	Patient Demographics
Hospital admissions- 35,343 Births (babies delivered)- 6,643 Emergency visits- 173,263 Outpatient clinic visits- 1,054,770	Self-Pay- 62.6% Medicaid and CHIP- 23.4% Medicare- 8.6% Other Funding- 3.6% Commercial Insurance- 1.8%	Hispanic- 57.4% African American- 26.3% Caucasian- 9.2% Asian- 4.8% Other- 2.2% American Indian- 0.2%

Intervention(s):
This project will improve emergency center throughput and reduce inappropriate use of emergency centers in the system through the implementation of a provider-in-triage model.

Need for the project:
In 2010, more than 40% of Harris County ER visits by Harris County residents were primary care related, these include visits for conditions that are non-urgent, primary care treatable, and primary care preventable.

Target Population:
All patients within the system seeking care in the ER for primary-care for treatable conditions may benefit from this project (Medicaid and CHIP-23.4% / Self-Pay- 62.6%). From January-September 2012, Harris Health saw 3,484 ESI 4 and ESI 5 patients combined.

Category 1 or 2 expected patient benefits:
Our goal is to decrease average length-of-stay in the ER by 1% compared to baseline in DY3, by 3% in DY4, and by 5% in DY5. We also aim to increase the number of patients seen through advanced triage model from 1,000 in DY3 to 5,000 by DY5.

Category 3 outcomes:
IT-9.4: Our goal is to reduce ER utilization rate for ESI level 5 patients by 5% of baseline in DY4 and 10% of baseline in DY5.

Project Option 2.8.6- Reduce Inappropriate ED Use: Emergency Center Advanced Triage Care

Unique RHP Project Identification Number: 133355104.2.3 / Pass 1
Performing Provider Name/TPI: Harris Health System / 133355104

Project Description:
Harris Health System proposes a project to improve emergency center throughput and reduce inappropriate use of emergency centers in the system.

In an effort to improve emergency center (EC) throughput, many emergency departments have placed physicians in the triage area. EMTALA mandates that all patients presenting to an Emergency Department be provided a medical screening exam to determine if an "emergency medical condition" exists that would require further evaluation and treatment. In the provider-in-triage model, a physician has the opportunity to provide this medical screening exam and determine if the patient should continue to receive care in the emergency department, or if the best care setting for the patient's condition would be at another care location (primary care office, urgent care center, etc.). Patients whose conditions can be treated appropriately in an outpatient clinic setting will be referred to a proximate same day outpatient clinic. In the event that a patient requires further care in the ED, the provider will initiate diagnostic testing (laboratory and imagining) while the patient returns to the waiting room. When the patient is evaluated later, testing should be completed, facilitating faster disposition.

The project will require 1.44 full-time equivalent (FTE) physicians initially, which will provide coverage for two shifts per week. By DY 5, 6.00 FTE will be dedicated to triage screening, or 5 shifts per week. The FTE will be split equally between Ben Taub Hospital and Lyndon B. Johnson Hospital.

Goals:
Project goals:

- Improving patient throughput times
- Improving efficiency by helping patients with non-urgent conditions receive appropriate care in the appropriate setting

This project addresses the following regional goals:

- Transform health care delivery from a disease-focused model of episodic care to a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary or duplicative services, and builds on the accomplishments of our existing health care system

Challenges:

There are concerns regarding adding additional providers to a defined space in the triage area. EC redesign will be occurring during this timeline as well.

5-Year Expected Outcomes for Provider and Patients:
Improve throughput times of EC patients who meet emergency severity index (ESI) level 3-5 criteria. Increase the number of patients referred to proximate same day clinics.

Starting Point/Baseline:
Average length of stay and number of patients per month by ESI level, January-September 2012:

Ben Taub Hospital:

ESI 3 = 757 minutes (12.6 hours); 4,352 patients
ESI 4 = 473 minutes (7.9 hours); 1,466 patients
ESI 5 = 395 minutes (6.6 hours); 579 patients

Lyndon B. Johnson Hospital:

ESI 3 = 810 minutes (13.5 hours); 2,374 patients
ESI 4 = 568 minutes (9.5 hours); 1,274 patients
ESI 5 = 494 minutes (8.2 hours); 165 patients

Rationale:

In 2010, more than 40% of Harris County ER visits by Harris County residents were primary care related, these include visits for conditions that are non-urgent, primary care treatable, and primary care preventable. The average cost to treat these patients in the ER versus a primary care setting was approximately $800 per visit for all age groups. Referring patients with primary care treatable conditions to proximate same day clinics can help to reduce costs of care for the affected individual patients, freeing resources and improving efficiency for patients who need emergent care.

Placing a physician in triage will allow patients to receive medical screening before occupying an EC bed. Studies have shown that effectively positioning a physician in triage can decrease the time spent in an EC bed.[229] Several advanced triage models (e.g. nurse-led teams) have proven effective but are wrought with opportunities to mistake subtle complaints or symptoms for a non-emergency and allow acutely ill patients to wait prolonged times for treatment. Optimal patient safety supports a physician at triage ensuring expedient evaluation, appropriate diagnostic work-up and treatment[230]. Thus, by implementing a physician in triage model, we expect to improve efficiency while maintaining high quality standards of care.

Project Components:

[229] Russ S, Jones I, Aronsky D, Dittus RS, Slovis CM. Placing physician orders at triage: the effect on length of stay.
[230] Burström L, Nordberg M, Örnung G, CastréM, Wiklund T, Engtsröm ML, Enlund M. Physician-led team triage based on lean principles may be superior for efficiency and quality? A comparison of three emergency departments with different triage models. *Scandanavian Journal of Trauma, Resuscitation and Emergency Medicine.* 2012; 20:57-68.

There are no required project components for option 2.8.6.

Milestones & Metrics:

- Process Milestones and Metrics: P-4 (P-4.1), P-10 (P-10.1), P-12 (P-12.1)
- Improvement Milestones and Metrics: I-13 (I-13.1), I-14 (I-14.1)

Number of patients reached through advanced triage (progress toward goal) and length of stay (efficiency) are the selected improvement metrics. Metrics will be measured per hospital to account for variations in patient populations.

Unique Community Needs Identification Number:

- CN14 – Reduction in inappropriate emergency department utilization
-

How the project represents a new initiative for the Performing Provider:
Harris Health currently does not position physicians in the triage area. This initiative will improve ER efficiency and lengths of stay.

Related Category 3 Outcome Measures:
OD-9 Right Care, Right Setting
IT-9.4 Other Outcome Improvement Target – EC Appropriate Utilization for ESI Level 5 Patients

Reasons/rationale for selecting the outcome measures:

In 2010, over 40% of Harris County ER visits by Harris County residents were primary care related, these include visits for conditions that are non-urgent, primary care treatable, and primary care preventable. The average cost to treat these patients in the ER versus a primary care setting was approximately $627 per visit for all age groups.[231] Referring patients with primary care treatable conditions to proximate walk-in clinics can help to reduce costs of care for the affected individual patients, freeing resources and improving efficiency for patients who need emergent care.

Relationship to Other Projects:
A primary focus of the waiver as well as our region is ensuring appropriate emergency department utilization for our patient base. The lack of primary care, specialty care, and behavioral health treatment currently creates congestion in the emergency departments thus increasing cost and comprehensive treatment of patients with chronic conditions. The ED initiatives focus to outcomes of readmission rates, appropriate ED utilization, and patient satisfaction and all initiative relationships can be found on the Region 3 initiative grid in the addendum.

Plan for Learning Collaborative: We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our

[231] School of Public Health, *Houston Hospitals Emergency Department Use Study: January 1, 2010 through December 31, 2010,* Houston, Texas: University of Texas Health Science Center at Houston, 2012.

participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system.

Project Valuation:

This project will improve patient throughput times for patients appropriately utilizing emergency room services, and improve the overall efficiency of the healthcare system by helping patients with non-urgent conditions receive appropriate care in a more cost effective setting. The value of the project is based on cost savings associated with a reduction in the utilization of emergency services by non-urgent patients. Referring patients with primary care treatable conditions to proximate walk-in clinics can also help to reduce costs of care for the affected individual patients, freeing resources and improving efficiency for patients who need emergent care.

133355104.2.3	***2.8.6***	***N/A***	***Reduce Inappropriate ED Use: Emergency Center Advanced Triage Care***
Harris Health System			*133355104*
Related Category 3 Outcome Measure(s):	*133355104.3.17*	*IT-9.4*	*Reduced EC Utilization for ESI Level 5 Patients*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-4]: Define operational procedures to improve efficiencies Metric 1 [P-4.1]: Report at least two new procedures (medical screening and advanced triage care) to improve care management efficiency Goal: Submission of analysis Data Source: Performing Provider report Milestone 1 Estimated Incentive Payment: $2,455,947	**Milestone 2** [P-10]: Develop a quality dashboard Metric 1 [P-10.1]: Submission of dashboard development, utilization and results Goal: Submission of dashboard Data Source: EHR, policies and procedures, sample report Milestone 2 Estimated Incentive Payment: $1,339,653 **Milestone 3** [I-14]:Measure efficiency Metric 1 [I-14.1]: Decrease average length of stay Goal: Decrease average LOS by 1% compared to baseline Data Source: EHR Milestone 3 Estimated Incentive Payment: $1,339,653	**Milestone 4** [P-12]: Report findings and learnings Metric 1 [P-12.1]: Report summary Goal: Submission of analysis Data Source: Performing Provider report Milestone 4 Estimated Incentive Payment: $895,698.33 **Milestone 5** [I-13]:Progress toward target Metric 1 [I-13.1]: Number or percent of all clinical cases that meet target/goal-Increase number of patients seen through advanced triage model Goal: Increase number of patients seen to 3,000 Data Source: EHR Milestone 5 Estimated Incentive Payment: $895,698.33 **Milestone 6** [I-14]:Measure efficiency Metric 1 [I-14.1]: Decrease average	**Milestone 7** [I-13]:Progress toward target Metric 1 [I-13.1]: Number or percent of all clinical cases that meet target/goal-Increase number of patients seen through advanced triage model Goal: Increase number of patients seen to 5,000 Data Source: EHR Milestone 7 Estimated Incentive Payment: $1,109,887 **Milestone 8** [I-14]:Measure efficiency Metric 1 [I-14.1]: Decrease average length of stay Goal: Decrease average LOS by 5% compared to baseline Data Source: EHR Milestone 8 Estimated Incentive Payment: $1,109,887

133355104.2.3	***2.8.6***	***N/A***	***Reduce Inappropriate ED Use: Emergency Center Advanced Triage Care***
Harris Health System			*133355104*
Related Category 3 Outcome Measure(s):	*133355104.3.17*	*IT-9.4*	*Reduced EC Utilization for ESI Level 5 Patients*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
		length of stay Goal: Decrease average LOS by 3% compared to baseline Data Source: EHR Milestone 6 Estimated Incentive Payment: $895,698.33	
Year 2 Estimated Milestone Bundle Amount: $2,455,947	Year 3 Estimated Milestone Bundle Amount: $2,679,306	Year 4 Estimated Milestone Bundle Amount: $2,687,095	Year 5 Estimated Milestone Bundle Amount: $2,219,774
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over DYs 2-5)***:** $10,042,122			

Harris County Hospital District Ben Taub General Hospital

Pass 3

Project Option 2.9.1- Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care: OB Navigation Program

Unique RHP Project Identification Number: 133355104.2.4 / Pass 3

Performing Provider Name/TPI: Harris Health System / 133355104

Project Summary:

Provider:

Harris Health System is comprised of 16 community health centers, seven school-based clinics, a dental center, dialysis center, five mobile health units, one outpatient specialty services clinic, and three hospitals. With a tax base of $511.6 million, Harris Health System was able to provide more than $1.254 billion in charity care during FY 2012.

Volume Statistics - FY2012	Patient Payor Mix	Patient Demographics
Hospital admissions- 35,343 Births (babies delivered)- 6,643 Emergency visits- 173,263 Outpatient clinic visits- 1,054,770	Self-Pay- 62.6% Medicaid and CHIP- 23.4% Medicare- 8.6% Other Funding- 3.6% Commercial Insurance- 1.8%	Hispanic- 57.4% African American- 26.3% Caucasian- 9.2% Asian- 4.8% Other- 2.2% American Indian- 0.2%

Intervention(s):

This project will improve access to pre- and postnatal care through comprehensive, effective patient navigation through the Harris Health System and throughout a woman's pregnancy, with a focus on high-risk mothers.

Need for the project:

Harris County had 68,167 births in 2010. In FY2012, Harris Health delivered 6,643 babies. The Healthy People 2020 goal for low birth-weight births is 7.8%, while the percentage of low birth-weight births at the Harris Health System for 2011 was 9.9%.

Target Population:

Potential prenatal care patients across the county and within the system will be targeted. (2009 Harris Health Delivery Payor Mix: Medicaid- 62%/ Self-Pay and Indigent- 33%).

Category 1 or 2 expected patient benefits:

Our goal is to increase the number of unique patients served by 10% over baseline in DY4 and 15% in DY5. The team may serve more than 5,000 by DY5, depending on the patient population and team size.

Category 3 outcomes:

IT-8.2: In DY4, of those patients who received the intervention, decrease the percentage of babies born weighing <2,500 grams to less than DY3 percentage. DY5 is goal to be determined.

Project Option 2.9.1- Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care: OB Navigation Program

Unique RHP Project Identification Number: 133355104.2.4 / Pass 3

Performing Provider Name/TPI: Harris Health System / 133355104

Project Description:

We propose a project that would improve access to pre- and postnatal care through comprehensive, effective patient navigation through the Harris Health System and throughout a woman's pregnancy. Navigation efforts will be aimed at overall improved birth outcomes for Harris Health System obstetrics patients, such as increased gestational age and birth weight, and low infant and maternal mortality rates. However, specific improvement targets are described in the table and in Category 3 measure documents.

Funding for the OB Navigation Program will provide for a collaborative team of Navigators to include Community Health Workers (CHWs), Case Managers (CMs), Social Workers (SWs), and Nurses, who will be responsible for navigating high-risk mothers through the healthcare system throughout their pregnancy and to their postpartum appointment. The care team will be spread to cover all 13 facilities that provide obstetrics care in the Harris Health System. The care team will be responsible for recruiting women into prenatal care across the system and will route those patients through to postpartum care. They may also route existing obstetrics patients into postpartum care and subsequent primary care in a medical home. Through encounters in the medical home setting and with navigators, chronic conditions can also be addressed through patient education opportunities at health centers and access to chronic disease management programs. Internal efforts through P-1 in DY2 will produce a plan detailing the specific target population, size and skill mix of the care team needed, and additional strategies that will be used to manage and capture the target population.

Strategic areas within Harris Health System to enroll women will include facilities offering free pregnancy testing, the postpartum and NICU inpatient units, and the Emergency Departments. The University Of Texas School Of Public Health's 2009 ED analysis of primary care visits to the ED revealed that of the top 20 primary care related diagnosis in the 18-24 year old age Medicaid group, the top 3 diagnoses were for pregnancy related conditions. Moreover, a total of 7 of the 20 overall were pregnancy related diagnoses. P-5 in DYs 4 and 5 will report on the navigation services occurring in the EDs.

In the community, CHWs will engage women at external venues, such as apartment complexes, community centers, and local businesses. The team will ensure proper access to care, appointment scheduling, Medicaid/CHIP enrollment, and will use targeted outreach strategies and health education to reach patients early in pregnancy, especially when patients are at risk of leaving the care of Harris Health System. Once enrolled, patients will receive follow-up phone

calls, appointment reminders, case management services, education, and support from Navigators to ensure that patients continue prenatal care, delivery, and postpartum follow-ups. For the purposes of Improvement Milestone I-12 measurement, the definition of "enrolled" will be established in DY2. Navigators will hand patients off to the care of a primary care provider after the postpartum visit. Improvement milestones and goals in DY4 and DY5 concentrate on increasing the number of unique patients enrolled in the program. While accurate data collection issues will be addressed in DY2, reports from the Harris Health System EMR indicate that an average of approximately 600 OB Screening visits are completed each month across all Harris Health System health centers. An OB Screening visit indicates a recent positive pregnancy test. Using the current volume of OB Screening visits, a 10% increase in DY4 over the baseline number of patients enrolled in DY3 is a reasonable goal, irrespective of when enrollment begins in DY3. Furthermore, the goal of a 15% increase over baseline in DY5 is a reasonable expectation as lessons learned in DY4 will enhance outreach and enrollment efforts.

Targeted, "high-risk" mothers will exhibit risk factors relating to medical conditions, previous pre-term birth experience, and/or other socio-economic and psychosocial risk factors. Each of the Harris Health System health centers are located in areas of the community with populations at high-risk of delivering with poor outcomes. Navigators will use the EPIC EMR to collect data and document patient encounters.

We propose to target zip codes in Harris County with the poorest perinatal outcomes, including: highest rates of pre-term birth, low birth weight, and infant and maternal mortality. In addition, these areas exhibit low rates of entry into prenatal care during the first trimester. These areas coincide with areas of low-income poor socio-economic status. This data is currently available from the State and internal sources at Harris Health System and is reliable. By comparing the zip codes to Harris Health System care locations, it becomes clear that all health centers are strategically located to serve the high-risk, pregnant population.

Target Zip Codes:

77003	77021	77033	77048	77072	77082	77091	77520
77004	77022	77036	77051	77073	77083	77093	77521
77013	77026	77038	77053	77074	77086	77096	77530
77016	77028	77040	77054	77077	77088	77099	77562
77018	77031	77045	77067	77078	77090	77338	77587
77020	77032	77047	77071	77081	77506		

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

The goal of this project is to utilize community health workers, case managers, social workers, and nurses as a comprehensive patient navigation team that will provide enhanced care

coordination, community outreach, social support and culturally competent care to high-risk obstetrics patients throughout their pregnancy. Patient Navigators will ensure that patients receive coordinated, timely, and site-appropriate health care services. Navigators may assist in connecting patients to Ob care providers in Harris Health medical home sites, as well as diverting non-urgent obstetrics care from the Emergency Department to site-appropriate locations.

Project Goals:

- Increase the number of unique patients served by the Ob navigation program.
- Decrease percentage of low birth-weight births among patients who complete the program and deliver at Harris Health System.

This project meets the following Region 3 goals:

- Transform health care delivery from a disease-focused model of episodic care to a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary or duplicative services, and builds on the accomplishments of our existing health care system, and
- Develop a regional approach to health care delivery that leverages and improves on existing programs and infrasturcutre, is responsive to patient needs throughout the intire region, and improves health care outcomes and patient satisfaction.

The Ob Navigation program uses a patient-centered, coordinated care navigation model that aims to improve perinatal outcomes, improve satisfaction through timely access to appropriate care, and builds on the existing, successful network of Harris Health prenatal care access points. The program leverages the existing Harris Health prenatal care infrastructure to meet the need for increased enrollment in prenatal care with the goal of improving the poor perinatal outcomes currently exhibited in Harris County.

Challenges:

Currently, local data illustrates that perinatal outcomes in Harris County remain poor, despite boasting a world-renowned medical center. Harris County's preterm birth rates (13.3%), low birth weight rates (8.8 %), infant mortality (6.3/1000 live births), fetal mortality (6.2 1000 live births plus fetal deaths) and maternal mortality (21.4/100,000 live births)[1] are all higher than the Healthy People 2020 goal. Since 2005, there has also been a steady decline in first trimester prenatal care in Harris County (62% of births, compared to only 52.4% in 2010). Cultural and social determinants that are difficult to overcome contribute to Harris County's poor outcomes. The Ob navigation program will attempt to address this challenge through targeted, concerted outreach efforts to patients at high-risk of experiencing poor perinatal outcomes and entering prenatal care late.

5-Year Expected Outcome for Provider and Patients:

Harris Health System expects to see improvements in perinatal outcomes, specifically related to birth-weight births, for patients completing the program and delivering within the Harris Health System. Expected outcomes will relate to the project goals described above.

Starting Point/Baseline:

Currently, a patient navigation program does not exist for obstetrics patients at the Harris Health System. Therefore, the baseline will be set at 0 for DY1-2.

Rationale:

Reasons for selecting the project option:

Patient navigators will help patients and their families navigate the complex Harris Health System. The Ob navigation team will include: Community Health Workers (CHWs), Case Managers (CMs), Social Workers (SWs), and Nurses. Patient navigators will be chosen based on their ability to be compassionate, culturally competent, and knowledgeable about the health care setting.

An Ob navigation team is needed in the Harris County community. Harris County has had an average of 71,000 births per year since 2005 (5.6% of Texas births), with 68,167 births in 2010. Harris County's low birth weight rate (8.8 %) for the same year is higher than the Healthy People 2020 goal of 7.8% and higher than the 2010 national average of 8.15%. Moreover, the percentage of low birth-weight births at the Harris Health System (LBJ General Hospital and Ben Taub General Hospital combined) for 2011 was 9.9%. While this project is targeting low birth-weight percentages for the selected Category 3 outcome measure, it is important to note that Harris County performs poorly across many perinatal outcome measures.

In 2010, Harris County's preterm birth rate was 13.3% (9,096 pre-term babies). This rate has decreased slightly since 2005 (13.7%), yet remains above the national rate of 11.99% and the Healthy People 2020 goal of 11.4%. Within Harris County, there are great disparities regarding preterm birth rates; zip-code level data shows preterm birth rates ranging from 3.8% to 19.8%[1].

Since 2005, there has been a steady decline in first trimester prenatal care in Harris County (62% of births, compared to only 52.4% in 2010). Zip-code data identify disparities within the county, with rates for first trimester prenatal care ranging from 32.8% to 74.2%. Approximately 3.8% of the births in 2010 received no prenatal care. Births with no prenatal care range from 0 to 10% at the zip-code level.

The infant mortality rate in 2010 was 6.3/1,000 live births, which is above the Healthy People 2020 goal of 6.0/1,000 live births. Fetal mortality is high as well, at 6.2/1,000 live births plus fetal deaths, placing our rates above the Healthy People 2020 goal of 5.6/1,000 live births plus fetal deaths. Entering in to care early in pregnancy allows for accurate dating of pregnancy, identifying and treating health risk factors for the mother, and providing education. This is

especially important as about 39% of women in Harris County are uninsured prior to pregnancy and a high proportion of women responding to the Pregnancy Risk Assessment Monitoring System questionnaire women reported suboptimal preconception health[2]. Early identification of women with a previous preterm birth enables interventions to potentially prevent a subsequent preterm birth.

By comparing the attached maps, which include markers where Harris Health System health centers are located as well as our target zip codes (listed above), it becomes clear that all health centers are strategically located to serve the high-risk, pregnant population.

Project Components:

Through the Ob Navigation Program, we propose to meet all required project components listed below and believe that the selected milestones and metrics relate to project components.

a) *Identify frequent ED users and use navigators as part of a preventable ED reduction program. Train health care navigators in cultural competency.* The navigation team will use the ED as contact point to engage pregnant women. Milestones 7 and 10 in DYs 4 and 5 will measure the navigation services provided to women the EDs at Ben Taub and LBJ General Hospitals. Cultural competency is not only part of required training for all Harris Health employees, but will also be a necessary skill for all members of the navigation team upon hiring.

b) *Deploy innovative health care personnel, such as case managers/workers, community health workers and other types of health professionals as patient navigators.* Milestones 2 and 3 in DY3 focus on the hiring and training of health professionals for this program, including: Case Manager, Social Workers, Community Health Workers, and Nurses.

c) Connect patients to primary and preventive care. While typically at the end of the navigation cycle, the connection from prenatal to postnatal and primary care is an integral part of the navigation team’s duties. Patients will be connected postnatal and primary care after delivery and during their pregnancy, as needed. As an established Harris Health patient, mothers will be quickly routed to their medical home.

d) Increase access to care management and/or chronic care management. As an established Harris Health patient, mothers will be quickly routed to their medical home. Many times, their prenatal care provider will be in the same facility as their primary care medical home. In the medical home, patients will find access to chronic disease management, care management, and education, as needed.

e) *Conduct quality improvement for project using methods such as rapid cycle improvement*. At a higher level, we will participate in face-to-face learning at least twice per year with other providers and the RHP to promote collaborative learning around similar navigation and obstetric-focused projects (DY3,4,5). At the ground level, we will monitor a consistent set of agreed-upon, evidence-based metrics to measure the effectiveness of the navigation program, both operationally and regarding outcomes. As opportunities for improvement are found, we will implement quality improvement processes and/or projects in partnership with our Quality Management Services department.

Patients will experience a hand-off to a primary care provider after the postpartum visit. If patients should need chronic care management or other treatment, a primary care visit will be scheduled. In addition, all preventive care needs will be met by the medical home.

Milestones & Metrics:

The following milestones and metrics have been chosen for the Ob Navigation Program project based on the core components and the needs of the target population:

- Process Milestones and Metrics: P-1 (P-1.1); P-2 (P-2.1); P-X (P-X.1); P-X2 (P-X2.1); P-8 (P-8.1);
- Improvement Milestones and Metrics: I-X (I-X.1) (I-X.2)

Customizable Improvement Milestones and Metrics were chosen in order to specifically tailor their intent to target the Ob population.

Unique community need identification number the project addresses:

The project addresses the following unique community needs as identified in the community needs assessment:

- CN.8- High rates of inappropriate emergency department utilization
- CN.14- High rates of poor birth outcomes and low birth-weight babies
- CN.15- Insufficient access to services for pregnant women, particularly low income women
- CN.23- Lack of patient navigation, patient and family education and information programs

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

Currently, a patient navigation program does not exist for obstetrics patients at the Harris Health System. The initiative will be new and will improve access for targeted patients while helping the system to reach capacity for treating obstetrics patients.

Related Category 3 Outcome Measure(s):

OD-8 Perinatal Outcomes:

IT-8.2 Percentage of Low Birth-weight Births

- The number of babies born weighing <2,500 grams at birth

Reasons/rationale for selecting the outcome measure(s):

Harris County's low birth weight rate (8.8 %) for the same year is higher than the Healthy People 2020 goal of 7.8% and higher than the 2010 national average of 8.15%. Moreover, the percentage of low birth-weight births at the Harris Health System (LBJ General Hospital and Ben Taub General Hospital combined) for 2011 was 9.9%. Low birth-weight rate is also a Healthy People 2020 objective. IT-8.2 will measure the percentage of low birth-weight births among those patients who have completed the OB Navigation program (received the intervention) by the time of delivery at a Harris Health System hospital. The definition of "program completion" will be determined during the DY2 planning period.

Relationship to other Projects and Other Performing Providers' Projects in the RHP:

The ability to properly identify and monitor specific patients with chronic conditions or frequent emergency department utilization trends will allow the region to accurately mange the very large patient base. Patient navigation includes a comprehensive list of tasks as well as unique provider types based on the focus of the initiative and will help the focus of cost containment, emergency department utilization, and chronic disease management. The Region 3 Initiative Grid in the addendum allows for a cross reference of all initiatives proposed within this concept.

Plan for Learning Collaborative: We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system.

Project Valuation:

The goal of this project is to utilize community health workers, case managers, social workers, and nurses as a comprehensive patient navigation team that will provide enhanced care coordination, community outreach, social support and culturally competent care to high-risk obstetrics patients throughout their pregnancy. The estimated number of high risk cases at Harris Health on an annual basis is over 2,000. All of those cases will be targeted by this program, with a goal to decrease the percentage of low birth-weight births among patients who complete the program and deliver at Harris Health System. Of those patients who receive patient navigation services, he goal is to decrease the percentage of babies born weighing <2,500 grams at birth to less than DY2 baseline.

[1]Texas Department of State Health Services Center for Health Statistics, (2010

[2]Wier, L.M. (Thomson Reuters), and Andrews, R.M. (AHRQ).*The National Hospital Bill: The Most Expensive Conditions by Payer, 2008*. HCUP Statistical Brief #107. March 2011. Agency for Healthcare Research and Quality, Rockville, MD. http://www.hcup-us.ahrq.gov/reports/statbriefs/sb107.pdf

133355104.2.4	*2.9.1*	*2.9.1 (A-E)*	***PROVIDE NAVIGATION SERVICES TO TARGETED PATIENTS WHO ARE AT HIGH RISK OF DISCONNECT FROM INSTITUTIONALIZED HEALTH CARE: OB NAVIGATION PROGRAM***
Harris Health System			*133355104*
Related Category 3 Outcome Measure(s):	*133355104.3.24*	*IT-8.2*	*Percentage of Low Birth-Weight Births*

Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Milestone 1 [P-1]: Conduct a needs assessment to identify the patient population(s) to be targeted with the Patient Navigator program. <u>Metric 1</u> [P-1.1]: Provide report identifying the following: • Targeted patient population characteristics • Gaps in services and service needs. • How program will identify, triage and manage target population • Ideal number of patients targeted for enrollment • Number of Patient Navigators needed to be hired • Available site, state, county and clinical data including flow patients, cases in a given year by race and ethnicity, number of cases lost to follow-up that required medical treatment, percentage of monolingual patients Goal: Produce a comprehensive report documenting all points	**Milestone 2** [P-2]: Establish a health care navigation program to provide support to patient populations who are most at risk of receiving disconnected and fragmented care including program to train the navigators, develop procedures and establish continuing navigator education. <u>Metric 1</u> [P-2.1]: Number of people trained as patient navigators, number of navigation procedures, or number of continuing education sessions for patient navigators. Baseline: In DY2, an Ob navigator program did not exist. In addition, a training program, procedures, and continuing education did not exist. Goal: Using report from DY2, develop a navigator training program with procedures and continuing education.	**Milestone 6** [I-10]: Improvements in access to care of patients receiving patient navigation services using innovative project option. <u>Metric 1</u> [I-10.3]: Documentation of increased number of unique patients served by innovative program. Demonstrate improvement over prior reporting period. Baseline: Established in DY3 Goal: Increase number of unique patients served by innovative program by 10% over baseline Data Source: Enrollment reports; EHR Milestone 6 Estimated Incentive Payment: $2,052,185 **Milestone 7** [P-5]: Provide reports on the types of navigation services provided to patients using the ED as high users or for episodic care. The	**Milestone 9** [I-10]: Improvements in access to care of patients receiving patient navigation services using innovative project option. <u>Metric 1</u> [I-10.3]: Documentation of increased number of unique patients served by innovative program. Demonstrate improvement over prior reporting period. Baseline: Established in DY3 Goal: Increase number of unique patients served by innovative program by 15% over baseline Data Source: Enrollment reports; EHR Milestone 9 Estimated Incentive Payment: $1,692,896 **Milestone 10** [P-5]: Provide reports on the types of navigation services provided to patients using the ED as high users or for episodic care. The

133355104.2.4	*2.9.1*	*2.9.1 (A-E)*	***PROVIDE NAVIGATION SERVICES TO TARGETED PATIENTS WHO ARE AT HIGH RISK OF DISCONNECT FROM INSTITUTIONALIZED HEALTH CARE: OB NAVIGATION PROGRAM***
Harris Health System			*133355104*
Related Category 3 Outcome Measure(s):	*133355104.3.24*	*IT-8.2*	*Percentage of Low Birth-Weight Births*

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
above. Data Source: Site gap analysis; Program documentation; EHR; State and county data sources Milestone 1 Estimated Incentive Payment (*maximum amount*): $4,060,624	Train team of hired navigators Data Source: Training and procedures documentation Milestone 5 Estimated Incentive Payment: $1,501,920 **Milestone 3** [P-X]: Hire patient navigation team according to plan developed in DY2 Metric 1 [P-X.1]: Documentation of patient navigation team employment Baseline: 0 hired in DY2 Goal: Hire navigation team Data Source: Human Resources documentation Milestone 4 Estimated Incentive Payment *(maximum amount):* $1,501,920 **Milestone 4** [P-X2]: Establish	navigation program is accountable for making PCP or medical home appointments and ensuring continuity of care. Metric 1 [P-5.1]: Collect and report on all the types of patient navigator services provided. Goal: Provide report on patient navigation services provided to patients using Harris Health System EDs for Ob care. Data Source: Reports documenting services provided to Ob patients. Milestone 7 Estimated Incentive Payment: $2,052,185 **Milestone 8 [P-8]:** Participate in	navigation program is accountable for making PCP or medical home appointments and ensuring continuity of care. Metric 1 [P-5.1]: Collect and report on all the types of patient navigator services provided. Goal: Provide report on patient navigation services provided to patients using Harris Health System EDs for Ob care. Data Source: Reports documenting services provided to Ob patients. Milestone 7 Estimated Incentive Payment: $1,692,896 **Milestone 11** [P-8]: Participate in

133355104.2.4	2.9.1	2.9.1 (A-E)	PROVIDE NAVIGATION SERVICES TO TARGETED PATIENTS WHO ARE AT HIGH RISK OF DISCONNECT FROM INSTITUTIONALIZED HEALTH CARE: OB NAVIGATION PROGRAM
Harris Health System			133355104
Related Category 3 Outcome Measure(s):	133355104.3.24	IT-8.2	Percentage of Low Birth-Weight Births

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
	baseline number of unique patients served by innovative program. Metric 1 [P-X2.1]: Documentation of number of unique patients served by innovative program. Baseline: 0 patients served in DY2 Data Source: EHR Milestone 4 Estimated Incentive Payment *(maximum amount):* $1,501,920 **Milestone 5 [P-8]:** Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance).	face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements. Metric 1 [P-8.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: Participate in all semi-annual face-to-face meetings or seminars. Data Source: Documentation of semiannual meetings including meeting agendas, slides from	face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements. Metric 1 [P-8.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: Participate in all semi-annual face-to-face meetings or seminars. Data Source: Documentation of

133355104.2.4	*2.9.1*	*2.9.1 (A-E)*	*PROVIDE NAVIGATION SERVICES TO TARGETED PATIENTS WHO ARE AT HIGH RISK OF DISCONNECT FROM INSTITUTIONALIZED HEALTH CARE: OB NAVIGATION PROGRAM*
Harris Health System			*133355104*
Related Category 3 Outcome Measure(s):	*133355104.3.24*	*IT-8.2*	*Percentage of Low Birth-Weight Births*

Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
	Each participating provider should publicly commit to implementing these improvements. Metric 1 [P-8.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: Participate in all semi-annual face-to-face meetings or seminars. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Milestone 5 Estimated Incentive Payment: $1,501,921	presentations, and/or meeting notes. Milestone 8 Estimated Incentive Payment: $2,052,184	semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Milestone 12 Estimated Incentive Payment: $1,692,895
Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone): $4,060,624	Year 3 Estimated Milestone Bundle Amount: $6,007,681	Year 4 Estimated Milestone Bundle Amount: $6,156,554	Year 5 Estimated Milestone Bundle Amount: $5,078,687
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over DYs 2-5)***:** $21,303,546			

Project Option 2.2.1 - Redesign the outpatient delivery system to coordinate care for patients with chronic diseases: Expansion of Point-Of-Care Services Provided by Clinical Pharmacists

Project Identification number: 133355104.2.5/ Pass 3

Performing Provider Name/TPI#: Harris Health/133355104

Project Summary:

Provider:

Harris Health System is comprised of 16 community health centers, seven school-based clinics, a dental center, dialysis center, five mobile health units, one outpatient specialty services clinic, and three hospitals. With a tax base of $511.6 million, Harris Health System was able to provide more than $1.254 billion in charity care during FY 2012.

Volume Statistics - FY2012	Patient Payor Mix	Patient Demographics
Hospital admissions- 35,343 Births (babies delivered)- 6,643 Emergency visits- 173,263 Outpatient clinic visits- 1,054,770	Self-Pay- 62.6% Medicaid and CHIP- 23.4% Medicare- 8.6% Other Funding- 3.6% Commercial Insurance- 1.8%	Hispanic- 57.4% African American- 26.3% Caucasian- 9.2% Asian- 4.8% Other- 2.2% American Indian- 0.2%

Intervention(s):

This project will expand point-of-care services provided by clinical pharmacists for the chronic management of patients receiving anticoagulation therapy and create an educational website.

Need for the project:

Current resources make it difficult to provide timely and efficient post-hospitalization follow up for patients discharged on anticoagulation therapy. While the community standard is for post-hospitalization follow up to occur within 7 days, Harris Health is averaging 20 days for this population.

Target Population:

Patient discharged on anticoagulation therapy within the system may benefit from this project (Overall Payor Mix: Medicaid and CHIP-23.4% / Self-Pay- 62.6%).

Category 1 or 2 expected patient benefits:

Our goals are to increase the number of care management visits to 7500 by DY5, realize a 15 % increase the number of refills handled by the refill clinic by DY5, and realize a 75% increase in the number of patients receiving an appointment within 7 days of hospital discharge by DY5.

Category 3 outcomes:

IT-1.20: Our goal is to see a 40% increase from baseline of the number of patients seen by clinical pharmacists with at least 2 consecutive INRs at goal by the end of DY5.

IT-2.3: Our goal is to realize a 15% reduction from baseline in hospital admissions and emergency room visits secondary to warfarin complications by the end of DY5.

Project Option 2.2.1 - Redesign the outpatient delivery system to coordinate care for patients with chronic diseases: Expansion of Point-Of-Care Services Provided by Clinical Pharmacists

Project Identification number: 133355104.2.5/ Pass 3
Performing Provider Name/TPI#: Harris Health/133355104

Project Description: ***Harris Health proposes to expand point-of-care services provided by clinical pharmacists for the chronic management of patients receiving anticoagulation therapy.***

Our patient population continues to grow and require anticoagulation therapy monitoring, medication therapy management review to reduce polypharmacy, and provision of medication refills. Current resources have made it difficult to provide timely and efficient post-hospitalization follow up for patients discharged on anticoagulation therapy. While the community standard is for post-hospitalization follow up to occur within 7 days, Harris Health is averaging 20 days for this population. Infrequent or untimely follow up can lead to thrombotic or hemorrhagic complications requiring treatment in the emergency setting or hospitalization. This project will not only allow for additional outpatient capacity but will also create an educational/informational webpage for patients requiring anticoagulation monitoring. The webpage will provide information to educate patients on subjects such as self-management, drug interactions, foods high in vitamin K, emergency procedures and contact numbers.

Goals and Relationship to Regional Goals:

Project Goals:

- Avoid costly hemorrhagic and thrombotic complications
- Provide appropriate intensive monitoring and management of warfarin therapy
- Reduce adverse drug interactions and contraindications by controlling polypharmacy
- Support timely refills of medications through use of the refill clinics and protocols developed by the primary care providers
- Provide patients the tools they need to take an active role in their healthcare through the use of innovative technology.

This project meets the following regional goals:

- Our program will increase access to specialty care services by allowing us to monitor patients in a timely manner therefore improving patient outcomes and reducing possible complications.
- We will transform health care delivery from a disease-focused model of episodic care to a patient-centered, coordinated delivery model through a coordinated effort involving nursing, pharmacy, physician and other ancillary services in attempts to prevent warfarin related complications. Studies have shown that this collaborative effort leads to improved patient outcomes and patient satisfaction.

- We will develop a culture of ongoing transformation and innovation that maximizes the use of technology and best-practices via the use of electronic medical records, facilitate regional collaboration and sharing with other institutions providing anticoagulation management services, and engage patients, providers, and other stakeholders in the planning, implementation, and evaluation processes through constant communication with our medical home team members.

Challenges:

- Need for additional pharmacy clinicians and nursing support staff
- Space for daily clinic at multiple community health centers
- Cost of additional Point-Of-Care testing devices and associated supplies
- EHR reports that identifies patients suitable for pharmacy management and reports that identify pharmacist-managed patients utilization of emergency center and hospital resources would pose a challenge due to limited FTEs in the Information Technology department and the time to build and run reports

5-year Expected Outcome for Provider and Patients:

- Timely and appropriate follow-up in a pharmacist-run anticoagulation clinic
- Reduction in hospital admissions and emergency room visits secondary to thromboembolic events and bleeding complications
- Increased number of refill requests performed by pharmacists

Starting Point/Baseline:

- **Patient visits (FY13- 3/12 to 9/12):** 23,350
- **Unduplicated patients:** approximately 2300
- **Providers Trained**: 15 Harris Health employed clinical pharmacists; 1 community partner clinical pharmacist
- **Patient Encounters**: Pharmacist-managed clinics have completed 64,459 patient encounters over the 19 month period (March 1, 2011 to September 30, 2012).
- **Clinic Refills over a 3 month period**:
  - Average: 561 refills per month
  - Average MD completed: 238 refills per month
  - Average Pharmacist completed: 323 refills per month

Rationale:

Project option 2.2.1 (Redesign the outpatient delivery system to coordinate care for patients with chronic diseases) was chosen to justify the need for the expansion of point-of-care services provided by pharmacists; more specifically for the chronic management of patients receiving anticoagulation therapy. Pharmacist-managed anticoagulation clinics have been shown to improve outcomes in patients on long-term warfarin therapy.[1-7] Warfarin is the mainstay of oral anticoagulation therapy and its utilization has dramatically increased over recent years.[8,9] As the indications for oral anticoagulation therapy rise, regular monitoring of patients is pertinent to prevent increasing incidences of warfarin-related complications. This vision directly aligns itself

with a Joint Commission's National Safety Goal of a face-to-face encounter with a healthcare professional for anticoagulation monitoring.

Multiple studies evaluated the clinical implications of high medication burden and identified a heightened risk for medication misadventures such as therapeutic duplication and dosing errors which increase the risk for adverse drug events.[18, 19] Pharmacists are a cost-effective solution to the concern of medication-related adverse events. Studies indicate that pharmacist-driven Medication Therapy Management (MTM) programs effectively mitigate the potential for medication misadventures translating into the diminution of hospital admission/readmission rates and greater patient and institutional cost-savings.[20]

Chronic diseases are also a significant cause of morbidity and mortality; especially in patients with poor adherence.[21-23] Difficulty obtaining medication refills may worsen medication adherence.[24, 25] The increase in morbidity may in turn cause increased burden on the healthcare system. Studies have demonstrated that multidisciplinary team approaches to care, such as those involving pharmacist-physician collaboration, have shown positive impact in patient care and satisfaction.[26] Additionally, it has been demonstrated that pharmacist managed refill clinics can increase time efficiency and patient safety.[27-30]

In recent years there has been an increasing shift in warfarin therapy management from standard care by a physician to dedicated anticoagulation clinic models.[10] Pharmacist-managed anticoagulation clinics have been established to provide specialized care and manage patients more effectively.[3] These focused services aim to increase length of time International Normalized Ratios (INR)remain within a therapeutic range as well as reduce thromboembolic and bleeding complications.[4] Pharmacist-managed anticoagulation clinics provide patients with expert care, frequent monitoring, and education to ensure optimal outcomes and increased patient safety. Education and patient involvement have been shown to increase compliance, leading to improved INR control.[3] Studies have shown that in comparison to standard care by a physician, specialized pharmacist-managed clinics are associated with improved patient outcomes as a result of more frequent monitoring.[10, 11-15] In 2003, a clinical pharmacist completed 1971 visits, but as of fiscal year to date (2013) and 15 pharmacists later, 23,350 visits have been completed.

The Harris Health System program: Expansion of point-of-care services provided by clinical pharmacists is relevant to the RHP population because the project can easily be emulated by our Regional Healthcare Partners as needed.

Project components:

a. *Design and implement care teams that are tailored to the patient's health care needs, including non-physician health professionals, such as pharmacists doing medication management; case managers providing care outside of the clinic setting via phone, email, and home visits; nutritionists offering culturally and linguistically appropriate education; and health coaches helping patients to navigate the health care system* -We will design

and implement care teams that are tailored to the patient's healthcare needs through the collaborative efforts of clinical pharmacists, nursing staff, nutritionists, physicians, behavioral services, social services, and health educators to provide exceptional warfarin medication therapy management, reduce polypharmacy and increase number of refill requests performed by pharmacists.

b. *Ensure that patients can access their care teams in person or by phone or Email*-We will ensure that patients have complete access to their personal care teams primarily through face-to-face appointments during scheduled clinic hours as well as through phone and email access via "my health" which a web resource for patients to communicate with physicians, access test results, view clinics visits, and obtain a copy of their medical record.

c. *Increase patient engagement, such as through patient education, group visits, self-management support, improved patient-provider communication techniques, and coordination with community resources*-We will increase patient engagement through the use of personal patient education. Clinical pharmacists will educate patients on warfarin side effects, drug interactions, diet restrictions and medication use primarily through face-to-face encounters and telephone encounters after hours.

d. *Implement projects to empower patients to make lifestyle changes to stay healthy and self-manage their chronic conditions*- We will implement projects to empower patients to make lifestyle changes to stay healthy and self-manage their chronic conditions through the innovative use of technology. A webpage designed for patients will include health tips that will assist in anticoagulation self-management and ultimately put the patient in control of their personal health. The collaborative efforts of all hospital services will help the patient make life-changing improvements in their health.

e. *Conduct quality improvement for project using methods such as rapid cycle improvement. Activities may include, but are not limited to, identifying project impacts, identifying "lessons learned," opportunities to scale all or part of the project to a broader patient population, and identifying key challenges associated with expansion of the project, including special considerations for safety-net population* - We will conduct quality improvement for our program by assessing the impact of the point-of-care expansion, reporting the volume of patients seen, refills completed, the number of ED visits and hospitalizations, and adverse drug events, and evaluating any challenges that may be faced over the implementation period.

Milestones and Metrics:

- Process Milestones and Metrics: DY2: P-1, P-1.1; P-X, P-X.1; P-2, P-2.1; P-9, P-9.1
- Improvement Milestones and Metrics: I-X1, I-X1.1, I-X2, I-X2.1; I-21, I-21.1

Community need: The expansion of point-of-care services provided by clinical pharmacists addresses:

- CN.2- Inadequate access to specialty care

- CN.7- Insufficient access to care coordination practice management and integrated care treatment programs
- CN.11- High rates of chronic disease and inadequate access to treatment programs and services for illnesses associated with chronic disease, including: Cancer, Diabetes, Obesity, Cardiovascular disease, Asthma, AIDS/HIV

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

This project significantly enhances our existing delivery system by increasing availability of persons qualified to manage acute and chronic care needs as related to anticoagulation management. This increase in availability not only allows for timely and more frequent patient follow up but also decreases the risk of potential complications which may require management in the acute care setting**.**

Related Category 3 Outcome Measure(s):

OD-1 Primary Care and Chronic Disease Management

IT-1.20 Other Outcome Improvement Target - Management of International Normalized Ratio (INR) for patients receiving anticoagulation monitoring (standalone measure)

The pharmacist-run point-of-care anticoagulation services provided by clinical pharmacists at Harris Health will ultimately result in improved patient outcomes. Pharmacist-managed anticoagulation clinics have been established to provide specialized care and manage patients more effectively.[3] These focused services aim to increase length of time INRs remain within a therapeutic range as well as reduce thromboembolic and bleeding complications.[4] Pharmacist-managed anticoagulation clinics provide patients with expert care, frequent monitoring, and education to ensure optimal outcomes and increased patient safety. Education and patient involvement have been shown to increase compliance; leading to improved INR control.[3] We will determine the total number of patients at Harris Health who have INR values for at least 2 consecutive visits by the end of DY2.

With the 6 additional anticoagulation clinics covering a volume of the large pool of patients on warfarin, we can expect that:

- 20% of all patients seen at Harris Health will have at least 2 consecutive INRs at goal by the end of DY3
- 30% of all patients seen at Harris Health will have at least 2 consecutive INRs at goal by the end of DY4
- 40% of all patients seen at Harris Health will have at least 2 consecutive INRs at goal by the end of DY5

OD-2 Potentially Preventable Admissions

IT-2.13 Other Admissions Rate – Hospital Admissions and Emergency Room Visits secondary to warfarin complications (Standalone measure)

There are numerous studies showing that anticoagulation clinics monitoring patients on warfarin have better outcomes as compared to traditional primary physician care. Mehta et al demonstrated that the implementation of an anticoagulation clinic decreased the rate of hemorrhagic and thromboembolic events and achieved better INR control when compared to traditional care by a physician.[7] A study by Cortelazzo et al, showed that an anticoagulation clinic attained superior anticoagulation control and reduced complication rates by 50% to 80% when compared with management provided by primary physicians and cardiologists.[16] Pharmacist-managed anticoagulation clinics have also been shown to decrease warfarin-related hospital admissions and length of stay.[3] This decrease in inpatient admissions, length of stay, and complications suggest that anticoagulation clinics may be a more cost-effective model than physician standard of care.[11,12,17] It is important that we establish a baseline for number of emergency room visits and hospital admissions from warfarin complications (i.e. major and minor bleeding events). We will compare this rate to the calculated rate post-initiation of the 6 pharmacist-run anticoagulation clinics. Based on prior studies and their outcomes, we can expect a:

- 5% reduction from baseline in the number of hospital admissions and emergency room visits secondary to warfarin complications rate at the end of DY3
- 10% reduction from baseline in the number of hospital admissions and emergency room visits secondary to warfarin complications rate at the end of DY4
- 15% reduction from baseline in the number of hospital admissions and emergency room visits secondary to warfarin complications rate at the end of DY5

Relationship to other Projects and Other Performing Providers' Projects in the RHP: Healthcare costs are significantly increased within a patient base with such aggressive chronic conditions that have gone untreated. The initiatives focused to chronic disease management focus to conditions such as asthma, hypertension, and diabetes and are similar in the approach of managing & proactively treating chronic conditions in order to reduce 30-day readmission rates, inappropriate emergency department utilization, and healthcare costs. The Region 3 Initiative grid allows a cross reference of initiatives associated with chronic disease management. (addendum)

Plan for Learning Collaborative: We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system.

Project Valuation: In recent years there has been an increasing shift in warfarin therapy management from standard care by a physician to dedicated anticoagulation clinic models. Pharmacist-managed anticoagulation clinics provide patients with expert care, frequent

monitoring, and education to ensure optimal outcomes and increased patient safety. Education and patient involvement have been shown to increase compliance, leading to improved patient outcomes as a result of more frequent monitoring. This project significantly enhances our existing delivery system by increasing availability of persons qualified to manage acute and chronic care needs as related to anticoagulation management. This increase in availability not only allows for timely and more frequent patient follow up but also decreases the risk of potential complications which may require management in the acute care setting, resulting in a measurable reduction in the number of hospital admissions and emergency room visits secondary to the warfarin complications rate.

133355104.2.5	2.2.1	2.2.1. (A-E)	REDESIGN THE OUTPATIENT DELIVERY SYSTEM TO COORDINATE CARE FOR PATIENTS WITH CHRONIC DISEASES: EXPANSION OF POINT-OF-CARE SERVICES PROVIDED BY CLINICAL PHARMACISTS
Harris Health System			133355104
Related Category 3 Outcome Measure(s):	133355104.3.25 133355104.3.26	IT-1.20 IT-2.13	Management of anticoagulation through use of INR (Stand-alone) Other Admissions Rate (Standalone measure)

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1: [P-1] Expand the Chronic Care Model to primary care clinics Metric 1: [P-1.1] Increase number of primary care clinics using the Chronic Care model Baseline: Identify 6 clinics in which to expand pharmacy services Goal : (a) Letter of commitment from nursing and administration at all sites (b) Signed collaborative agreement with 2 physicians at each of 3 sites; (c) Recruit, hire and train three pharmacists and three patient care technicians (PCTs) to participate in pharmacy managed care. Data Source : Documentation of practice management Milestone 1 Estimated Incentive Payment (*maximum amount*): $332,998 **Milestone 2**: [P-X] Increase the current	**Milestone 6**: [P-1] Expand the Chronic Care Model to primary care clinics Metric 1: [P-1.1] Increase number of primary care clinics using the Chronic Care model Baseline: Identify 6 clinics in which to expand pharmacy services Goal : (a) Letter of commitment from nursing and administration at all sites (b) Signed collaborative agreement with 2 physicians at additional 3 sites for a total of 6 sites; (c) Recruit, hire and train three pharmacists and three patient care technicians (PCTs) for a total of 6 pharmacists and PCTs to participate in pharmacy managed care. Data Source : Documentation of practice management Milestone 5 Estimated Incentive Payment (*maximum amount*): $583,526	**Milestone 11:** [I-X2] Increase the number of patients enrolled in a care management Metric 1: [I-X2.1]Number of patients enrolled in a care management Goal: Increase the number of patient visits to 5000 Data source: Program enrollment records, EHR Milestone 10 Estimated Incentive Payment (*maximum amount*): $996,955 **Milestone 12**: [I-X1] Monitor improvement in the number of refills handled by the refill clinic Metric 1: [I-X1.1] Number of refills handled by the refill clinic Goal : 10 % increase from baseline in the number of refills handled by the refill clinic	**Milestone 14:** [I-X2] Increase the number of patients enrolled in a care management Metric 1: [I-X2.1]Number of patients enrolled in a care management Goal: Increase the number of patient visits to 7500 Data source: Program enrollment records, EHR Milestone 13 Estimated Incentive Payment (*maximum amount*): $825,102 **Milestone 15**: [I-X1] Monitor improvement in the number of refills handled by the refill clinic Metric 1: [I-X1.1] Number of refills handled by the refill clinic Goal:15 % increase from baseline in the number of refills handled by the refill clinic

133355104.2.5	2.2.1	2.2.1. (A-E)		REDESIGN THE OUTPATIENT DELIVERY SYSTEM TO COORDINATE CARE FOR PATIENTS WITH CHRONIC DISEASES: EXPANSION OF POINT-OF-CARE SERVICES PROVIDED BY CLINICAL PHARMACISTS
Harris Health System				133355104
Related Category 3 Outcome Measure(s):	*133355104.3.25* *133355104.3.26*	*IT-1.20* *IT-2.13*	*Management of anticoagulation through use of INR (Stand-alone)* *Other Admissions Rate (Standalone measure)*	

Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	Year 5 (10/1/2015 – 9/30/2016)
number of refills handled by pharmacist-run refill clinics <u>Metric 1:</u> [P-X.1] Number of refills handled by the refill clinic Baseline: Goal: Establish baseline number of refills handled by pharmacist-run refill clinics Data Source: Report Milestone 2 Estimated Incentive Payment (*maximum amount*): $332,998 **Milestone 3**: [P-2] Train staff in the Chronic Care Model, including the essential components of a delivery system that supports high-quality clinical and chronic disease care <u>Metric 1</u>: [P-2.1] Increase percent of staff trained Baseline: 15 trained clinical	**Milestone 7**: [P-2] Train staff in the Chronic Care Model, including the essential components of a delivery system that supports high-quality clinical and chronic disease care <u>Metric 1</u>: [P-2.1] Increase percent of staff trained Baseline: 15 clinical pharmacists and 15 PCTs to assist pharmacists (baseline DY2) Goal: Increase the number of pharmacists and PCTs by 40% from baseline for a total of 21 clinical pharmacists and 21 PCTs Data Source: HR, training program materials Milestone 6 Estimated Incentive Payment	Data Source: Report Milestone 11 Estimated Incentive Payment (*maximum amount*): $996,955 **Milestone 13**: [I-21]: Improvements in access to care of patients receiving chronic care management services using innovative project option <u>Metric 1</u>: [I-21.1] Increase percentage of identified population reached Goal: 50% increase in the number of patients receiving an appointment within 7 days of hospital discharge as compared to baseline. Data Source: Documentation of target population reached, as	Data Source: Report Milestone 14 Estimated Incentive Payment (*maximum amount*): $825,102 **Milestone 16**: [I-21]: Improvements in access to care of patients receiving chronic care management services using innovative project option <u>Metric 1</u>: [I-21.1] Increase percentage of identified population reached Goal: 75% increase in the number of patients receiving an appointment within 7 days of hospital discharge as compared to baseline. Data Source: Documentation of target population reached, as designated in

133355104.2.5	2.2.1	2.2.1. (A-E)	REDESIGN THE OUTPATIENT DELIVERY SYSTEM TO COORDINATE CARE FOR PATIENTS WITH CHRONIC DISEASES: EXPANSION OF POINT-OF-CARE SERVICES PROVIDED BY CLINICAL PHARMACISTS
Harris Health System			133355104
Related Category 3 Outcome Measure(s):	133355104.3.25 133355104.3.26	IT-1.20 IT-2.13	Management of anticoagulation through use of INR (Stand-alone) Other Admissions Rate (Standalone measure)

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
pharmacists; 15 trained PCTs to assist pharmacists Goal: Increase the the number of trained pharmacists and PCTs by 20% from baseline for a total of 18 clinical pharmacists and 18 PCTs. Data Source: HR, training program materials Milestone 3 Estimated Incentive Payment (*maximum amount*): $332,998 **Milestone 4:** [P-9] Develop program to identify and manage chronic care patients needing further clinical intervention Metric 1: [P-9.1]Increase the number of patients identified as needing screening test, preventive tests, or other clinical services Baseline: TBD Goal: Identify population of patients needing 7 day follow up for	(*maximum amount*): $583,526 **Milestone 8:** [I-X1] Monitor improvement in the number of refills handled by the refill clinic Metric 1: [I-X1.1] Number of refills handled by the refill clinic Goal : 5 % increase from baseline in the number of refills handled by the refill clinic Data Source: Report Milestone 7 Estimated Incentive Payment (*maximum amount*): $583,527 **Milestone 9:** [I-21]: Improvements in access to care of patients receiving chronic care management services using innovative project option	designated in the project plan. Milestone 12 Estimated Incentive Payment (*maximum amount*): $996,955	the project plan. Milestone 15 Estimated Incentive Payment (*maximum amount*): $825,102

133355104.2.5	**2.2.1**	*2.2.1. (A-E)*	***REDESIGN THE OUTPATIENT DELIVERY SYSTEM TO COORDINATE CARE FOR PATIENTS WITH CHRONIC DISEASES: EXPANSION OF POINT-OF-CARE SERVICES PROVIDED BY CLINICAL PHARMACISTS***
Harris Health System			**133355104**
Related Category 3 Outcome Measure(s):	*133355104.3.25* *133355104.3.26*	*IT-1.20* *IT-2.13*	*Management of anticoagulation through use of INR (Stand-alone)* *Other Admissions Rate (Standalone measure)*

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
anticoagulation services Data Source: EHR, patient registry Milestone 4 Estimated Incentive Payment (*maximum amount*): $332,998 **Milestone 5:** [P-X] Create an educational/informational webpage for patients requiring anticoagulation monitoring Metric 1: Increase the number of webpages available for patients requiring anticoagulation monitoring Baseline: 0 Goal: Increase the number of webpages from 0 to 1 Data source: Harris Health website Milestone 4 Estimated Incentive Payment (*maximum amount*): $332,999	Metric 1: [I-21.1] Increase percentage of identified population reached Goal: 25% increase in the number of patients receiving an appointment within 7 days of hospital discharge as compared to baseline. Data Source: Documentation of target population reached, as designated in the project plan. Milestone 8 Estimated Incentive Payment (*maximum amount*): $583,527 **Milestone 10:**[I-X] Increase the number of patients enrolled in a care management Metric 1: [I-X.1]Number of patients		

133355104.2.5	*2.2.1*	*2.2.1. (A-E)*	***REDESIGN THE OUTPATIENT DELIVERY SYSTEM TO COORDINATE CARE FOR PATIENTS WITH CHRONIC DISEASES: EXPANSION OF POINT-OF-CARE SERVICES PROVIDED BY CLINICAL PHARMACISTS***
Harris Health System			**133355104**
Related Category 3 Outcome Measure(s):	*133355104.3.25* *133355104.3.26*	*IT-1.20* *IT-2.13*	*Management of anticoagulation through use of INR (Stand-alone)* *Other Admissions Rate (Standalone measure)*

Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	Year 5 (10/1/2015 – 9/30/2016)
	enrolled in a care management Goal: Increase the number of patient visits to 2500 Data source: Program enrollment records, EHR Milestone 9 Estimated Incentive Payment (*maximum amount*): $583,527		
Year 2 Estimated Milestone Bundle Amount: **$ 1,664,991**	Year 3 Estimated Milestone Bundle Amount: **$ 2,917,633**	Year 4 Estimated Milestone Bundle Amount: **$ 2,990,865**	Year 5 Estimated Milestone Bundle Amount: **$ 2,475,306**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)**:** *$ 10,048,795*			

Appendix A: References

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Project Option 2.6.4 – Implement Evidence-based Health Promotion Program in an Innovative Manner: Integrated Promotion of Fruit and Vegetable Consumption in Primary Care through a Prescription for Healthy Eating Program.

Unique RHP Project Identification Number: 133355104.2.6/ Pass 3
Performing Provider Name/TPI: Harris Health System/133355104

Project Summary:

Provider:
Harris Health System is comprised of 16 community health centers, seven school-based clinics, a dental center, dialysis center, five mobile health units, one outpatient specialty services clinic, and three hospitals. With a tax base of $511.6 million, Harris Health System was able to provide more than $1.254 billion in charity care during FY 2012.

Volume Statistics - FY2012	Patient Payor Mix	Patient Demographics
Hospital admissions- 35,343 Births (babies delivered)- 6,643 Emergency visits- 173,263 Outpatient clinic visits- 1,054,770	Self-Pay- 62.6% Medicaid and CHIP- 23.4% Medicare- 8.6% Other Funding- 3.6% Commercial Insurance- 1.8%	Hispanic- 57.4% African American- 26.3% Caucasian- 9.2% Asian- 4.8% Other- 2.2% American Indian- 0.2%

Intervention(s):
This project will develop a program for promoting increased consumption of fruits and vegetables among primary care patients through an integrated approach that includes multi-provider and multi-modal patient education and access to a clinic-based farmer's market.
Need for the project:
The need for health promotion activities related to fruit and vegetable consumption in Harris County is great. Less than 25% of individuals in the Houston area eat recommended servings of fruits and vegetables. Increase in consumption of fruits and vegetables are both targets for Healthy People 2020.
Target Population:
The target population for these goals includes any patient seen in primary care. (Medicaid and CHIP-23.4% / Self-Pay- 62.6%).
Category 1 or 2 expected patient benefits:
Our goal is to increase percentage of target population reached. The DY5 enrollment goal is 1000 patients/month.
Category 3 outcomes:
IT-6.1: Our goal is to increase patient satisfaction scores by 5% above baseline in DY3, 10% in DY4, and 15% in DY5.

Project Option 2.6.4 – Implement Evidence-based Health Promotion Program in an Innovative Manner: Integrated Promotion of Fruit and Vegetable Consumption in Primary Care through a Prescription for Healthy Eating Program.

Unique RHP Project Identification Number: 133355104.2.6/ Pass 3
Performing Provider Name/TPI: Harris Health System/133355104

Project Description:
Harris Health will develop a program for promoting increased consumption of fruits and vegetables among primary care patients through an integrated approach that includes multi-provider and multi-modal patient education and access to a clinic-based farmer's market.

The Integrated Promotion of Fruit and Vegetable Consumption in Primary Care project will bring together primary care providers, health educators, and nutrition specialists to promote increased fruit and vegetable consumption among primary care patients served by Harris Health System. The program will leverage a clinic-based farmer's market program as the platform from which educational activities will stem.

Harris Health System is the safety-net health system for Harris County, TX. It serves largely ethnic-minority populations (57% Hispanic and 26% African American) from low-income communities. Twenty-eight percent of patients are Medicaid or CHIP, 60% are self pay, and 98% live at or below 200% of the Federal Poverty Level. The health system has 13 community health centers in low-income communities throughout the county. Each is designated as a Medical Home and serves adults and pediatric populations. Approximately half of the clinics are located in United States Department of Agriculture designated food deserts.

Currently a small portion of patients within the system receive healthy eating education or nutrition counseling of any kind. None of the available services focuses specifically on the consumption of fruits and vegetables. This integrated promotion project will involve primary care providers discussing the importance and health benefits of fruit and vegetable consumption with their patients. This will be facilitated by the use of a "healthy eating prescription." The prescription will allow for the purchasing of discounted produce at a Medical Home-based produce market. In addition to the opportunity to purchase affordable produce, patients will receive education from a designated health educator and dietitian who will reinforce concepts related to the health benefits of the available produce. Likewise, a chef will be present on a regular basis to provide cooking demonstrations using foods from the market so that patients will have greater skill and understanding about how to prepare healthy foods for themselves and their families. Easy to understand recipes will be provided so that patients can practice their learned skills at home. The markets will be present in the Medical Home one half-day weekly so that even without "prescriptions" patients can return and benefit from access to fruits and vegetables, weekly education, and healthy food preparation activities.

Consistent with the Patient Centered Medical Home Model, the multi-component, multi-provider fruit and vegetable promotion team (individual primary care providers, dedicated health educator, nutritionist, and chef) will be located in the Medical Home locations. The team will initially rotate through each of 5 participating clinics. Expansion to 10 sites is expected in year 3 of the project period. Through the prescription program, it is expected that the health promotion team will be able to provide evidence-based, multi-component health promotion education about

fruit and vegetable consumption to an additional 1000 patients monthly. Quantification of participation will be assessed through redeemed prescriptions.

Goals and Relationship to Regional Goals:

The goal of this project is to use a multi-provider, multi-modal approach in the primary care setting to increase fruit and vegetable consumption promotion in high-risk patients. The primary care provider will be the initiator of the health promotion activity and will guide the patient to the other team members who will use the farmers markets as a means to encourage purchasing and consumption of fresh produce and who will provide demonstrations to increase patient taste preferences and self-efficacy around preparation of fresh produce.

Project Goals:

- Increase the number of primary care providers promoting the consumption of fruits and vegetables with patients
- Increase the number of patients receiving health promotion to increase fruit and vegetable consumption

This project meets the following regional goals:

- Develop a regional approach to health care delivery that leverages and improves on existing programs and infrastructure, is responsive to patient needs throughout the entire region, and improves health care outcomes and patient satisfaction
- Transform health care delivery from a disease-focused model of episodic care to a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary or duplicative services, and builds on the accomplishments of our existing health care system

The program leverages and builds on existing Harris Health Medical Home farmer's market infrastructure to meet the need for increased health promotion regarding fruit and vegetable consumption among of high-risk individuals served by the health system.

Challenges:

A primary challenge facing the program includes consistent provider promotion of fruit and vegetable consumption. Studies show that physician counseling on lifestyle behavior change has a positive impact on behavior adoption among patients.[1, 2] Providers in Harris Health System recognize the need to counsel patients on healthy lifestyle behavior, but are often hesitant because of the challenges patients face with compliance. This project will leverage the motivating power of the provider-patient relationship. It will equip providers with a tangible tool (prescription) to use in their counseling and will give patients a specific avenue for adoption of the recommended behavior.

An additional challenge involves patient-related barriers to buying fresh produce.[3] Evidence suggests that increasing access to produce in strategic ways can improve healthy eating practices.[4] In this project, the barrier of access is overcome by the presence of markets in the Medical Home. The barrier of cost is addressed by providing a discount on produce cost to patients who present/redeem their prescription at the market.

A third challenge is patient self-efficacy for fruit and vegetable preparation and consumption. Knowledge and skill on how to prepare fresh produce can be a barrier. There is evidence that cooking demonstrations and preparation plans can improve intake.[5, 6] This project will use cooking demonstrations and recipe cards to tackle those barriers.

5-Year Expected Outcome for Provider and Patients:

Harris Health System expects to provide evidence-based fruit and vegetable promotion services to high-risk primary care patients within the health system. Patients can expect to experience consistent, multi-provider integrated health promotion messaging around the health benefits of fruit and vegetable consumption.

Starting Point/Baseline:

Currently, Harris Health System has no evidence-based program to promote fruit and vegetable consumption.

Rationale:

It is recommended by the CDC and other health promoting organizations that individuals consume at least five servings of fruits and vegetables each day. For high risk populations, eight to ten servings are recommended.[7, 8] There is strong evidence from studies like Dietary Approaches to Stop Hypertension that diets high in fruits and vegetables can reduce blood pressure, stroke risk, and weight. It has also been shown to prevent some cancers, and diabetes.[7, 9-11]

The need for health promotion activities related to fruit and vegetable consumption in Harris County is great. Less than 25% of individuals in the Houston area eat recommended servings of fruits and vegetables. By eleventh grade, only 13% of youth eat adequate servings of fruit daily and only 5% eat adequate servings of vegetables.[12] For every serving above two servings of fruits or vegetables eaten daily, risk of ischemic heart disease related mortality decreases by 4%.[13] Increase in consumption of fruits and vegetables are both targets for Healthy People 2020. Specifically, an increase in total vegetable intake in persons two years of age and older is considered a Leading Health Indicator.[14]

Fruit and vegetable promotion interventions are most successful when there are multiple components to the educational initiative.[15] Hands on activities also enhance effectiveness and self-efficacy,[5] and behavioral prescriptions have been show to have positive impact on patient health promotion activities.[16] The project will enhance the medical home model by mitigating silo-based approaches to health promotion; it will integrate and coordinate messages from the primary care provider, health educator, and nutritionist. In addition, the project has the potential to transform the culture and the meaning of the Medical Home itself into one that truly communicates wellness and healthy living to its patients, staff, and the community in which it resides.

The process milestones and accompanying metrics for years 2-3 are consistent with P-3, P-7, and P-X of the RHP Planning Protocol. A multi-provider and multi-component health promotion team will be established to educate, model, and engage patients in the importance of fruits and vegetables for health. A baseline number of patients reached by the program will be established in DY2 and will be the basis for growth going forward. Ongoing plan-do-study-act cycles will allow for review of project data and response to data with new ideas and solutions for improvement.

Improvement outcomes in years 3, 4, and 5 will be based on I-8, increase percentage of target population reached. The establishment of the program will allow an increased number of patients to be reached by focused and coordinated promotion of fruit and vegetable consumption. The goal will be to educate 1000 patients monthly across 10 medical home sites on the health promoting benefits of fruit and vegetable intake.

Project Components:

The core project component will be met as the program is implemented, evaluated, strengthened and expanded into additional clinical sites.

a) *Conduct quality improvement for the project using methods such as rapid cycle improvement. Activities may include, but are not limited to, identifying 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.* Health promotion team members (health educator, dietitian) will meet weekly to review the number of "healthy eating prescriptions" written and redeemed. This will be facilitated by IT reports through the Electronic Health Record and hand-counts of prescriptions collected at the market. Based on utilization, team members will work with health center medical directors to increase provider prescribing patterns and increase patient use of the onsite markets and interactive health promotion activities.

Unique community need identification numbers the project addresses:

- CN.20 - Lack of access to programs providing health promotion education, training and support, including screenings, nutrition counseling, patient education programs

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

Currently there is no coordinated program for the promotion of fruit and vegetable consumption in Harris Health System. The education provided by primary care providers, health educators, and dietitians within the Medical Home is not coordinated or consistent. This initiative will provide a new, focused, and integrated health promotion program for patients served by the health system. It will also significantly enhance the effectiveness and reach of the health center-based farmer's market program that was piloted in 2011-12.

Related Category 3 Outcome Measures:

OD-6 Patient Satisfaction

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

The Category 3 Outcome Measure selected for this project reflects the practice's ability to support the adoption of healthy behaviors. Evidence suggests that patient satisfaction surveys are a useful tool for assessing and improving quality in practice.[17] Because the primary goal of this project is to increase the number of patients receiving health promotion counseling and self-management guidance around fruit and vegetable consumption, satisfaction regarding the integration of healthy eating promotion into care is an acceptable and established marker of reach and quality. Currently, Harris Health System's Press-Ganey administered patient satisfaction survey for out-patients includes a domain of questions about the care provider including an item specific to behaviors that improve health.

Relationship to Other Projects and Other Performing Providers in the RHP:

Healthcare treatment cannot focus to only the acute or chronic encounter and properly treat the patient. It is critical that our region focuses to patient education and community education to ensure a proactive and responsive approach to healthcare needs. The education

models represented in the Region 3 RHP plan can be identified in the Initiative Grid (addendum) and all focus to outcome measures such as appropriate utilization, patient satisfaction scores, and stand alone chronic condition scores such as diabetes and asthma.

Plan for Learning Collaborative:

We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system.

Project Valuation:

The goal of the this project is to develop a program for promoting increased consumption of fruits and vegetables among primary care patients through an integrated approach that includes multi-provider and multi-modal patient education and access to a clinic-based farmer's market. Providers in Harris Health System recognize the need to counsel patients on healthy lifestyle behavior, but are often hesitant because of the challenges patients face with compliance. This project will leverage the motivating power of the provider-patient relationship. It will equip providers with a tangible tool (prescription) to use in their counseling and will give patients a specific avenue for adoption of the recommended behavior. The goal will be to educate 1,000 patients monthly across 10 medical home sites on the health promoting benefits of fruit and vegetable intake. Evidence from studies like Dietary Approaches to Stop Hypertension have determined that diets high in fruits and vegetables can reduce blood pressure, stroke risk, and weight. It has also been shown to prevent some cancers, and diabetes. Given the high level of chronic disease in the Harris Health patient population, improved diet can have immediate positive impact on the health of our patients, and result in long-term savings in emergency and acute care costs.

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133355104.2.6	***2.6.4***	***N/A***	***IMPLEMENT EVIDENCE-BASED HEALTH PROMOTION PROGRAM: INTEGRATED PROMOTION OF FRUIT AND VEGETABLE CONSUMPTION IN PRIMARY CARE THROUGH A PRESCRIPTION FOR HEALTHY EATING PROGRAM***
Harris Health System			1333355104
Related Category 3 Outcome Measure(s):	*133355104.3.27*	*IT-6.1*	*Patient Satisfaction*

Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Milestone 1 [P-3]: Implement, document and test an evidence-based innovative project for targeted population Metric 1 [P-3.1]: Document implementation strategy and testing outcomes Goal: Implement integrated, coordinated promotion program for fruit and vegetable consumption Data Source: HR hiring records of dietitian, health educator, chef; health eating prescriptions; program materials Milestone 1 estimated Incentive Payment: $106,529 **Milestone 2** [P-X]: Establish baseline number of patients receiving health promotion program (prescriptions for healthy eating)	**Milestone 4** [P-7]: Review project data and respond to it every week with tests of new ideas, practices, tools, or solutions. Metric 1 [P-7.1]: Number of new ideas practices, tools, or solutions tested by each provider Goal: Weekly improvement in provider and patient engagement in integrated health promotion program Data Source: Brief description of the idea, practice, tool, or solution tested by each provider each week. Milestone 4 estimated Incentive Payment: $657,978 **Milestone 5** [I-8]: Increase access to health promotion programs and activities using innovative project option.	**Milestone 6** [I-8]: Increase access to health promotion programs and activities using innovative project option. Metric 1 [P-8.1]: Increase percentage of target population reached Goal: Increase by 50% above previous year's enrollment (Goal 750 patients/month) Data source: EHR record review for number of prescriptions written and number of prescriptions redeemed at the market Milestone 6 estimated Incentive Payment: $1,349,980	**Milestone 7** [I-8]: Increase access to health promotion programs and activities using innovative project option. **Metric 1** [P-8.1]: Increase percentage of target population reached Goal: Increase by 30% above previous year's enrollment (Goal 1000 patients/month) Data source: EHR record review for number of prescriptions written and number of prescriptions redeemed at the market Milestone 7 estimated Incentive Payment: $1,125,884

133355104.2.6	*2.6.4*	*N/A*	***Implement Evidence-based Health Promotion Program: Integrated Promotion of Fruit and Vegetable Consumption in Primary Care Through a Prescription for Healthy Eating Program***
Harris Health System			1333355104
Related Category 3 Outcome Measure(s):	*133355104.3.27*	*IT-6.1*	*Patient Satisfaction*

Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Metric 1 [P-X.1]: Number of patients receiving prescriptions during first 6 months of program Goal: Document number of patients receiving prescriptions Data Source: EHR record review for number of prescriptions written Milestone 2 estimated Incentive Payment: $106,528 **Milestone 3** [P-7]: Review project data and respond to it every week with tests of new ideas, practices, tools, or solutions. Metric 1 [P-7.1]: Number of new ideas practices, tools, or solutions tested by each provider Goal: Weekly improvement in provider and patient engagement in integrated health promotion program	Metric 1 [I-8.1]: Increase percentage of target population reached Goal: Increase percentage of patients receiving prescriptions for healthy eating by 25% above baseline (Goal 500 patients/month) Data source: EHR record review for number of prescriptions written and number of prescriptions redeemed at the market Milestone 5 estimated Incentive Payment: $657,977		

133355104.2.6	***2.6.4***	***N/A***	***IMPLEMENT EVIDENCE-BASED HEALTH PROMOTION PROGRAM: INTEGRATED PROMOTION OF FRUIT AND VEGETABLE CONSUMPTION IN PRIMARY CARE THROUGH A PRESCRIPTION FOR HEALTHY EATING PROGRAM***
Harris Health System			1333355104
Related Category 3 Outcome Measure(s):	*133355104.3.27*	*IT-6.1*	*Patient Satisfaction*

Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Data Source: Brief description of the idea, practice, tool, or solution tested by each provider each week. Milestone 3 estimated Incentive Payment: $106,528			
Year 2 Estimated Milestone Bundle Amount: $319,585	Year 3 Estimated Milestone Bundle Amount: $1,315,955	Year 4 Estimated Milestone Bundle Amount: $1,349,980	Year 5 Estimated Milestone Bundle Amount: $1,125,884
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over DYs 2-5)***:** $4,111,404			

Project Option 2.10.2 - “Other”: Implement other evidence-based project to implement use of palliative care programs: Use of Palliative Care Programs

Unique RHP Project Identification Number: 133355104.2.7/ Pass 3
Provider Name/TPI: Harris Health System / 133355104

Project Summary:

Provider:
Harris Health System is comprised of 16 community health centers, seven school-based clinics, a dental center, dialysis center, five mobile health units, one outpatient specialty services clinic, and three hospitals. With a tax base of $511.6 million, Harris Health System was able to provide more than $1.254 billion in charity care during FY 2012.

Volume Statistics - FY2012	Patient Payor Mix	Patient Demographics
Hospital admissions- 35,343 Births (babies delivered)- 6,643 Emergency visits- 173,263 Outpatient clinic visits- 1,054,770	Self-Pay- 62.6% Medicaid and CHIP- 23.4% Medicare- 8.6% Other Funding- 3.6% Commercial Insurance- 1.8%	Hispanic- 57.4% African American- 26.3% Caucasian- 9.2% Asian- 4.8% Other- 2.2% American Indian- 0.2%

Intervention(s):
This project will expand our comprehensive palliative care program through the creation of an integrated, interprofessional team of specially trained providers.

Need for the project:
The cost of care for seriously ill and dying patients is frequently greater than the reimbursement for such care due to long length-of-stay and utilization of high-cost beds (ICU), drugs, and procedures, and the fixed payment design of reimbursement.

Target Population:
The target population includes any patients with life-limiting or life-threatening diseases in the hospital clinic and at home. (Medicaid and CHIP-23.4% / Self-Pay- 62.6%).

Category 1 or 2 expected patient benefits:
Our goal is to improved access to Palliative Care Services for residents that did not have access. The goal for DY3 is 750 patients, 1250 in DY4, and 1500 in DY5.

Category 3 outcomes:
IT-13.1- Increase by 3% in DY4 and 5% in DY5 the percentage of who screened positive for pain and received a clinical assessment of pain within 24 hours of screening.
IT-13.3- Decrease the percentage of patients who died from cancer with more than one emergency room visit in the last days of life by 3% in DY4 and 5% in DY5.
IT-13.4- Decrease the percentage of patients who died from cancer or other life-limiting illness admitted to the ICU in the last 30 days of life by 3% in DY4 and 5% in DY5.

Project Option 2.10.2 - "Other": Implement other evidence-based project to implement use of palliative care programs: Use of Palliative Care Programs

Unique RHP Project Identification Number: / Pass 3
Provider Name/TPI: Harris Health System / 133355104

Project Description:

Harris Health System proposes to expand our comprehensive palliative care program. Costs at the end of life are greater than any time period during the lifespan due to multiple emergency center visits, unnecessary hospital admissions and long stays in the Intensive Care Unit. The central mission of palliative medicine is to improve or maintain quality of life in patients with life-limiting or life-threatening diseases. Palliative medicine is a recognized medical subspecialty of both the American Board of Medical Specialties and American Osteopathic Association. Palliative medicine involves the control of symptoms associated with chronic disease such as nausea, pain and shortness of breath, as well as management of the symptoms that are part of the dying process. Along with symptom control, palliative medicine teams provide comfort and social and spiritual interventions for patients & their families.

In our current program, we treat patients that have patients with life-limiting or life-threatening diseases in the hospital clinic and at home - in order to avoid unnecessary EC visits, ambulance rides, and hospital and ICU admissions. Numerous published articles have shown palliative care decreases hospital days, increases quality of care, and cuts cost. Since hospice care is not part of the schedule of benefits for the Harris Health System our palliative care team has been making house calls as a strategy to help these high-cost, debilitated, home-limited patients get access to care.

Harris Health System, in partnership with the University of Texas Health Science Center, plans to extend this palliative care program to serve more of the population in need within the region. This project will transform the course of care at the end of life and moves it from the EC and hospital setting to the home environment. This project will also increase access to services for the vulnerable palliative population and reduce costs of care. We propose to provide better, more cost-effective care to the most debilitated, expensive patients served by Harris Health within Harris County through the creation of an integrated, interprofessional team of specially trained providers. Care will be furnished by a physician /nurse practitioner-directed team of health care professionals who are available 24/7 (typically by telephone) to carry out individualized plans of care[9]. Our target population will be patients with life-limiting illness including cancer and heart failure who are at high risk for readmission after discharge home [8]. Therefore, a significant number of our new patient house calls will be "immediately" post-discharge visits[8].

In Demonstration Year 2 we will augment the existing Bridge Team by adding 2 NP FTEs and 1.5 MD FTEs. Each Bridge Team will care for 500 patients and make 2500 visits per year once fully active and subscribed. Other professionals, including dedicated pharmacists, therapists, and case managers, will participate in Interdisciplinary Team Meetings held face-to-face or virtually to discuss new and active patients. This interchange will facilitate communication and will contribute to the teaching component. Because the geographic area is so large, a key addition to the team will be a logistics expert who will design processes and schedule visits to minimize traveling distance and maximize efficiency.

Goals and Relationship to Regional Goals:
The goal of this project is to expand our Palliative Care Program with an increase in mid-level practitioners, physicians and social workers to provide palliative care to patients who would otherwise not have access.
Project goals:

- Improve access to palliative care providers which is very limited for this vulnerable population
- Maximize independence
- Reduce unnecessary emergency center visits
- Reduce unnecessary hospital and ICU visits
- Allow patients to receive pain and symptom control resulting in increased patient and caregiver satisfaction

This project meets the following regional goals:

- Develop a regional approach to health care delivery that leverages and improves on existing programs and infrastructure, is responsive to patient needs throughout the entire region, and improves health care outcomes and patient satisfaction.
- Increase access to primary and specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their condition, regardless of where they live or their ability to pay.
- Transform health care delivery from a disease-focused model of episodic care to a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary or duplicative services, and builds on the accomplishments of our existing health care system

Challenges:

The primary challenge will be recruitment of qualified professionals. Data from the 2007 American Hospital Association Annual Survey showed that between 2000 and 2005, the number of hospitals with palliative medicine programs grew by 96% from 632 to 1240[17]. U.S. News and World Report has included palliative medicine as a criterion in its rankings of America's Best Hospitals since 2003[18]. The development of programs is limited by the dearth of palliative medicine physicians – only 100 per year graduate from US programs [19]. Our affiliation with the training program for Palliative Physicians at the University of Texas Medical School Division of Geriatric and Palliative Medicine will help us address this challenge.

We have a long experience with Palliative Medicine and house calls programs (geriatric, elder abuse and palliative) and already know how to address liability issues, personal safety concerns, time constraints, reimbursement issues, lack of available technology, and logistic issues. We propose a single virtual technology driven coordinating site that will address many of these obstacles including some of the training issues and by linking cost avoidance to the effort in addition to reimbursement, the financial picture is enhanced greatly.

5-Year Expected Outcome for Providers and Patients:
Harris Health intends to improve the end of life care for thousands of residents in our region by increasing the access to pain and symptom control provided by palliative care. We will reduce the usually high costs of caring for these patients by providing the right type of care, in the right setting (hospital, clinic or home). This strategy will provide high satisfaction for patients and their families as well as the providers who serve them. It also allows the emergency center,

hospital and ICUs to be used for appropriate care as pain and symptom control are best delivered outside of these settings.

Starting Point/Baseline:

Our current comprehensive palliative house call program began in 2007. The program is currently staffed by 2.0 FTE nurse practitioners (NP) with palliative experience and 1.0 FTE palliative physician at LBJ Hospital. The panel size ranges from 50-60 patients and we make 300 house calls, 500 clinic visits and 350 new inpatient visits each year.

In order to create teams to serve more patients, we estimate that the ideal PC Team would be comprised of 2.5 physicians and 4 mid-level practitioners such as a nurse practitioner or physician assistants, which would be able to manage 250 palliative patients at any given time with a total of 500 patients being managed in a year. We expect the PC Team patients to survive for approximately six months out of a year. We estimate that we would see each patient for an average of 5 visits per year, completing about 2500 visits per year for each PC Team. The goal in Year 2 of the Waiver is to enhance the current PC Team within Harris Health. The goal in DY 3 and DY4 is to increase by 2 more PC Teams for a total of 4 PC Teams to cover each quadrant of the region served by the Harris Health System.

Rationale:

Palliative medicine programs markedly reduce lengths of stay in hospitals on both wards and ICU settings. According to Morrison et al JAGS supplement April 2007 n>25,000 subjects, palliative care teams saved $1,506 per acute care admission and $5,248 per ICU admission [20]. Palliative care is not hospice, but nonetheless does provide emotional support and relieving symptoms for people in the final six months of a terminal illness. In fact, palliative care can ease illnesses that aggressive treatments often trigger. Expansion of our current program can prevent futile hospital based care where each crisis can cost tens of thousands of dollars [22].

House call based care for home-bound individuals works [1]. Call Doctor Medical Group in San Diego reduced ER visits by 59%[1]. In New York, Mount Sinai Visiting Doctors program reduced hospitalizations by 66% [3]. And the patients are very happy with these programs. At a patient satisfaction rating of 82.7%, the VA House Calls program is the highest satisfaction rating ever received by a VA program[4, 5]. The Mount Sinai program reported 100% of the patients/caregivers believe the program improved their quality of life, 92% reported the quality of care as “outstanding” or “very good”, and 88% reported that the program “definitely” meets their needs[1]. We can have the best of both worlds, better care at lower costs.

Project Components:

This project option does not include any required core project components. However, we will increase our capacity to provide palliative care to more individuals, by: a) adding additional palliative care providers, b) adding social workers/case managers, c) adding a logistics expert, and d) forming multidisciplinary care teams. Additionally, we will use performance improvement principles to modify the selection criteria to increase the efficacy of the house calls intervention. We will compare the resource utilization for the three months prior to enrollment in the house calls program to the months after the house calls begin to start to assess the effects of this effort on resource utilization.

Milestones and Metrics:

Process:

P-5 Milestone: Implement/expand a palliative care program
P-5.1 Metric: Implement comprehensive palliative care program
P-6 Milestone: Increase the number of palliative care consults
P-6.1 Metric: Palliative care consults meet targets established by the program
P-X1 Establish patterns of resource usage including EC and hospital utilization and ICU stays.
P-X1.1 Metric: Evaluate intervention, modify intervention as appropriate, develop policies/ procedures, and share lessons learned.
Improvement:
I-11 Milestone: Establish the comfort of dying for patients with terminal illness within their End-of-life stage of care
I-11.2 Metric: Pain assessment (NQF-1637) Percentage of hospice or palliative care patients who screened positive for pain and who received a clinical assessment of pain within 24 hours of screening.
I-14 Milestone: Improvements in palliative care services using innovative project option.
I-14.2 Metric: Target population reached through palliative care program: Improved access to PC Services for residents that did not have access.

Unique community need identification number the project addresses:
CN.2–Inadequate access to specialty care (palliative care); CN.6-Inadequate access to treatment and services designed for special needs populations, including disabled, homeless, children, elderly; CN.8-High rates of inappropriate emergency department utilization; CN.9-High rates of preventable hospital readmissions; and CN.10-High rates of preventable hospital admissions.

How the project represents a new initiative or significantly enhances an existing deliver system reform initiative:
Currently we provide this type of care to less than 350 persons a year with 2.0 providers (1 NP and 1 MD). We intend to increase the patient population served to 500/year per team for a total of 2000 patients served by the end of demonstration year (DY) 5.

<u>Related Category 3 Outcome Measures:</u>
OD- 13 Palliative Care
IT-13.1 Pain assessment (NQF-1637) *(Non-standalone measure)*
Increase the percentage of hospice or palliative care patients who screened positive for pain and who received a clinical assessment of pain within 24 hours of screening. Exclusion: patients with length of stay < 1 day in palliative care who were not screened for pain. Patients who screen negative for pain are excluded from the denominator.
IT-13.3 Proportion with more than one emergency room visit in the last days of life (NQF 0211)- Percentage of patients who died from cancer with more than one emergency room visit in the last days of life.*(Standalone measure)*
IT-13.4 Proportion admitted to the ICU in the last 30 days of life (NQF 0213)-Percentage of patients who died from cancer admitted to the ICU in the last 30 days of life. *(Standalone measure)*

Reasons/rationale for selecting the outcome measures:
Provide palliative care services to improve patient outcomes and quality of life. Palliative medicine represents a different model of care, focusing not on cure at any cost but on relief and prevention of suffering. The priority is to support the best possible quality of life for the patient

and family, regardless of prognosis. Ideally, the principles of palliative care can be applied as far upstream as diagnosis, in tandem with cure-directed treatment, although it's still associated in most people's minds with end-of-life care. There is an economic incentive for hospitals to support palliative care—research shows significant reductions in pharmacy, laboratory, and intensive care costs.

Relationship to other Projects:
There is a proposed house calls program that is similar but targets a population of patients that are home-bound but not necessarily at the end of life, nor have life-limiting disease such as cancer or end stage heart failure. These two projects are complementary and not duplicative since the interventions on house calls will be vastly different.

Relationship to Other Performing Providers' Projects: The regional need for palliative care is that of upmost priority and is addressed in this initiative. This initiative is unique to Pass 1 initiatives and focuses to outcome measures of pain assessments, treatment preferences, and patients receiving hospice and palliative care. The Region 3 Initiative Grid (addendum) can provide a cross reference to all other initiatives.

Plan for Learning Collaborative: We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system.

Project Valuation: The goal of this project is to expand our Palliative Care Program with an increase in mid-level practitioners, physicians and social workers to provide palliative care to patients who would otherwise not have access. This model has been shown to prevent emergency center visits, as well as hospital and ICU admissions. The cost of care for seriously ill and dying patients is frequently greater than the reimbursement for such care due to long length-of-stay and utilization of high-cost beds (ICU), drugs, and procedures, and the fixed payment design of reimbursement. Currently we provide this type of care to less than 350 persons a year. We intend to increase the patient population served to a total of 2000 patients by the end of demonstration year (DY) 5. The research available regarding palliative care shows significant reductions in pharmacy, laboratory, and intensive care costs for care coordinated through a palliative program.

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133355104.2.7	2.10.2	N/A	"OTHER": IMPLEMENT OTHER EVIDENCE-BASED PROJECT TO IMPLEMENT USE OF PALLIATIVE CARE PROGRAMS: USE OF PALLIATIVE CARE PROGRAMS
Harris Health System			133355104
Related Category 3 Outcome Measure(s):	133355104.3.28 133355104.3.29 133355104.3.30	IT-13.1 IT-13.3 IT-13.4	Pain assessment Proportion with more than one emergency room visit in the last days of life Proportion admitted to the ICU in the last 30 days of life

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-5]: Expand a palliative care program Metric 1 [P-5.1]: Implement comprehensive palliative care program Baseline: 1 partial team (2 NP FTE and 1.0 MD FTEs) Goal: 1 full team (4 NP FTEs and 2.5 MD FTEs) Data Source: Charter for Palliative care program ; Operational Plan; palliative care team and hiring agreements Milestone 1 Estimated Incentive Payment: $ 964,888 **Milestone 2** [P-6]: Increase the number of palliative care consults Metric 1 [P-6.1]: Palliative Care consults meet targets established by the program Baseline: 350 Goal: 500 Data Source: EHR, palliative care database Milestone 2 Estimated Incentive Payment: $964,887	**Milestone 3** [P-5]: Expand a palliative care program Metric 1 [P-5.1]: Implement comprehensive palliative care program Baseline: 1 full team (4 NP FTEs and 2.5 MD FTEs) Goal: Hire one additional team (4 NP FTEs and 2.5 MD FTEs) for total of 2 teams Data Source: Charter for Palliative care program ; Operational Plan; palliative care team and hiring agreements Milestone 3 Estimated Incentive Payment: $ 1,077,618 **Milestone 4** [I-14]: Improvements using Innovative Program option. Metric 1[I-14.2]: Improved access to PC Services for residents that did not have access. Goal:750 patients Data Source: EHR and PC database Milestone 4 Estimated Incentive Payment: $ 1,077,618	**Milestone 6** [P-5]: Expand a palliative care program Metric 1 [P-5.1]: Implement comprehensive palliative care program Baseline: 2 full teams (4 NP FTEs and 2.5 MD FTEs) Goal: Hire one additional team (4 NP FTEs and 2.5 MD FTEs) for total of 3 teams Data Source: Charter for Palliative care program ; Operational Plan; palliative care team and hiring agreements Milestone 6 Estimated Incentive Payment: $ 1,104,600 **Milestone7** [I-14]: Improvements using Innovative Program option. Metric 1[I-14.2]: Improved access to PC Services for residents that did not have access. Goal:1250 patients Data Source: EHR and PC database Milestone 7 Estimated Incentive Payment: $ 1,104,601	**Milestone 9** [P-5]: Expand a palliative care program Metric 1 [P-5.1]: Implement comprehensive palliative care program Baseline: 3 full teams (4 NP FTEs and 2.5 MD FTEs) Goal: Hire one additional team (4 NP FTEs and 2.5 MD FTEs) for total of 4 teams Data Source: Charter for Palliative care program ; Operational Plan; palliative care team and hiring agreements Milestone 9 Estimated Incentive Payment: $ 685,220 **Milestone 10** [I-14]: Improvements using Innovative Program option. Metric 1[I-14.2]: Improved access to PC Services for residents that did not have access. Goal:1500 patients Data Source: EHR and PC database Milestone 10 Estimated Incentive Payment: $685,220

133355104.2.7	*2.10.2*	*N/A*	*"OTHER": IMPLEMENT OTHER EVIDENCE-BASED PROJECT TO IMPLEMENT USE OF PALLIATIVE CARE PROGRAMS: USE OF PALLIATIVE CARE PROGRAMS*
Harris Health System			*133355104*
Related Category 3 Outcome Measure(s):	*133355104.3.28* *133355104.3.29* *133355104.3.30*	*IT-13.1* *IT-13.3* *IT-13.4*	*Pain assessment* *Proportion with more than one emergency room visit in the last days of life* *Proportion admitted to the ICU in the last 30 days of life*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	Milestone 5 [P-X1]: Establish patterns of resource usage including EC and hospital utilization and ICU stays. Metric 1 [P-X1.1]: Evaluate intervention, modify intervention as appropriate, develop policies/ procedures, and share lessons learned. Goal: Evaluate usage of these resources before and after intervention Data Source: Electronic health record Milestone 5 Estimated Incentive Payment: $ 1,077,618	**Milestone 8** [I-11]: Establish the comfort of dying patients with terminal illness within their end-of-life stage of care Metric 1 [I-11.2]: Pain screening (NQF-1634) Percentage of hospice or palliative care patients who were screened for pain during the palliative care initial encounter. Goal: 5% increase in number of patients screened Data Source: EHR, palliative care database Milestone 8 Estimated Incentive Payment: $ 1,104,601	**Milestone 11** [I-11]: Establish the comfort of dying patients with terminal illness within their end-of-life stage of care Metric 1[I-11.2]: Pain screening (NQF-1634) Percentage of hospice or palliative care patients who were screened for pain during the palliative care initial encounter. Goal: 10% increase Data Source: EHR, palliative care database Milestone 11 Estimated Incentive Payment: $ 685,220 **Milestone 12** [P-X]: Establish patterns of resource usage including EC and hospital utilization, and ICU stays. Metric 1 [P-X1.1]: Evaluate intervention, modify intervention as appropriate, develop policies/ procedures, and share lessons learned. Goal: Evaluate usage of these resources before and after intervention Data Source: Electronic health record

133355104.2.7	***2.10.2***	***N/A***	***"OTHER": IMPLEMENT OTHER EVIDENCE-BASED PROJECT TO IMPLEMENT USE OF PALLIATIVE CARE PROGRAMS: USE OF PALLIATIVE CARE PROGRAMS***
Harris Health System			*133355104*
Related Category 3 Outcome Measure(s):	*133355104.3.28* *133355104.3.29* *133355104.3.30*	*IT-13.1* *IT-13.3* *IT-13.4*	*Pain assessment* *Proportion with more than one emergency room visit in the last days of life* *Proportion admitted to the ICU in the last 30 days of life*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
			Milestone 12 Estimated Incentive Payment: $ 685,221
Year 2 Estimated Milestone Bundle Amount: $1,929,775	Year 3 Estimated Milestone Bundle Amount: $3,232,854	Year 4 Estimated Milestone Bundle Amount: $3,313,802	Year 5 Estimated Milestone bundle Amount: $ 2,740,881
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over DYs 2-5)***:**$ 11,217,312			

Matagorda Regional Medical Center

Pass 2

Project Option 2.9.1: Provide navigation services to targeted patients who are at risk of disconnect from institutionalized health care: Establish a Patient Care Navigation Program

Unique RHP Project Identification Number: 130959304.2.1 / Pass 2
Performing Provider Name/TPI: Matagorda Regional Medical Center/ 130959304

Project Summary:

Provider:
Matagorda Regional Medical Center is a wholly owned part of Matagorda County Hospital District. The District also operates a primary care clinic for patients qualified for the District's Medical Assistance Program. The Hospital is a 58 bed acute care facility with a Level III trauma designation.

Volume Statistics - FY2012	Patient Payor Mix	Patient Demographics
Hospital admissions- 2594 Births - 381 Emergency visits- 18600 Surgeries – 1598 Outpatient visits -18260	Self-Pay- 11.5% Medicaid and CHIP- 12.8% Medicare- 50.1% Commercial Insurance- 22.5% Charity- 3.1%	Hispanic- 31.1% African American- 17.2% Caucasian- 50.1% Other- 1.6%

Intervention(s):
The Patient Care Navigation Service will utilize community health workers, case managers, and /or other types of health care professionals to provide enhanced social support and culturally competent care to vulnerable and/or high risk patients; to assist patients in connecting to available primary, specialty, and chronic disease care sites; and to decrease inappropriate visits to the hospital emergency department by steering non-urgent care to available alternatives.

Need for the project**:**
While there has been positive progress in expanding access to community based care, current data reflects that between 40 and 50% of Matagorda Regional Medical Center Emergency Department visits are for diagnosis that could safely be treated in a clinic setting.

Target Population**:**
All patients within the system with may benefit from this project (Medicaid and CHIP-23.4% / Self-Pay- 62.6%), specifically those with no primary care home.

Category 1 or 2 expected patient benefits**:**
Matagorda Regional Medical Center expects to see a decrease in the number of unnecessary visits to the Emergency Department by patients enrolled in the Navigation Program. Our goal is to have 500 frequent ED patients actively enrolled in the Navigation Program by the end of year 5.

Category 3 outcomes:
IT-9.2: Our goal is a 25% reduction in unnecessary Emergency Department visits within one year of each patient's enrollment date in the Patient Care Navigation Service.

Project Option 2.9.1: Provide navigation services to targeted patients who are at risk of disconnect from institutionalized health care: Establish a Patient Care Navigation Program

Unique RHP Project Identification Number: 130959304.2.1 / Pass 2
Performing Provider Name/TPI: Matagorda Regional Medical Center/ 130959304

Project Description:
A joint planning team was formed with representatives of Matagorda County Hospital District/Matagorda Regional Medical Center, Matagorda Episcopal Health Outreach Program (MEHOP – FQHC), and Palacios Community Medical Center to explore potential models for collaboration. The transformation goals described in the Waiver helped the group crystallize their plans and a new partnership was formed to move the joint planning effort forward. This new organization, Coastal Health Connection, is being incorporated to further the concept of shared infrastructure and shared planning to improve the health of the community. The DSRIP project to establish a Patient Care Navigation Program is an outgrowth of this shared vision of a healthier community.

While there has been positive progress in expanding access to community based care, current data reflects that between 40 and 50% of Matagorda Regional Medical Center Emergency Department visits are for diagnosis that could safely be treated in a clinic setting. During the past 3 years, the community has seen the addition of a well-organized and staffed FQHC (MEHOP), expanded use of physician extenders, and the opening of a private urgent care center and there are active plans in place to continue to improve access to both primary and specialty care throughout the region. The continued inappropriate use of the hospital emergency department as a source of non-emergent care underscores the need for a program or service that will ensure patients receive coordinated, timely, and site-appropriate health care services.

The target zip codes include all of those in Matagorda County and it is expected this program will receive patients from surrounding counties since the patient panels at MEHOP include patients from Matagorda, Wharton, Jackson, and Brazoria counties.

Target Zip Codes:
77414,77404,77456,77465,77457,77419,77458,77415,77428,77440,77480,77483

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

Project Goals:

- Utilize community health workers, case managers, and /or other types of health care professionals as patient navigators;
- Provide enhanced social support and culturally competent care to vulnerable and/or high risk patients;
- Assist patients in connecting to available primary, specialty, and chronic disease care sites;

- Decrease inappropriate visits to the hospital emergency department by steering non-urgent care to available alternatives.

This project meets the following Region 3 goals:

- Develop a regional approach to health care delivery that leverages and improves on existing programs and infrastructure, is responsive to patient needs throughout the entire region, and improves health care outcomes and patient satisfaction.
- Transform health care delivery from a disease-focused model of episodic care to a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary or duplicative services, and builds on the accomplishments of our existing health care system.

Challenges or Issues Faced:

As a designated health manpower shortage area, access to care is a challenge – particularly access to primary care. The access issue is compounded by the high poverty rate of the County.

The population profile of Matagorda County shows that approximately 50% of the residents live outside the county seat in remote low density areas. Communication about available resources is a challenge.

As a result of these factors, the emergency departments of both hospitals in the county have become the first choice for routine care for many residents of the county. These patterns are long established and often multi-generational. EMTALA, lack of resources, and cultural habits make the emergency department a difficult place from which to steer patients to more appropriate venues for care.

How the Project Addresses Challenges/Issues:

The Patient Care Navigation Program will be a critical component of expanding access to care in the community. There are a number of exciting plans in Matagorda County to expand access and recruit additional providers. Without a mechanism to communicate about the available resources, particularly in more remote areas, patients will not know to seek other venues and continue to rely on the emergency departments. Because the Navigation Program will be custom to the needs of the target populations, the most effective and culturally sensitive method of communication and education can be used.

5-Year Expected Outcome for Provider and Patients:

Matagorda Regional Medical Center expects to see a decrease in the number of unnecessary visits to the Emergency Department by patients enrolled in the Navigation Program. By effectively using community based navigators to "connect" to the target population they are assigned, it is anticipated that through personal communication, education, and advice, patients will more often receive the right care in the right setting. By creating a system of care focused on a coordinated, collaborative approach and early intervention, patients will not be as likely to get "lost" and end up in health crises. The expected outcome is to reduce unnecessary visits to the Emergency Department for the population of patients managed through the Patient Care Navigation Program. Our goal is to have 500 frequent ED patients actively enrolled in the

Navigation Program by the end of year 5 with a 25% reduction in unnecessary Emergency Department visits within one year of each patient's enrollment date.

Starting Point/Baseline:
A Patient Care Navigation Program does not exist for the Matagorda County region and therefore we have no patients in a system of care navigation.

Rationale/Reasons for selecting the project option:
The county is served by two acute care hospitals, Matagorda Regional Medical Center and Palacios Community Medical Center. In 2010, the facilities reported 19,368 emergency visits. The hospitals provided more than $16 million in uncompensated care, which accounted for 14.9% of total patient revenue, the second highest percentage in the region.[232] Between 40 and 50% of the visits to the MRMC Emergency Department in 2012[233] could be considered non-emergent and potentially could be cared for in a less costly venue.

Matagorda County includes the towns of Bay City and Palacios, as well as 15 smaller communities spread throughout the county of more than 1,000 square miles. More than 36,000 people live within the county which has a median household income of $39,874. Nearly 20% of the population lives below the poverty level, and the county has the second highest rate of children living in poverty at 28.4%.[234]

These factors supported recognition that a personal, almost one-on-one approach was needed to begin re-educating a population that for generations have relied on the emergency department as a primary source of health care. The Patient Care Navigation Program represents that approach.

Project Components:
The required core project components include the following:

a) Identify frequent ED users and use navigators as part of a preventable ED reduction program. Train health care navigators in cultural competency.
b) Deploy innovative health care personnel, such as case managers/workers, community health workers and other types of health professionals as patient navigators.
c) Connect patients to primary and preventive care.
d) Increase access to care management and/or chronic care management, including education in chronic disease self-management.
e) Conduct quality improvement for project using methods such as rapid cycle improvement. Activities may include, but are not limited to, identifying project impacts, identifying "lessons learned," opportunities to scale all or part of the project to a broader patient population, and identifying key challenges associated with expansion of the project, including special considerations for safety-net populations.

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[232] 2010 Cooperative DSHS/AHA/THA Annual Survey of Hospitals and Hospitals Tracking Database
[233] 2012 MCHD Statistical Data Sheet
[234] U.S. Census Bureau, 2010 Census

We will meet these project components with the establishment of the Patient Care Navigation Program as follows:

15. Identification of the target patient base defined by frequent emergency department visits
    - Estimated cost for analysis: $50,000 - $75,000
16. Development of patient care navigator team including support and administrative staff
    - Staffing plan development including job descriptions: $25,000 - $30,000
    - Recruitment: $20,000
    - Training: $150,000 initial; $25,000/year ongoing
    - Staffing: $600,000
17. Program Offices
    - Space Lease (4 – 5 locations): $120,000/year
    - Furniture/equipment: $50,000
    - Vehicles: $60,000
18. Develop a collaborative model with the primary care community to utilize navigation program
    - Informational material, education, etc: $10,000/year
19. Establish of baseline metrics and then continual measurement for improvement while utilizing process techniques such as PDSA cycles for improvement
    - IT (patient tracking, scheduling, referral systems): $20,000 (one time) + $10,000/year
20. Communication of program information and success in the county, area and region.
    - Educational material, etc.: $10,000

Milestones & Metrics:
The following milestones and metrics have been chosen for the Chronic Care Clinic project based on the core components and the needs of the target population:
Process Milestones and Metrics:P-1 (P-1.1); P-2 (P-2.1; 2.2);P-3(P-3.1); P-5 (P-5.1); P-8 (P-8.1); Improvement Milestones and Metrics: I-6(I-6..2); I-8(I-8.1)

Unique community need identification number the project addresses:
The project addresses the following unique community needs as identified in the community needs assessment:

CN.1 Access to primary and specialty care
CN.2 High utilization of hospital emergency room for non-emergent care
CN.3 Percent Uninsured (29.2%) and Percent Poverty (22%) in Matagorda County
CN.4 HPSA score of 16

How the project represents a new initiative for the Performing Provider or significantly enhances an existing delivery system reform initiative:
As a Hospital District, the main focus of the organization has been on the acute end of the care continuum – primarily hospital and emergency department services. This initiative partners the District with the community through a collaborative with other providers to help patients get the right care in the right setting. This project will also enhance another project goal of creating a

system of care for chronic diseases by placing trained patient care navigators in the community to identify opportunities to steer patients into that system.

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

- Reduce all ED visits (including ACSC)[235]
- Reduce pediatric Emergency Department visits (CHIPRA Core Measure)[236]
- Reduce Emergency Department visits for target conditions
    - Congestive Heart Failure
    - Diabetes
    - End Stage Renal Disease
    - Cardiovascular Disease /Hypertension
    - Behavioral Health/Substance Abuse
    - Chronic Obstructive Pulmonary Disease
    - Asthma

Reasons/rationale for selecting the outcome measure(s):
Because such a high percentage of the population is uninsured, low income, and under-educated, connecting to the right setting for care can be challenging. The barriers created by these factors include economic and communication. Generations of families have come to rely on the emergency department of hospitals as their sole source of health care.

While there are many factors involved in calculating actual cost savings available if a patient receives care in the most cost effective setting, the charge associated with the lowest acuity visit for a local hospital ED visit is over double that of the same coded visit in a local community clinic.[237] With over 9000 emergency department visits per year in Matagorda County potentially being eligible for care in a different venue, the impact could be significant.

Relationship to Other Projects:
MCHD is also developing a Chronic Disease Specialty Clinic. While the Patient Care Navigation System is not specifically aimed at the chronic disease population, the two projects will overlap with an integrated referral system and have positive impact on appropriate use of the ED.

Relationship to Other Performing Providers' Projects in the RHP:
The ability to properly identify and monitor specific patients with chronic conditions or frequent emergency department utilization trends will allow the region to accurately mange the very large patient base. Patient navigation includes a comprehensive list of tasks as well as unique provider types based on the focus of the initiative and will help the focus of cost containment, emergency department utilization, and chronic disease management. The Region 3 Initiative Grid in the addendum allows for a cross reference of all initiatives proposed within this concept.

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[235]http://archive.ahrq.gov/data/safetynet/billappb.htm
[236]http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/CHIPRA-Initial-Core-Set-of-Childrens-Health-Care-Quality-Measures.html
[237] MCHD, MEHOP charge master

Plan for Learning Collaborative: We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system.

Project Valuation:
Matagorda Regional Medical Center has approximately 20,000 visits to the Emergency Department annually. Records reflect a potential of 40 – 50%[238] of the visits could have been treated in another venue. If the Patient Care Navigator Program is successful at reducing unnecessary ED visits by a conservative 10%, a savings of as much as $2,000,000[239] could be realized by the end of the project period (as compared to a standard physician office visit).

[238] MCHD ED Records 2012
[239]Cost of an average ED visit compared to an office visit.*Consumer Health Ratings, 2011*

130959304.2.1	*2.9.1*	*2.9.1(A-E)*	*PATIENT CARE NAVIGATION PROGRAM*	
Matagorda Regional Medical Center				130959304
Related Category 3 Outcome Measure(s):	*130959304.3.2*	*IT-9.2*	*ED Appropriate Utilization*	

Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Milestone 1[P-1]: Conduct needs assessment Metric 1[P-1.1]:Provide report identifying targeted patient population. Baseline: No gap assessment has been conducted Goal: Completion of gap assessment Data Source: Community Needs Assessment; Gap analysis; EHR Milestone 1Estimated Incentive Payment *(maximum amount):* $81,033 Milestone 3 [P-8]: Participate in face-to-face learning Metric 1 [P-8.1]: Participate in semi-annual face-to-face meetings or seminars organized by RHP Milestone 3 Estimated Incentive Payment: $81,032	**Milestone 4**[P-5]: Provide reports on the types of navigation services provided Metric 1 [P-5.1]Collect and report on all the types of patient navigator services provided. Baseline: Full complement of navigators with initial focus on frequent users of ED Goal: Create a profile of patient needs Data Source: Program records, ED EHR Milestone 4 Estimated Incentive Payment: $90,349 **Milestone 2 [P-2): establish health care navigation program** **Metric 1 ([P-2.1]: select and train navigators**	**Milestone 5 [P-3]: Provide navigation services to targeted patients** **Metric 1 [P-3.1] Increase in the number or percent of patients enrolled** Baseline: Full complement of navigators Goal: Average 15 new enrolled patients per month Data Source: Program records, ED EHR Milestone 5 Estimated Incentive Payment: $91,660 **Milestone 6**[I-6]: Increase the number of PCP referrals Metric 1 [I-22.1]:Percent of patients without a PCP who received education about a primary care provider in the ED. Baseline: Patients without a PCP	**Milestone 7**[I-8]: Reduction in ED use by identified ED frequent users receiving navigation services Metric 1 [I-8.1]:ED visits pre and post navigation services Baseline: Year 3 reports establishing pre navigation service visits. Goal: Decrease of 25% Data Source: ED and Navigation program records. Milestone 7Estimated Incentive Payment: $150,902

130959304.2.1	*2.9.1*	*2.9.1(A-E)*	***PATIENT CARE NAVIGATION PROGRAM***
Matagorda Regional Medical Center			130959304
Related Category 3 Outcome Measure(s):	*130959304.3.2*	*IT-9.2*	*ED Appropriate Utilization*

Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
	Baseline: There are currently no job descriptions or individuals in a navigator position Goal: Using developed job descriptions, recruit and train initial navigator staff with skill sets to address info from the needs analysis. First patients enrolled by beginning of 2nd quarter. Data source: needs assessment, training material, HR documents **Milestone 2 Estimated Incentive Payment: $90,350**	documented in the medical record Goal: 50% of targeted patients receive documented education about PCP services. Data Source: ED and Navigator program records Milestone 6 Estimated Incentive Payment: $91,660	
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):*$162,065	Year 3 Estimated Milestone Bundle Amount: $180,699	Year 4 Estimated Milestone Bundle Amount: $183,320	Year 5 Estimated Milestone Bundle Amount: $150,902
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:**$676,986			

Memorial Hermann Hospital

Pass 1

Project Option: 2.9.2 Expand COPE/ER Navigation Program
Performing Provider: Memorial Hermann Hospital/TPI 137805107
Unique Project ID: 137805107.2.1

- Provider: Memorial Hermann Hospital (Memorial) is an 860 bed hospital located in Houston, TX and is part of the Houston-Sugarland-Baytown MSA. The MSA population served by Memorial is approximately 6,000,000 people.

- Intervention(s): Memorial will expand the current Community Outreach for Personal Empowerment (COPE) and ER Navigation programs to further identify uninsured and Medicaid patients utilizing emergency rooms for lower acuity conditions. The expansion will be located in Memorial's three busiest emergency rooms during the busiest shifts and include hiring additional Navigators to meet demand.

- Need for the project: Emergency Department (ED) use for conditions preventable or treatable with appropriate primary care is associated with inefficient processes and increased risk for poor outcomes. The expansion of COPE and the Navigation will improve access to health care, reduce inappropriate utilization of healthcare facilities and educate individuals about the health and social service resources available to them.

- Target population: The target population is all uninsured patients that access the ER for primary care purposes. Future plans are to add Medicaid patients. The expansion of the existing COPE and ER Navigation programs will benefit an estimated 15,000 to 30,000 additional patients annually.

- Category 1 or 2 expected patient benefits: The expansion of the COPE and ER Navigation programs will establish a baseline of patients reached by Navigators and by DY5 will increase patient contact by 15% over the baseline measured in DY2.

- Category 3 outcomes: IT 9.4 – Memorial will collect ED utilization data for patients enrolled in the programs and by DY5, Memorial intends to reduce ED visits in 6 months after enrollment in the programs by 10% under the DY3 baseline.

Project Option 2.9.2- Other Option: Expand COPE /ER Navigation Program

Unique RHP Project Identification Number: 137805107.2.1
Performing Provider Name/TPI: Memorial Hermann Hospital (Memorial)/137805107

Project Description: This project will identify uninsured and Medicaid patients utilizing emergency rooms for lower acuity conditions and uninsured patients with a history of repeat ER visits and hospitalizations and, through education, guidance, and follow-up by Certified Community Health Workers (Navigators) and social workers improve access to health care, reduce inappropriate utilization of health care facilities, and educate individuals about the health and social service resources available to them. Through this education and referral to accessible resources, the use of the ER as a primary source of healthcare and/or the escalation of medical conditions resulting from the lack of primary care follow-up that end up in the ER and hospital should be reduced. This project is an expansion of Memorial Hermann's current Community Outreach For Personal Empowerment (COPE) and ER Navigation programs.

Emergency Department (ED) use for conditions preventable or treatable with appropriate primary care is associated with inefficient processes and increased risk for poor outcomes. The Memorial Hermann COPE and ER Navigation programs will engage social workers and certified Community Health Workers who have the training, cultural understanding, and linguistic capacity to help the uninsured and at-risk populations, who disproportionately use emergency rooms and other hospital services for healthcare, 'navigate' the complex health system, obtain a medical home, schedule appointments, and cope with future healthcare concerns.

The navigation program will be located in Memorial Hermann's three busiest emergency rooms, during the busiest shifts, and serve all uninsured patients that access the ER for primary care purposes. Near future plans are to add Medicaid patients who are uncertain of or uninformed regarding their primary care provider. The COPE program will place mobile staff across all nine Memorial Hermann acute care hospitals and cover high utilizers of inpatient and observation care as well as ER care via collaboration with ER Navigators, phone and travel.

This project proposes to increase the current four Certified Community Health Workers (Navigators) to 14 navigators and one manager to cover all nine of Memorial Hermann's ERs and to increase the current four person COPE staff (three social workers and one navigator) by 6 social workers and 2 navigators to increase program penetration, flexibility, and productivity. One Director to manage both programs is also included. This expansion will result in navigation and follow-up of 28,470 additional patients annually.

Both programs require active interventions, tools, and empowering communication to help patients identify, access and obtain community-based services. By using patient navigators to effectively connect uninsured and Medicaid patients with medical homes and other resources and support services, overall primary care ER utilization and costs among target populations will decrease.

Goal(s) and relationship to Regional goal(s):

Project goals:

The goal of this project is to improve access to health care, reduce inappropriate utilization of health care facilities, and to educate individuals about the health and social service resources available to them. Through education and referral to accessible resources, the use of the ER as a primary source of healthcare and/or the escalation of medical conditions resulting from the lack of primary care follow-up that end up in the ER should be reduced. To ensure success, staff will be carefully selected and appropriately trained based on his or her familiarity with the local community's culture, language, values and vast knowledge about local health care services and community programs. Staff will work one-on-one with individuals and families to identify their needs and link them to community resources that will improve their health, quality of their lives and overall well-being. Much of the work will be done in follow-up, after discharge, ensuring that a clinic appointment was made and was successful; assisting with paperwork required to qualify for Medicaid, CHIP, or county indigent programs; helping individuals and families access resources available in the community such as food, clothing, shelter, employment support, and counseling; and, referring individuals and families to area Benefit Bank of Texas (TBB-TX) counselors to sign up for local, state and federal health care resources and social services such as SNAP/Food Stamps, FAFSA, Medicaid, CHIP, Medicare Extra Help – Prescription and federal taxes. (TBB-TX has recently expanded into Houston.)

This project meets the following Region 3 goals:

- Transform health care delivery from a disease-focused model of episodic care to a patient-centered, coordinated delivery model improving patient satisfaction and health outcomes, reducing unnecessary or duplicative services, and building on accomplishments of our existing health care system.

Challenges and how addressed:

Integral to success is the work done post discharge, ensuring that a clinic appointment was made and kept and assisting with paperwork required to qualify for Medicaid, CHIP, or county indigent programs. The population "navigated" is often transient, and communicating with them beyond the short-term is often difficult with phone numbers and residences changing frequently. Memorial will structure this project in order to overcome these challenges, through careful planning, and conducting ongoing quality improvement activities upon its implementation.

5-year expected outcome for provider and patients:

This request proposes to increase the current four Certified Community Health Workers (navigators) to 14 navigators and one manager to cover all nine of Memorial Hermann's ERs and to increase the current four person COPE staff (three social workers and one navigator) by six social workers and two navigators to increase program penetration, flexibility, and productivity. One Director to manage both programs is also included. This expansion will result in navigation and follow-up of 28,470 additional patients annually.

Starting Point/Baseline: Memorial currently has a COPE and ER Navigation program but is looking to expand them within all Memorial facilities in Region 3. ER Navigation is currently at Memorial Hermann Hospitals Southwest, Northwest, and TMC and will be expanded to Southeast, The Woodlands, Memorial City, Katy, Sugar Land, and Northeast. COPE currently covers all Memorial acute facilities but with only a 4 person staff. Expansion of COPE staff will increase program penetration, flexibility, and productivity within all 9 facilities.

Rationale:

Traditionally, a hospital's care of patients ends the instant the patient is discharged. This has resulted in fragmented or overlapping care that is complicated for patients to access and navigate. This complexity often results in no follow-up care, and an inappropriate return to the hospital. This project will offer targeted patient populations assistance in coordinating their care. In addition to helping individual patients, this project will allow all providers across the spectrum of care to utilize their resources more efficiently, delivering care to patients in the most appropriate setting. This will result in lower costs for the delivery system and higher patient satisfaction.

This project uses staff in an effective, cost efficient model to help uninsured and at-risk patients who are high utilizers of health services and/or use the ERs for primary care purposes to: become empowered participants, capable of taking control of their healthcare through the use of appropriate, available, local community resources; to decrease hospital ER visits, observation stays, and inpatients admissions; and to document decreased reliance on the ER as a source for primary and chronic health care. The pilot study of Memorial Hermann's existing ER Navigation Program found that in our target population of uninsured and publicly insured patients, mean ER visits significantly declined in the 12-month post-intervention period, compared to the 12-month pre-intervention period. After conducting several sub-analyses based on frequency of pre-intervention PCR ED use, we found this result to be robust for both low and high utilizers of ED services. The pilot study of Memorial Hermann's existing COPE Program found that in our target population of uninsured patients reductions in ER/Observation/Inpatient utilization resulted in a savings of $5,328 per patient. The savings associated with both programs far outweighs the costs to implement them. Additionally, Both programs' findings are consistent with previous research demonstrating that case management effectively reduced the total number of visits for high ED utilizers (Okin et al., 2000; Pope, Fernandes, Bouthillette, & Etherington, 2000).

Project Components:

This project option does not have any required core components.

Unique community need identification number the project addresses:

- CN.8: High rates of inappropriate emergency department utilization
- CN.9: High rates of preventable hospital readmissions
- CN.10: High rates of preventable hospital admissions

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

Memorial currently completes limited post-discharge support for a small subset of its patient population. This program would allow Memorial to expand the level of post-discharge support by dedicating personnel and resources, offering enhanced support such as transportation, and offering navigation services to all patients with certain targeted conditions.

Related Category 3 Outcome Measure(s): OD-9: Right Care, Right Setting; IT 9.4 Other Outcome Improvement Target—ED Appropriate Utilization.

Data Collection Methodology: Memorial Hermann resources are compared pre/post-navigation intervention at like pre/post intervals; i.e. pre/post 6 months, pre/post 1 year, etc.

- Pre data: # of ER visits 6 months pre-navigation intervention.
- Post data: # of ER visits 6 months post-navigation intervention.
  - This data is similarly compared at 12 months, 18 months, and 24 months.
  - This data is similarly compared for a sub-population identified as frequent flyers: those with 1+ pre-navigation visits, 3+ pre-navigation visits, and 5+ pre-navigation visits.
- For COPE patients, Inpatient and Observation activity is presented in pre/post data in addition to ER at 6 months, 12 months, 18 months, and 24 months.
- (Note: pre/post data activity of navigated patients is available for all Memorial Hermann patient activity but not for services rendered at non Memorial Hermann facilities.)

Reasons/rationale for selecting the outcome measure(s):
If patients are educated on the resources available to assist them, the use of the ER as a primary source of healthcare and/or the escalation of medical conditions resulting from the lack of primary care follow-up that end up in the ER should be reduced.

Relationship to other Projects: This project is part of Memorial Hermann's larger plans to expand and develop primary care and specialty care services, while improving access to care and implementing delivery improvements targeted to specific populations (in this case, uninsured and Medicaid patients facing access barriers). It works closely with the greater Houston Safety Net Community.

Relationship to Other Performing Providers' Projects in the RHP: Memorial Hermann Healthcare System reflects the vision of other Performing Providers' in the RHP by increasing individual and family access to healthcare, improving the quality of healthcare, reducing costly ED usage for primary care treatable issues, educating the community on alternative healthcare resources available to them, the importance of a medical home, and reducing overall healthcare costs. It works closely with the greater Houston Safety Net Community.

The ability to properly identify and monitor specific patients with chronic conditions or frequent emergency department utilization trends will allow the region to accurately mange the very large patient base. Patient navigation includes a comprehensive list of tasks as well as unique provider types based on the focus of the initiative and will help the focus of cost containment, emergency

department utilization, and chronic disease management. The Region 3 Initiative Grid in the addendum allows for a cross reference of all initiatives proposed within this concept.

Plan for Learning Collaborative: We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers in the region having similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system.

Project Valuation:

Approach for valuing project: The valuation of each Memorial Hermann project takes into account the transformational impact of the project, the population served by the project (both number of people and complexity of patient needs), the alignment of the project with community needs, the magnitude of costs avoided or reduced by the project, the degree of collaboration involved in the project, and the sustainability of the project.

Rationale/justification for valuation: The implementation of a patient care navigation program will significantly improve access to both primary and specialty care for targeted patient populations, foster more efficient use of the community's healthcare resources, and ultimately result in reduction of healthcare costs; Memorial took these factors into account when considering the appropriate incentive payment value for this project.

137805107.2.1	2.9.2		COPE (COMMUNITY OUTREACH FOR PERSONAL EMPOWERMENT) AND ER NAVIGATION
Memorial Hermann Hospital			137805107
Related Category 3 Outcome Measure(s):	137805107.3.9	IT-9.4	OTHER OUTCOME IMPROVEMENT TARGET—ED APPROPRIATE UTILIZATION

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1 [P-1]: Conduct a Needs Assessment to identify patient population(s) to be targeted with the Patient Navigator Program. Metric 1 [P-1.1]: Provide report identifying targeted patient population characteristics; how the program will identify, triage, and manage patient population; and number of required navigators to be hired. Data Source: Program documentation, EHR, claims, and needs assessment survey. Goal: To target populations and improve the efficiency of the project. Milestone 1 Estimated Incentive Payment: $1,258,319 **Milestone 2** [P-X1]: Establish baseline for number of target population reached by patient navigators. Metric 1 [P-X1.1]: Establish baseline for future years. Data Source: Submission of documentation demonstrating study	**Milestone 4** [P-2]: Establish/expand a health care navigation program which will provide support to patient populations most at risk of receiving disconnected and fragmented care, including a program to train navigators, develop procedures and establish continuing navigator education. Metric 1 [P-2.3]: Frequency of contact with care navigators for high-risk patients. Data Source: Patient navigation program materials and database, EHR. Baseline/Goal: Increase patient contact by 5% over baseline measured in DY2. Milestone 4 Estimated Incentive Payment: $1,029,569 **Milestone 5** [P-8]: Participate in interactions with other providers and RHP to promote collaborative learning around shared or similar projects.	**Milestone 8** [P-2]: Establish/expand a health care navigation program which will provide support to patient populations most at risk of receiving disconnected and fragmented care, including a program to train navigators, develop procedures and establish continuing navigator education. Metric 1 [P-2.3]: Frequency of contact with care navigators for high-risk patients. Data Source: Patient navigation program materials and database, EHR. Baseline/Goal: Increase patient contact by 10% over baseline measured in DY2. Milestone 8 Estimated Incentive Payment: $1,032,561 **Milestone 9** [P-8]: Participate in interactions with other providers and RHP to promote collaborative learning around shared or similar projects.	**Milestone 12** [P-2]: Establish/expand a health care navigation program which will provide support to patient populations most at risk of receiving disconnected and fragmented care, including a program to train navigators, develop procedures and establish continuing navigator education. Metric 1 [P-2.3]: Frequency of contact with care navigators for high-risk patients. Data Source: Patient navigation program materials and database, EHR. Baseline/Goal: Increase patient contact by 15% over baseline measured in DY2. Milestone 12 Estimated Incentive Payment: $852,985 **Milestone 13** [P-8]: Participate in interactions with other providers and RHP to promote collaborative learning around shared or similar projects. Metric 1 [P-8.1]: Number of meetings, conference calls or webinars organized

137805107.2.1	2.9.2		COPE (COMMUNITY OUTREACH FOR PERSONAL EMPOWERMENT) AND ER NAVIGATION
Memorial Hermann Hospital			137805107
Related Category 3 Outcome Measure(s):	137805107.3.9	IT-9.4	OTHER OUTCOME IMPROVEMENT TARGET—ED APPROPRIATE UTILIZATION

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
of baseline numbers. Goal: To determine baseline for measure of project improvement in future years. Milestone 2 Estimated Incentive Payment: $1,258,318 **Milestone 3** [P-8]: Participate in interactions with other providers and RHP to promote collaborative learning around shared or similar projects. Metric 1 [P-8.1]: Number of meetings, conference calls or webinars organized by the RHP that the provider participated in. Data Source: Meeting Agendas, sign-in sheets, conference calls, presentations, and emails. Milestone 3 Estimated Incentive Payment: $1,258,318	Metric 1 [P-8.1]: Number of meetings, conference calls or webinars organized by the RHP that the provider participated in. Data Source: Meeting Agendas, sign-in sheets, conference calls, presentations, and emails. Milestone 5 Estimated Incentive Payment: $1,029,569 **Milestone 6** [P-3]: Provide care management/navigation services to targeted patients. Metric 1 [P-3.1]: Increase in the number or percent of targeted patients enrolled in the program . Baseline/Goal: Increase number of patients enrolled in program by 5%. Data Source: Enrollment reports. Milestone 6 Estimated Incentive Payment: $1,029,568 **Milestone 7** [I-6]: Increase number of PCP referrals for patients without a medical home who use the ED, urgent	Metric 1 [P-8.1]: Number of meetings, conference calls or webinars organized by the RHP that the provider participated in. Data Source: Meeting Agendas, sign-in sheets, conference calls, presentations, and emails. Milestone 9 Estimated Incentive Payment: $1,032,562 **Milestone 10** [P-3]: Provide care management/navigation services to targeted patients. Metric 1 [P-3.1]: Increase in the number or percent of targeted patients enrolled in the program. Baseline/Goal: Increase number of patients enrolled in program by 10%. Data Source: Enrollment reports. Milestone 10 Estimated Incentive Payment: $1,032,562 **Milestone 11** I-6: Increase number of PCP referrals for patients without a medical home who use the ED,	by the RHP that the provider participated in. Data Source: Meeting Agendas, sign-in sheets, conference calls, presentations, and emails. Milestone 13 Estimated Incentive Payment: $852,986 **Milestone 14** [P-3]: Provide care management/navigation services to targeted patients. Metric 1 [P-3.1]: Increase in the number or percent of targeted patients enrolled in the program. Baseline/Goal: Increase number of patients enrolled in program by 15%. Data Source: Enrollment reports. Milestone 14 Estimated Incentive Payment: $852,986 **Milestone 15** I-6: Increase number of PCP referrals for patients without a medical home who use the ED, urgent care and/or hospital services.

137805107.2.1	2.9.2		COPE (COMMUNITY OUTREACH FOR PERSONAL EMPOWERMENT) AND ER NAVIGATION
Memorial Hermann Hospital			137805107
Related Category 3 Outcome Measure(s):	137805107.3.9	IT-9.4	OTHER OUTCOME IMPROVEMENT TARGET—ED APPROPRIATE UTILIZATION

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
	care and/or hospital services. Metric 1 [I-6.4]: Percentage of patients without a primary care provider who are given a scheduled primary care provider appointment. Goal: 5% increase over baseline. Data Source: Performing Provider administrative data on patient encounters and scheduling records from Patient Navigator program. Milestone 7 Estimated Incentive Payment: $1,029,568	urgent care and/or hospital services. Metric 1 I-6.4: Percentage of patients without a primary care provider who are given a scheduled primary care provider appointment. Goal: 5% increase over baseline. Data Source: Performing Provider administrative data on patient encounters and scheduling records from Patient Navigator program. Milestone 11 Estimated Incentive Payment: $1,032,561	Metric 1 I-6.4: Percentage of patients without a primary care provider who are given a scheduled primary care provider appointment. Goal: 5% increase over baseline. Data Source: Performing Provider administrative data on patient encounters and scheduling records from Patient Navigator program. Milestone 15 Estimated Incentive Payment: $852,986
Year 2 Estimated Milestone Bundle Amount: $3,774,956	Year 3 Estimated Milestone Bundle Amount: $4,118,274	Year 4 Estimated Milestone Bundle Amount: $4,130,246	Year 5 Estimated Milestone Bundle Amount: $3,411,943
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $15,435,419			

Project Option: 2.10.1 Implement a Palliative Care Program
Performing Provider: Memorial Hermann Hospital/TPI 137805107
Unique Project ID: 137805107.2.2

- Provider: Memorial Hermann Hospital (TMC) is an 860 bed hospital located in Houston, TX and is part of the Houston-Sugarland-Baytown MSA. The MSA population served by Memorial is approximately 6,000,000 people.

- Intervention(s): Memorial will implement a comprehensive palliative care program that will engage patients with life threatening, acute or chronic conditions. The program will also educate health care professionals so they can better advise their patients who need end-of-life care outside an acute care setting.

- Need for the project: Currently, the region only has light adoption of palliative care and there are many hospitals that have no access to palliative care, and there is virtually no access to outpatient palliative care. A palliative care program is needed to improve the quality of life for patients and their families and could be more widely embraced by dying patients and caregivers if they were better educated about this service and made aware of its benefits.

- Target population: There are two types of people the program will target 1) health care professionals and caregivers that will be educated on the services and benefits of palliative care, and 2) patients that would normally seek end-of-life care in an acute care setting so they may be transitioned to home care, hospice or a skilled nursing facility. Memorial expects to be managing a population of approximately 140,000 patients in the next 12 months, and will be enrolling all eligible patients from that population into the palliative care program that meet clinical criteria. In addition, in years two and three of the program, after the infrastructure is implemented, the palliative care program will be enrolling all eligible identified Medicaid/uninsured populations that meet clinical eligibility criteria.

- Category 1 or 2 expected patient benefits: Patients in need of palliative care will benefit from having options to their end-of-life care other than seeking out an emergency room or an acute care setting.

- Category 3 outcomes: IT 13.3 Proportion with more than one ER visit in the last days of life – 10% improvement over baseline. The palliative care program will accelerate the growth and increase the availably of palliative care in the region providing an alternative to ER utilization for patients in the last days of life.

Project Option- 2.10.1 Implement a Palliative Care Program to address patients with end-of-life decisions and care needs: Use of Palliative Care Programs

Unique RHP Project Identification Number: 137805107.2.2
Performing Provider Name/TPI: Memorial Hermann Hospital (Memorial)/137805107

Project Description: Implement a comprehensive palliative care program in cooperation with MHMD that will engage patients through the Primary Care physician network and enroll patients in the palliative care program through physician offices rather than waiting for an acute hospitalization to occur. This project will target patients with life threatening acute or chronic conditions.

Palliative care is a newer medical specialty focusing on improving life and providing comfort to people of all ages with serious, chronic, and life-threatening illnesses. These diseases may include cancer, congestive heart failure, kidney failure, chronic obstructive pulmonary disease, AIDS, and Alzheimer's, and others. This focus also reduces readmissions, health care costs and improves quality of life for families and those providing the care and support to these patients.

Goal(s) and relationship to Regional goal(s):

Project goals:

Provide palliative care services to improve patient outcomes and quality of life. Palliative medicine represents a different model of care, focusing not on care at any cost but on relief and prevention of suffering. Here the priority is supporting the best possible quality of life for the patient and family, regardless of prognosis. Ideally, the principles of palliative care can be applied as far upstream as initial diagnosis of a serious illness, and may be used in tandem with cure-directed treatment. Program goals include: improved pain and symptom control, improved patient satisfaction, reductions in hospital length of stay, reduced cost of care by transitioning appropriate acute care patients to the program, and decreased inpatient mortality.

This project meets the following Region 3 goals:

This project addresses the RHP's goal to "[t]ransform health care delivery from a disease-focused model of episodic care to a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary or duplicative services, and builds on the accomplishments of our existing health care system."

Challenges and how addressed: Challenges to this project include: upstream application of palliative care principles; application of a model of care with which many patients and families may be unfamiliar; selecting reliable program partners in forming the palliative care program; integrating the program into the current care model; integrating providers who may be resistant to changing their practice methodology; and improving patient satisfaction who are suffering from chronic or terminal illnesses.

Memorial will address the challenge of selecting a reliable program partner by thoroughly analyzing potential community collaborators. Memorial will integrate the program into the current care model by identifying and accepting patients to participate in the supportive and end

of care program. Memorial will also integrate the program by embracing evidence-based care transitions and interventions designed to improve quality of life and satisfaction for patients with chronic and terminal conditions. Furthermore, extensive education will increase physician understanding and will increase patient satisfaction. The palliative care program will address patient satisfaction by developing tailored education, training and standard communication protocols to ensure patients are provided informed choice on the topic of advanced care wishes. Patient advocacy, patient preferences, and patient choice will be a top priority and documentation of patient preference will be recorded within the individual's health record.

5-year expected outcome for provider and patients:

Providers will have better access to and a better understanding of palliative care treatment. Patients will have better satisfaction and quality of life during end of life care.

Starting Point/Baseline: Currently, the Houston area only has light adoption of palliative care as a solution to patient satisfaction and outcomes in patients who have serious or life-threatening acute or chronic illnesses. There are many hospitals that have no access to palliative care, and there is virtually no access to outpatient palliative care services. Because the majority of the milestones and metrics for this project are associated with educating clinical staff on the appropriate use of palliative care, the baseline will need to be assessed by surveying providers in ICU and other specialty areas to care to gauge their current education level.

Rationale:

While end-of-life care was once associated almost exclusively with terminal cancer, today people receive end-of-life care for a number of other conditions, such as congestive heart failure, other circulatory conditions, COPD, and dementia. Further, some experts have suggested that palliative and hospice care could be more widely embraced by dying patients and caregivers if they were better educated about this service and made aware of its benefits. However, these experts say that overly rigid quality standards and poorly aligned reimbursement incentives discourage appropriate end-of-life care and foster incentives to provide inappropriate restorative care and technologically intensive treatments. Experts also note that hospitals, nursing homes, and home health agencies need stronger incentives to provide better access to palliative care and care coordination either directly, themselves, or by contract with outside suppliers. It seems clear that improving care coordination near the end of life can improve care for patients with chronic conditions; however, palliative care should also allow children who are enrolled in either Medicaid or CHIP to receive hospice services without foregoing curative treatment related to a terminal illness.

A palliative care program is needed in an acute care setting in order to improve the quality of life for patients and their families facing the issues associated with life-threatening illness through the prevention and relief of suffering by means of early identification and assessment and treatment of issues including physical, psychosocial and spiritual. Today's healthcare environment has seen an increase in the number of older patients with co-morbidities which results in much sicker patients in the hospital setting. This increase in patient acuity can greatly benefit from palliative care.

This palliative end of life care program will provide value by decreasing inpatient costs, increasing patient and family satisfaction, and improving quality through symptom management and comfort care at end of life. Palliative care consultation services will optimize symptom management, facilitate end-of-life conversations, and assist with timely transitions between sites of care.

Project components:

This project will meet the following required core components:

(a) Develop a business case for palliative care and conduct planning activities necessary as a precursor to implementing a palliative care program;

- Memorial will develop a palliative care business case and conduct planning activities as part of the negotiation and contracting process

(b) Transition palliative care patients from acute hospital care into home care, hospice or a skilled nursing facility;

- Memorial will transition palliative care patients from its facilities to into home care

(c) Implement a patient/family experience survey regarding the quality of care, pain and symptom management, and degree of patient/family centeredness in care and improve scores over time

- will implement a patient/family experience survey as part of this project, to be administered to the population of patients served by the project, and their families.

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

- Memorial will conduct quality improvement activities as part of the hospice program established under this project.

Unique community need identification number the project addresses:

- CN.2 - Inadequate access to specialty care
- CN.6 - Inadequate access to treatment and services designed for special needs populations, including disabled, homeless, children, elderly
- CN.8-High rates of inappropriate emergency department utilization

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

There is only a small palliative care presence relative to the population of Region 3. This project would be a significant improvement to the healthcare delivery system by addressing that deficiency.

Related Category 3 Outcome Measure(s): OD-13: Palliative Care; IT-13.3 Proportion with more than one ER visit in the last days of life.

Reasons/rationale for selecting the outcome measure(s):

The ER is not the appropriate site of treatment for end of life care. This project will, therefore, reduce the reliance on ERs for patients who are terminally ill.

Relationship to other Projects: This project is part of Memorial Hermann's larger plans to expand and develop primary care and specialty care services, while improving access to care and implementing delivery improvements targeted to specific populations (in this case, terminally ill patients). This project reinforces Project 2.9, Establish/Expand a Patient Navigation System. The palliative care program will redirect terminally and chronically ill patients out of acute care and into the program. This compliments several goals of Project 2.9—decreasing health care costs and increasing high quality patient-centered care.

This project is also related to Project 2.2, Expand Chronic Care Models. Both projects aim to increase efficiency through improved management of chronic conditions. Additionally, these projects are focused on improving care while also specific patients out of acute care centers.

Relationship to Other Performing Providers' Projects in the RHP: The regional need for palliative care is that of upmost priority and is addressed in this initiative. This initiative is unique to Pass 1 initiatives and focuses to outcome measures of pain assessments, treatment preferences, and patients receiving hospice and palliative care. The Region 3 Initiative Grid (addendum) can provide a cross reference to all other initiatives.

Plan for Learning Collaborative: We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system.

Project Valuation:

Approach for valuing project: The valuation of each Memorial Hermann project takes into account the transformational impact of the project, the population served (both number of people and complexity of patient needs), the alignment with community needs, the magnitude of costs avoided or reduced, the degree of collaboration involved, and the sustainability of the project.

In valuing this project, Memorial took into account the extent to which a palliative and end of life care program would potentially meet the goals of the Waiver (support the development of a

coordinated care delivery system, improve outcomes while containing costs, improve the healthcare infrastructure), the extent to which it will address the community needs, the population served, and resources and cost necessary to implement the project.

The expansion of palliative care will help address a substantial need in the community for patient-centered care for chronically ill and terminally ill patients. It also advances the Waiver goal of improving outcomes while curbing the risk of healthcare costs.

137805107.2.2	*2.10.1*	*A-C*	***IMPLEMENT A PALLIATIVE CARE PROGRAM TO ADDRESS PATIENTS WITH END-OF-LIFE DECISIONS AND CARE NEEDS: USE OF PALLIATIVE CARE PROGRAMS***
Memorial Hermann Hospital			*137805107*
Related Category 3 Outcome Measure(s):	***137805107.3.10***	*IT-13.3*	***Proportion with More than One ER Visit in the Last Days of Life***
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-X1]: Establish baselines to be used to determine the success of project in future years. Metric 1 [P-X1.1]: Establish baseline for future years. Goal: To establish baseline for future years. Data Source: Submission of documentation demonstrating study of baseline measures. Milestone 1 Estimated Incentive Payment: $1,849,979 **Milestone 2** [P-8]: Document the conditions for which palliative care is consulted. Metric 1 [P-8.1]: Breadth of conditions for which palliative care is utilized. Baseline/Goal: Establish baseline for above criteria Data Source: EHR; palliative care database/ case management database Milestone 2 Estimated Incentive Payment: $1,849,978	**Milestone 3** [P-2]: Educate primary care specialties (e.g., family medicine, Internal Medicine, Pediatrics, Geriatrics, and other IM subspecialties) in providing palliative care. Metric 1 [P-2.1]: Primary care specialties training and education in palliative care. Baseline/Goal: Educate 10% of the provider workforce that is involved in ICU, Medical, Internal Medicine, and other specialty fields with patients who are hospice appropriate. Data Source: Training and Education Materials, dates of trainings and attendance. Milestone 3 Estimated Incentive Payment: $2,018,227 **Milestone 4** [CQI P-19]: Participate in interactions (meetings, conference calls, or webinars) with other providers and the RHP to promote collaborative learning around shared or similar projects.	**Milestone 5** [P-2]: Educate primary care specialties (e.g., family medicine, Internal Medicine, Pediatrics, Geriatrics, and other IM subspecialties) in providing palliative care. Metric 1 [P-2.1]: Primary care specialties training and education in palliative care. Baseline/Goal: Educate 20% of the provider workforce that is involved in ICU, Medical, Internal Medicine, and other specialty fields with patients who are hospice appropriate. Data Source: Training and Education Materials, dates of trainings and attendance Milestone 5 Estimated Incentive Payment: $1,349,396 **Milestone 6** [CQI P-19]: Participate in interactions (meetings, conference calls, or webinars) with other providers and the RHP to promote collaborative learning around shared or similar projects. Metric 1 [P-19.1]: Number meetings,	**Milestone 8** [P-2]: Educate primary care specialties (e.g., family medicine, Internal Medicine, Pediatrics, Geriatrics, and other IM subspecialties) in providing palliative care. Metric 1 [P-2.1]: Primary care specialties training and education in palliative care. Baseline/Goal: Educate 25% of the provider workforce that is involved in ICU, Medical, Internal Medicine, and other specialty fields with patients who are hospice appropriate. Data Source: Training and Education Materials, dates of trainings and attendance Milestone 8 Estimated Incentive Payment: $1,114,718 **Milestone 9** [CQI P-19]: Participate in interactions (meetings, conference calls, or webinars) with other providers and the RHP to promote collaborative learning around shared or similar projects. Metric 1 [P-19.1]: Number meetings, conference calls, or webinars organized by the RHP that the provider participated in. Baseline/Goal: Participate in learning collaborative./meetings Data Source: Documentation of phone

137805107.2.2	*2.10.1*	*A-C*	*IMPLEMENT A PALLIATIVE CARE PROGRAM TO ADDRESS PATIENTS WITH END-OF-LIFE DECISIONS AND CARE NEEDS: USE OF PALLIATIVE CARE PROGRAMS*
Memorial Hermann Hospital			*137805107*
Related Category 3 Outcome Measure(s):	***137805107.3.10***	*IT-13.3*	***Proportion with More than One ER Visit in the Last Days of Life***

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	Metric 1 [P-19.1]: Number meetings, conference calls, or webinars organized by the RHP that the provider participated in. Baseline/Goal: Participate in learning collaborative./meetings Data Source: Documentation of phone meetings, conference calls, or webinars including agendas for phone calls, slides from webinars, and/or meeting notes. Milestone 4 Estimated Incentive Payment: $2,018,227	conference calls, or webinars organized by the RHP that the provider participated in. Baseline/Goal: Participate in learning collaborative./meetings Data Source: Documentation of phone meetings, conference calls, or webinars including agendas for phone calls, slides from webinars, and/or meeting notes. Milestone 6 Estimated Incentive Payment: $1,349,396 **Milestone 7** [I-9]: Palliative care patients transitioned from acute hospital care into hospice, home care, or a skilled nursing facility (SNF) with and without hospice services. Metric 1 [I-9.1]: Transitions accomplished. Baseline/Goal: 10% increase over DY2 baseline to increase hospice appropriate consults and discharges. Data Source: EHR; data warehouse; palliative care database Milestone 7 Estimated Incentive Payment: $1,349,396	meetings, conference calls, or webinars including agendas for phone calls, slides from webinars, and/or meeting notes. Milestone 9 Estimated Incentive Payment: $1,114,719 **Milestone 10** [I-9]: Palliative care patients transitioned from acute hospital care into hospice, home care, or a skilled nursing facility (SNF) with and without hospice services. Metric 1 [I-9.1]: Transitions accomplished. Baseline/Goal: 10% increase over DY2 baseline to increase hospice appropriate consults and discharges. Data Source: EHR; data warehouse; palliative care database. Milestone 10 Estimated Incentive Payment:$1,114,719

137805107.2.2	***2.10.1***	*A-C*	***Implement a Palliative Care Program to address patients with end-of-life decisions and care needs: Use of Palliative Care Programs***
Memorial Hermann Hospital			*137805107*
Related Category 3 Outcome Measure(s):	***137805107.3.10***	*IT-13.3*	***Proportion with More than One ER Visit in the Last Days of Life***

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Year 2 Estimated Milestone Bundle Amount: $3,699,957	Year 3 Estimated Milestone Bundle Amount: $4,036,454	Year 4 Estimated Milestone Bundle Amount: $4,048,188	Year 5 Estimated Milestone Bundle Amount: $3,344,156
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $15,128,755			

Memorial Hermann Northwest Hospital

Pass 1

Project Option: 2.2.5 Psych Response Team – Case Management
Performing Provider: Memorial Hermann Hospital System/TPI 020834001
Unique Project ID: 020834001.2.1

- Provider: Memorial Hermann Hospital System (Memorial Hermann) is a 1,164 bed hospital system consisting of 4 campuses in the Houston-Sugarland-Baytown MSA. The system serves a population of approximately 6,000,000 people.

- Intervention(s): The project will provide a 24/7 liaison to act as an adjunct to the Psych Response Team and provide case management of post-discharge behavioral health patients. Case management will identify individuals whose chronic mental illness predicts they will likely have repeat visits to the ER and connect them with case management services for follow-up after discharge.

- Need for the project: Follow-up with behavioral health patients after discharge is a service not currently provided. The patients struggle with non-compliance in prescribed health maintenance activities post-discharge. This project will give behavioral health patients access to necessary follow-up information, as well as a resource for questions regarding their diagnosis and treatment.

- Target population: The target population is all behavioral patients whose conditions are chronic and require individual case management to ensure their treatment is given in a suitable setting and manner. It is estimated that 20% of people in Harris County suffer from behavioral health issues of which 25% are uninsured and another 18% or 701,559 are covered by Medicaid. Of the 18% of residents covered by Medicaid, approximately 8% have received some type behavioral health treatment. Memorial Hermann anticipates this project will address the needs of 500 to 2,000 patients annually.

- Category 1 or 2 expected patient benefits: Most of the target population are frequent patients of the emergency room, which is not an appropriate setting for chronic behavioral health care. This project will provide the patients with more individualized treatment for their conditions and provide them with options for seeking treatment in more appropriate settings.

- Category 3 outcomes: IT 3.8 – The case management project will result in more intensive case management of post-discharge behavioral health patients. The Behavioral Health/Substance Abuse (BH/SA) 30-day readmission rate should see a 10% reduction in BH/SA readmissions by DY5.

Project Option- 2.2.5 Develop care management functions that integrate the primary and behavioral health needs of individuals: Psych Response Team - Case Management

Unique RHP Project Identification Number: 020834001.2.1
Performing Provider Name/TPI: Memorial Hermann Hospital System/020834001

Project Description:

Provide a 24/7 liaison to act as an adjunct to the Psych Response Team to provide more intensive case management of "post-discharge" behavioral health patients to reduce recidivism and increase compliance with follow-up. Emergent Psych Patient Volumes increased 25% in all Memorial Acute Care hospitals from FY 2007 – 2012; which averaged an annual volume increase of almost 5% per year (Total Response Team Volume for FY 2012: 6,924 Patient Encounters). Reasons for increases: ERs identified Primary Care Provider for many indigent; current provider appointment scheduled but symptoms too acute to wait for services; missed appointments, patients have insurance but do not know how to access/navigate Behavioral Care.

Goal(s) and relationship to Regional goal(s):

Project Goal:

Reduce readmission rates and increase compliance with follow-up after discharge through case management.

This project meets the following Region 3 goals:

This project addresses the RHP's goal to "[i]ncrease access to primary and specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their condition, regardless of where they live or their ability to pay."

Challenges and how addressed:

Individuals with chronic mental health conditions struggle with non-compliance in prescribed health maintenance activities, such as medicine management, follow-up, and Medicaid enrollment activities. Memorial also anticipates difficulties in recruiting competent behavioral health staff to provide 24/7 services. To address these challenges, Memorial will engage in an aggressive recruitment campaign and deliver services in a manner that places the patient at the center of care decisions wherever possible, which has shown to improve the behavior of non-compliant patients.

5-year expected outcome for provider and patients:

After the project has been fully implemented, Memorial expects that there will be a significant decrease in potentially preventable readmissions.

Starting Point/Baseline: Memorial does not currently have case management component to its psychiatric response team. The volume on patients served by this project will come from the existing psychiatric response team and additional referrals.

Rationale:

This project will give behavioral health patients access to necessary follow up information, as well as a resource for questions regarding their diagnosis and treatment. This source of information will prevent unnecessary ED visits, and will achieve better compliance with follow-up care.

Project components:
There are no required components for this project option.

Unique community need identification number the project addresses:

- CN.5 – Inadequate access to care for veterans and active military, particularly mental health and substance abuse services.
- CN.3 -- Inadequate access to behavioral healthcare.

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

The Psych Response Team Program does not have a case management component in its current state. The primary charge of the Psych Response Team is to evaluate the behavioral health patients in Memorial Hermann Acute Care Hospitals (ED's or medical units) and refer the patient to the appropriate level of care necessary. Follow-up with the patient after discharge is a not service currently provided. The thirteen year history of the Psych Response Team has revealed that patients with psychiatric illnesses are higher utilizes of ED services than the general population. This is in-part due to poor follow-up after discharge. The new initiative, the Case Management adjunct to the Psych Response Team, would identify individuals whose chronic mental illness will likely predict they will have repeat visits to EDs for on-going services and connect with case management services for follow-up after discharge. These services would provide consistent support to ensure compliance with follow-up recommendations and proactively engage the patient in aftercare services in order to prevent reliance on the most expensive level of care in the community, hospital EDs.

Related Category 3 Outcome Measure(s): OD-3: Potentially Preventable Re-Admissions – 30 day Readmission Rates (PPRs); IT-3.8 Behavioral Health/Substance Abuse 30 day readmission rate.

Reasons/rationale for selecting the outcome measure(s):
Coordination of behavioral healthcare has a direct and proven impact on the reduction of potentially preventable readmissions, for both behavioral care issues as well as comorbidities. Therefore, this Category 3 outcome measure in an appropriate measure for the success of this project.

Relationship to other Projects: This project is part of Memorial Hermann's larger plans to enhance healthcare delivery with a model of care management that allows staff to work with at-risk patients with chronic behavioral health disorders. Due to the high incidence of non-compliance with treatment recommendation in the targeted population, these patients are high utilizers of ERs. This project would seek to educate and empower consumers to access and

navigate a healthcare delivery system through the use of appropriate, available, local community resources; to decrease hospital ER visits and to document decreased reliance on emergency rooms as a resource for chronic behavioral healthcare.

Relationship to Other Performing Providers' Projects in the RHP: The behavioral health crisis in Region 3 is considerable and the proposed initiatives in our RHP plan will only imply a small impression into the overall community need for treatment, but is a good start. The outpatient focus of many RHP Plan initiatives will help numerous facilities focus to treating the patients in an ambulatory setting as well as continued navigation of services with a focus to keeping patients from the inpatient unit. This initiative is similar to many others in the sense of the category of behavioral health. The Region 3 Initiative Grid attached in the addendum will show the relationship to other programs.

Plan for Learning Collaborative: We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system.

Project Valuation:

Approach for valuing project: The valuation of each Memorial Hermann project takes into account the transformational impact of the project, the population served by the project (both number of people and complexity of patient needs), the alignment of the project with community needs, the magnitude of costs avoided or reduced by the project, the degree of collaboration involved in the project, and the sustainability of the project.

Rationale/justification for valuation: This particular project improves both the quality of healthcare and the efficiency of the delivery system—both important goals of the Waiver. In addition, this project promotes the delivery of behavioral health, which is particularly needed in Region 3.

020834001.2.1	2.2.5	N/A	DEVELOP CARE MANAGEMENT FUNCTIONS THAT INTEGRATE THE PRIMARY AND BEHAVIORAL HEALTH NEEDS OF INDIVIDUALS: PSYCH RESPONSE TEAM - CASE MANAGEMENT
Memorial Hermann Hospital System			020834001
Related Category 3 Outcome Measure(s):	020834001.3.7	IT-3.8	Behavioral Health/Substance Abuse (BH/SA) 30-Day Readmission Rate

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1[P-X1]: Establish baseline for number of staff for community based behavioral patients enrolled in a self-management program, number of patients identified as needing screening tests, preventative tests, or other clinical services, and number of patients with self-management goals. Metric 1[P-X1.1]: Establish baseline for future years. Goal: To determine baseline for measure of project improvement in future years. Data Source: Submission of documentation demonstrating study of baseline numbers. Milestone 1 Estimated Incentive Payment: $1,999,180 **Milestone 2** [P-8]: Participate in interactions with other providers and RHP to promote collaborative learning around shared or similar projects. Metric 1[**P-8.1]:** Number of meetings, conference calls or webinars organized by the RHP that the provider participated in. Baseline/Goal: Participate in learning collaborative/meetings Data Source: Meeting Agendas, sign-in	**Milestone 3** [P-8]: Participate in interactions with other providers and RHP to promote collaborative learning around shared or similar projects. Metric 1 [P-8.1]: Number of meetings, conference calls or webinars organized by the RHP that the provider participated in. Baseline/Goal: Participate in learning collaborative/meetings Data Source: Meeting Agendas, sign-in sheets, conference calls, presentations, email. Milestone 3 Estimated Incentive Payment: $1,090,500 **Milestone 4** [P-9]: Develop program to identify and manage chronic care patients needing further clinical intervention. Metric 1 [P-9.1]: Increase the number of patients identified as needing screening tests, preventative tests, or other clinical services. Baseline/Goal: 5% increase over DY2 baseline. Data Source: EHR; patient registry. Milestone 4 Estimated Incentive Payment: $1,090,499	**Milestone 7** [P-8]: Participate in interactions with other providers and RHP to promote collaborative learning around shared or similar projects. Metric 1[P-8.1]: Number of meetings, conference calls or webinars organized by the RHP that the provider participated in. Baseline/Goal: Participate in learning collaborative/meetings Data Source: Meeting Agendas, sign-in sheets, conference calls, presentations, email. Milestone 7 Estimated Incentive Payment: $1,458,226 **Milestone 8** [P-9]: Develop program to identify and manage chronic care patients needing further clinical intervention. Metric 1 [P-9.1]: Increase the number of patients identified as needing screening tests, preventative tests, or other clinical services. Baseline/Goal: 10% increase over DY2 baseline. Data Source: EHR; patient registry. Milestone 8 Estimated Incentive Payment: $1,458,226	**Milestone 10** [I-21]: Improvements in access to care for patients receiving chronic care management services. Metric 1 [I-21.1]: Increase percentage of target population reached. Baseline/Goal: 15% increase over baseline established in DY2. Data Source: Documentation of target population reached, as designated in the project plan. Milestone 10 Estimated Incentive Payment: $1,806,932 **Milestone 11** [P-9]: Develop program to identify and manage chronic care patients needing further clinical intervention. Metric 1 [P-9.1]: Increase the number of patients identified as needing screening tests, preventative tests, or other clinical services. Baseline/Goal: 15% increase over DY2 baseline. Data Source: EHR; patient registry. Milestone 11 Estimated Incentive Payment: $1,806,932

020834001.2.1	2.2.5	N/A	DEVELOP CARE MANAGEMENT FUNCTIONS THAT INTEGRATE THE PRIMARY AND BEHAVIORAL HEALTH NEEDS OF INDIVIDUALS: PSYCH RESPONSE TEAM - CASE MANAGEMENT
Memorial Hermann Hospital System			020834001
Related Category 3 Outcome Measure(s):	020834001.3.7	IT-3.8	Behavioral Health/Substance Abuse (BH/SA) 30-Day Readmission Rate

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
sheets, conference calls, presentations, email. Milestone 2 Estimated Incentive Payment: $ 1,999,181	**Milestone 5** P-11.1: Increase the number of patients enrolled in a self-management program. Metric 1[P-11.1]: Increase the number of patients enrolled in a self-management program. Baseline/Goal: 5% increase over DY2 baseline. Data Source P-11.1: EHR, patient registry, class enrollment and attendance records. Milestone 5 Estimated Incentive Payment: $1,090,499 **Milestone 6** [I-21]: Improvements in access to care for patients receiving chronic care management services. Metric 1 [I-21.1]: Increase percentage of target population reached. Baseline/Goal: 5% increase over baseline established in DY2. Data Source: Documentation of target population reached, as designated in the project plan. Milestone 6 Estimated Incentive Payment: $1,090,499	**Milestone 9** [I-21]: Improvements in access to care for patients receiving chronic care management services. Metric 1 [I-21.1]: Increase percentage of target population reached. Baseline/Goal: 10% increase over baseline established in DY2. Data Source: Documentation of target population reached, as designated in the project plan. Milestone 9 Estimated Incentive Payment: $1,458,226	

020834001.2.1	*2.2.5*	*N/A*	*DEVELOP CARE MANAGEMENT FUNCTIONS THAT INTEGRATE THE PRIMARY AND BEHAVIORAL HEALTH NEEDS OF INDIVIDUALS: PSYCH RESPONSE TEAM - CASE MANAGEMENT*
Memorial Hermann Hospital System			*020834001*
Related Category 3 Outcome Measure(s):	***020834001.3.7***	*IT-3.8*	***Behavioral Health/Substance Abuse (BH/SA) 30-Day Readmission Rate***

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $3,998,361	Year 3 Estimated Milestone Bundle Amount: $4,361,997	Year 4 Estimated Milestone Bundle Amount: $4,374,678	Year 5 Estimated Milestone Bundle Amount: $3,613,864
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $16,348,900			

Project Option: 2.9.2 MHMD Care Management
Performing Provider: Memorial Hermann Hospital System/TPI 020834001
Unique Project ID: 020834001.2.2

- Provider: Memorial Hermann Hospital System (Memorial Hermann) is a 1,164 bed hospital system consisting of 4 campuses in the Houston-Sugarland-Baytown MSA. The system serves a population of approximately 6,000,000 people.

- Intervention(s): Memorial Hermann will implement a comprehensive care management infrastructure for populations attributed to the MHMD Clinical Integrated Network of Patient Centered Medical Home (PCMH) practices. Care Managers will be assigned to these practices to identify frequent ED users and connect patients to primary and preventative care.

- Need for the project: The region suffers from a higher- than- average at risk rate for diseases when compared to the statewide average. Through this project the coordination of care for patients will improve quality of life and healthcare cost effectiveness with decreased ER visits, decreased hospital length of stay and decreased end -of -life hospital admissions.

- Target population: The target population is attributed PCMH patients in Harris, Montgomery and Fort Bend Counties. Memorial Hermann anticipates the number of patients managed by this program will be about 160,000 by April of 2013. We anticipate the number of managed Medicaid/uninsured populations under this program to increase significantly over the next 3 years.

- Category 1 or 2 expected patient benefits: MHMD Case Management will provide support to patient populations who are at most risk of receiving disconnected or fragmented care and will increase patient contact by 15% over baseline measured in DY2.

- Category 3 outcomes: IT 6.1 – Percent Improvement over baseline of patient satisfaction scores (patient's rating of whether patients are getting timely care, appointments and information).

Project Option- 2.9.2 "Other" project option: MHMD Care Management

<u>Unique RHP Project Identification Number</u>: 020834001.2.2
<u>Performing Provider Name/TPI</u>: Memorial Hermann Hospital System/TPI 020834001

<u>Project Description</u>:

Implementation of comprehensive care management infrastructure across the continuum of care for populations attributed to the MHMD Clinical Integrated Network of Patient Centered Medical Home (PCMH) practices, embedding care managers into those practices, tracking patient compliance with referral patterns and assigning Case Managers (CMs) to emergency department, inpatient discharges, and high risk patients. These activities will serve all the attributed PCMH patients in Harris, Montgomery, and Fort Bend counties.

<u>Goal(s) and relationship to Regional goal(s)</u>:

<u>Project Goal(s)</u>:

The goal of this project is to utilize community health workers, case managers, or other types of health care professionals as patient navigators to provide enhanced social support and culturally competent care to vulnerable and/or high-risk patients. Patient navigators will help and support these patients to navigate through the continuum of healthcare services. Patient Navigators will ensure that patients receive coordinated, timely, and site-appropriate health care services. Navigators may assist in connecting patients to primary care physicians and/or medical home sites, as well as diverting non-urgent care from the Emergency Department to site-appropriate locations. The goal in implementing this Patient Care Navigation program is to improve at-risk patients' experience of the healthcare delivery system by demystifying the often lengthy process of diagnosis and treatment, by assisting with scheduling appointments and keeping up with treatment regimens, and by providing professional support to patients and their families where and when needed.

<u>This project meets the following Region 3 goals</u>:

This project addresses the RHP's goal to "Transform health care delivery from a disease-focused model of episodic care to a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary or duplicative services, and builds on the accomplishments of our existing health care system."

<u>Challenges and how addressed</u>:

We have created a model that embeds care managers in the physicians' offices, to create direct responsibility for the population in each practice. Challenges will be centered around timely and accurate data, connectivity of information systems, communication, and creation of clinical data repositories to inform physicians and care managers. Memorial will address those challenges by putting in place processes which will promote timely and accurate data.

<u>5-year expected outcome for provider and patients</u>:

MHMD has a population of patients for which we have accountable responsibility, from Medicare to commercial populations. We anticipate the number of patients will total about 160,000 by January 1, 2013. We expect our care managers will interface heavily with the most chronically ill patients and focus on condition and continuum of care management.

<u>Starting Point/Baseline</u>: Memorial does not currently have a care management program.

<u>Rationale</u>:

Region 3 suffers from higher-than-average at-risk rates when compared to the statewide average. Coordination of care for patients, improves patient quality of life and healthcare cost effectiveness with decreased emergency room visits, decreased hospital length of stay, and decreased end-of-life hospital admissions. Patient navigators help patients and their families navigate the fragmented maze of doctors' offices, clinics, hospitals, out-patient centers, payment systems, support organizations and other components of the healthcare system.

Project components:

Required core project components:

a) Identify frequent ED users and use navigators as part of a preventable ED reduction program. Train health care navigators in cultural competency.

- Memorial care managers and information systems will identify frequent patients both at risk for future hospitalization as well as those that are currently high utilizers of ED services. Program elements will focus on proactive management of this population.

b) Deploy innovative health care personnel, such as case managers/workers, community health workers and other types of health professionals as patient navigators.

- Memorial will deploy care managers and other allied health personnel as necessary to help at risk patients enroll in chronic disease management programs and engage with their primary care physicians. These efforts will be guided by stratification of the population based on evidence based clinical protocols and outcomes data. This data will suggest the best methods to manage the disease incidence within the population.

c) Connect patients to primary and preventive care

- Chronic disease programs combined with primary care intervention will be a core component of this effort. Memorial programs will focus on the most costly and high incidence patients. These support programs will include education and clinical intervention.

d) Conduct quality improvement for project using methods such as rapid cycle improvement. Activities may include, but are not limited to, identifying project impacts,

identifying "lessons learned," opportunities to scale all or part of the project to a broader patient population, and identifying key challenges associated with expansion of the project, including special considerations for safety-net populations.

- Create a series of "Joint Operation Councils" that will be multidisciplinary in nature, bringing together physician leadership, care managers, clinical informaticists and other allied health professionals to review progress and opportunities in managing at risk patients. The lessons learned from these forums will serve to inform our activities as we take on additional populations in the Memorial patient centered medical home.

Unique community need identification number the project addresses:
- CN1 – Primary Care

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

This will considerably improve Memorial's capacity to deliver efficient behavioral healthcare.

Related Category 3 Outcome Measure(s): OD-6: Patient Satisfaction IT-6.1 Percent improvement over baseline of patient satisfaction scores: are patients getting timely care, appointments and information.

Reasons/rationale for selecting the outcome measure(s):
Patient satisfaction is a measure of this project's success, as patients receive better access to and better information for services, their satisfaction will improve.

Relationship to other Projects: This project is part of Memorial Hermann's larger plan to expand and develop primary care and specialty care services, while improving access to care and implementing delivery improvements targeted to specific populations (in this case, behavioral health patients).

Relationship to Other Performing Providers' Projects in the RHP: Primary Care/Ambulatory Care clinics are a top priority to Region 3 due to the acuity of the regional patient mix, population concentration, and lack of primary care access points for our patient base. The regional approach of collaboration as well as existing patient referral pattern relationships allowed our team to properly identify the community needs based on the necessity of population, uninsured, and medically underserved patient bases. This program is consistent with our region and similar to numerous initiatives in our RHP plan sharing both concepts as well as outcome measures focused to percent improvement over baseline of patient satisfaction scores, reduction of inappropriate ED utilization, and third next available appointment status. The Region 3 Initiative Grid attached as a RHP Plan addendum reflects a grid of relationship for all initiatives.

Plan for Learning Collaborative: We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have

similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system.

Project Valuation:

The valuation of each Memorial Hermann project takes into account the transformational impact of the project, the population served by the project (both number of people and complexity of patient needs), the alignment of the project with community needs, the magnitude of costs avoided or reduced by the project, the degree of collaboration involved in the project, and the sustainability of the project.

Rationale/justification for valuation: Establishing a patient navigation program will make more efficient use of the healthcare system and lower costs of care in the community — a vital goal of the Waiver.

020834001.2.2	*2.9.2*	*A-E*	***"OTHER" PROJECT OPTION: MHMD CARE MANAGEMENT***
Memorial Hermann Hospital System			*020834001*
Related Category 3 Outcome Measure(s):	*020834001.3.8*	*IT-6.1*	***Percent Improvement Over Baseline of Patient Satisfaction***

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-1]: Conduct a Needs Assessment to identify the patient population(s) to be targeted with the Patient Navigator Program Metric 1 [P-1.1]: Provide report identifying targeted patient population characteristics; how the program will identify, triage, and manage patient population; number of navigators needed to be hired Data Source: Program documentation, EHR, claims, needs assessment survey Goal: To target populations to improve the efficiency of the project. Milestone 1 estimated incentive payment: $1,365,696 **Milestone 2** [P-X1]: Establish baseline for number of target population reached by patient navigators. Metric 1 [P-X1.1]: Establish baseline for future years. Goal: To determine baseline for measure of project improvement in future years. Data Source: Submission of documentation demonstrating study of baseline numbers.	**Milestone 4** [P-2]: Establish/expand a health care navigation program to provide support to patient populations who are most at risk of receiving disconnected and fragmented care including program to train the navigators, develop procedures and establish continuing navigator education. Metric 1 [P-2.3]: Frequency of contact with care navigators for high risk patients. Baseline/Goal: Increase patient contact by 5% over baseline measured in DY 2. Data Source: Patient navigation program materials and database, EHR. Milestone 4 estimated incentive payment: $1,117,425 **Milestone 5** [P-8]: Participate in interactions with other providers and RHP to promote collaborative learning around shared or similar projects Metric 1 [P-8.1] Number meetings, conference calls or webinars organized by the RHP that the	**Milestone 8** [P-2]: Establish/expand a health care navigation program to provide support to patient populations who are most at risk of receiving disconnected and fragmented care including program to train the navigators, develop procedures and establish continuing navigator education. Metric 1 [P-2.3]: Frequency of contact with care navigators for high risk patients. Baseline/Goal: Increase patient contact by 10% over baseline measured in DY 2. Data Source: Patient navigation program materials and database, EHR. Milestone 8 estimated incentive payment: $1,120,674 **Milestone 9**[P-8]: Participate in interactions with other providers and RHP to promote collaborative learning around shared or similar projects Metric 1 [**P-8.1]:** Number meetings, conference calls or webinars organized	**Milestone 12** [P-2]: Establish/expand a health care navigation program to provide support to patient populations who are most at risk of receiving disconnected and fragmented care including program to train the navigators, develop procedures and establish continuing navigator education. Metric 1 [P-2.3]: Frequency of contact with care navigators for high risk patients. Data Source: Patient navigation program materials and database, EHR. Baseline/Goal: Increase patient contact by 15% over baseline measured in DY 2. Milestone 12 estimated incentive payment: $925,774 **Milestone 13** [P-8]: Participate in interactions with other providers and RHP to promote collaborative learning around shared or similar projects Metric 1[P-8.1]: Number meetings, conference calls or webinars organized by the RHP that the provider participated in. Data Source: Meeting Agendas, sign-in sheets, conference calls, presentations, email

020834001.2.2	2.9.2	A-E	"OTHER" PROJECT OPTION: MHMD CARE MANAGEMENT
Memorial Hermann Hospital System			020834001
Related Category 3 Outcome Measure(s):	020834001.3.8	IT-6.1	Percent Improvement Over Baseline of Patient Satisfaction
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 2 estimated incentive payment: $1,365,695 **Milestone 3**[P-8]: Participate in interactions with other providers and RHP to promote collaborative learning around shared or similar projects Metric 1 [P-8.1]: Number meetings, conference calls or webinars organized by the RHP that the provider participated in. Data Source: Meeting Agendas, sign-in sheets, conference calls, presentations, email Milestone 3 estimated incentive payment: $1,365,695	provider participated in. Data Source: Meeting Agendas, sign-in sheets, conference calls, presentations, email Milestone 5 estimated incentive payment: $1,117,425 **Milestone 6** [P-3]: Provide care management/navigation services to targeted patients. Metric 1 [P-3.1]: Increase in the number or percent of targeted patients enrolled in the program Baseline/Goal: Increase number of patients enrolled in program by 5%. Data Source: Enrollment reports Milestone 6 estimated incentive payment: $1,117,425 **Milestone 7** [I-6]: Increase number of PCP referrals for patients without a medical home who use the ED, urgent care and/or hospital services . Metric 1 [I-6.4]: Percentage of patients without a primary care	by the RHP that the provider participated in. Data Source: Meeting Agendas, sign-in sheets, conference calls, presentations, email Milestone 9 estimated incentive payment: $1,120,674 **Milestone 10** [P-3]: Provide care management/navigation services to targeted patients. Metric 1 [P-3.1]: Increase in the number or percent of targeted patients enrolled in the program Baseline/Goal: Increase number of patients enrolled in program by 10%. Data Source: Enrollment reports Milestone 10 estimated incentive payment: $1,120,673 **Milestone 11** [I-6]: Increase number of PCP referrals for patients without a medical home who use the ED, urgent care and/or hospital services . Metric 1 [I-6.4]: Percentage of patients	Milestone 13 estimated incentive payment: $925,774 **Milestone 14** [P-3]: Provide care management/navigation services to targeted patients. Metric 1 [P-3.1]: Increase in the number or percent of targeted patients enrolled in the program Baseline/Goal: Increase number of patients enrolled in program by 15%. Data Source: Enrollment reports Milestone 14 estimated incentive payment: $925,774 **Milestone 15** [I-6]: Increase number of PCP referrals for patients without a medical home who use the ED, urgent care and/or hospital services . Metric 1 [I-6.4]: Percentage of patients without a primary care provider who are given a scheduled primary care provider appointment Goal: 5% increase over baseline. Data Source: Performing Provider administrative data on patient encounters and scheduling records from Patient Navigator

020834001.2.2	*2.9.2*	*A-E*	***"OTHER" PROJECT OPTION: MHMD CARE MANAGEMENT***
Memorial Hermann Hospital System			*020834001*
Related Category 3 Outcome Measure(s):	*020834001.3.8*	*IT-6.1*	***Percent Improvement Over Baseline of Patient Satisfaction***
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	provider who are given a scheduled primary care provider appointment Goal: 5% increase over baseline. Data Source: Performing Provider administrative data on patient encounters and scheduling records from Patient Navigator program. Milestone 7 estimated incentive payment: $1,117,425	without a primary care provider who are given a scheduled primary care provider appointment Goal: 5% increase over baseline. Data Source: Performing Provider administrative data on patient encounters and scheduling records from Patient Navigator program. Milestone 11 estimated incentive payment: $1,120,673	program. Milestone 15 estimated incentive payment: $925,773
Year 2 Estimated Milestone Bundle Amount: $4,097,086	Year 3 Estimated Milestone Bundle Amount: $4,469,701	Year 4 Estimated Milestone Bundle Amount: $4,482,694	Year 5 Estimated Milestone Bundle Amount: $3,703,095
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $16,752,576			

Memorial Medical Center

Pass 2

Project Option 2.5.4- Implement other evidence-based project that will impact cost efficiency in an innovative manner: Medication Dispensing Safety & Efficiency
Unique RHP Project ID: 137909111.2.1
Performing Provider Name/TPI: Memorial Medical Center / 137909111
Project Summary:
Provider:
Memorial Medical Center is a county-owned, 25 bed Critical Access Hospital and serves as the only hospital for Calhoun County. Located on the Gulf Coast, Memorial Medical Center serves 60% of the 21,382 County residents. With a tax base of $13,972,000, Memorial Medical Center was able to provide more than $8 million in charity care (includes uncompensated) during FY 2012.

Volume Statistics – 11 months Year to date 2011 - 2012	Patient Payer Mix for Inpatient Services	Patient/Community Demographics
Hospital admissions- 1056 Births (babies delivered)- 98 Emergency visits- 9084 Outpatient visits- 13,430 Laboratory procedures- 224,562	Medicaid and CHIP- 18% Medicare- 53% Commercial Insurance- 19% Uninsured, Charity, Indigent Care- 10%	Hispanic- 47.1% African American- 3.3% Caucasian- 44.4% Asian- 4.5% American Indian- 0.7%

Intervention(s):
The automation of a medication dispensing system significantly increases pharmacist and nursing staff time to spend on patient care and education; reduce pick errors for wrong medications increasing patient safety; and facilitate cost containment/savings due to the addition time allowed for pending expired medication to be disposed compared to the regulations for disposal via a manual model, efficiency in labor and reduction in needed supplies.
Need for the project:
The purpose of this project is to provide cost containment, improved patient care and safety. Currently, our nursing staff spends 1.5 to 2 hours per patient ordering, receiving and administering medication. With a dispensing system in place, 95% of the medications administered in a care area would be stored for ready access. This method allows for "now orders" on medication which in return leads to better patient services by keeping the patient more comfortable. Pharmaceutical automation will provide 99.99% prescription dispensing accuracy for improved medication safety.
Target Population:
All patients within the system with may benefit from this project (Medicaid and CHIP-18% / Medicare- 53%), specifically those with chronic diseases.
Category 1 or 2 expected patient benefits:
Through the medication dispensing project, MMC plans to provide increased efficiency and safety in delivery of pharmaceutical services along with increased access to one-on-one nursing care. Net cost savings are approximately $712,000 through use of automation as compared to the current manual prescription processing.
Category 3 outcomes:
OD-5: The value of the project is based on cost avoidance, projecting savings associated with reducing the costs incurred in filling 120,000 current patient prescriptions on an annual basis all the while improving patient satisfaction and experience. In DY5, cost savings result from a 31% decrease from baseline in the average labor cost per prescription using the total salaries and benefits/total number of MMC automated prescriptions as found on the monthly operating statement compared to baseline. The cost savings are a result of automation efficiencies.

Project Option 2.5.4- "Other" project option: Implement other evidence-based project that will impact cost efficiency in an innovative manner: Medication Dispensing Safety and Efficiency

Unique RHP Project Identification Number: 137909111.2.1
Performing Provider Name/TPI: Memorial Medical Center / 137909111

Project Description:
Currently, Memorial Medical Center has no automated prescription counting technology. Annually, 120,000 prescriptions are counted manually, using only a counting tray and spatula. According to HealthMEDX, on average, 74% of a typical nurse's workday is spent outside of the patient room on non-value added activity. Currently, our nursing staff spends 1.5 to 2 hours per patient ordering, receiving and administering medication. With a dispensing system in place, 95% of the medications administered in a care area would be stored for ready access. This method allows for "now orders" on medication which in return leads to better patient services by keeping the patient more comfortable. To avoid errors during the administration of medications, we would implement bedside bar-code scanning utilizing Computers on Wheels (COWS). Further, by using a dispensing system with COWS, nursing staff will have more time to spend with the patients assisting with their recovery process resulting in decreased length of stay and cost savings.

The benefits of a Medication Dispensing System include improved patient services, safety, and cost efficiency. Focused on safety, high-risk drugs are stored in high-security pockets allowing less room for error and threat of diversion minimized. Since only one pocket opens up with one medication, nurses are restricted from the wrong medication during dispensing or take one that they aren't authorized to take. The ability to layout medications in the order allows staff to keep look-alike and sound-alike drugs far away from each other which substantially reduces the risk of "pick errors". This type of "checks and balances" further assures patients receive the correct medication in most efficient process possible. Pharmaceutical automation will provide 99.99% prescription dispensing accuracy for improved medication safety.

Project managers will consist of an interdisciplinary team of pharmacy, IT, and planning representatives.

Goals and Relationship to Regional Goals:
Project Goals:

- Implement an in-house automated medication dispensing system that can process up to 10,000 prescriptions per day with the capability of increasing volume at a negligible cost.
- Decreasing the average labor cost per prescription from baseline.
- Engineering pharmacy operations to develop a patient centered delivery model ensuring comprehensive medication management for optimal outcomes.
- Enhancing patient satisfaction by decreasing pharmacy wait times and increasing nursing and pharmacy access.
- To become a provider of choice for our patients and for the medically underserved individuals and families of Calhoun County.

This project meets the following regional goals:

- Develop a regional approach to health care delivery that leverages and improves on existing programs and infrastructure, is responsive to patient needs throughout the entire region, and improves health care outcomes and patient satisfaction. The MMC medication dispensing system will improve efficiency in the pharmacy and improve patient satisfaction with improved wait times and patient adherence.
- Transform health care delivery from a disease-focused model of episodic care to a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary or duplicative services, and builds on the accomplishments of our existing health care system. The MMC Medication Dispensing project will allow on site pharmacists to focus on clinical patient centered activities such as Medication Therapy Management. These programs promote patient adherence and wellness as well as decrease emergency room visits for refills.
- Develop a culture of ongoing transformation and innovation that maximizes the use of technology and best-practices, facilitates regional collaboration and sharing, and engages patients, providers, and other stakeholders in the planning, implementation, and evaluation processes. Automation technology represents best practices currently in use by the Veterans Administration, the United States Armed Services, as well as other public hospitals and retail pharmacy services.

Challenges:

- Funding – this is addressed by the DSRIP project.
- Software operating system - the pharmacy software operating system will be transitioned to operating system that supports medication dispensing and interfaces with CPSI (our current patient care system).
- Project development – Due to the large scale nature of the project, the medication dispensing DSRIP project will be supported by a multidisciplinary team including; an Information Technology (IT) project manager, Planning project manager and Pharmacy project manager.

5 -Year expected outcome for Provider and Patients: Through the medication dispensing project, Memorial Medical Center plans to provide increased efficiency and safety in delivery of pharmaceutical services along with increased access to one-on-one nursing care. Net cost savings are approximately $712,000 through use of automation as compared to the current manual prescription processing. This estimate is based on the current 120,000 prescription volume.

Starting Point/Baseline:
Currently, all prescriptions (approximately 120,000 annually) at Memorial Medical Center are manually filled on site by frontline pharmacy staff with no available automation. Patients and Nursing Staff either wait for their prescriptions or come back at a later date. Efficiency, safety and access would be greatly enhanced with the creation of a dispensing system.

Rationale:

Project option 2.5.4, "Other" project option: Implement other evidence-based project that will impact cost efficiency in an innovative manner, was chosen to justify the pharmacy prescription processing redesign for cost containment. The Memorial Medical Center Department of Pharmacy is committed to providing high quality pharmacy services in the most cost effective and efficient manner through implementation of an automated medication dispensing system. Memorial Medical Center serves approximately 28,000 unduplicated lives, and the Department of Pharmacy currently fills approximately 120,000 prescriptions per year at one pharmacy located in the hospital. Pharmaceutical services at MMC are currently 100% manual. It is expected that approximately 90% of the total Memorial Medical Center prescription volume could be efficiently processed by an automated dispensing systems. These medications would consist primarily of maintenance medications for chronic disease conditions. The automated system would afford time for the on-site clinical pharmacist to provide expanded clinical services as such as Medication Therapy Management (MTM), and nursing staff to extend patient care. These clinical value added benefits enhance the efficiency and significance of the redesign. Furthermore, the MMC Medication Dispensing Project will lend to cost containment as associated with expired medications. Under a non-automated model, pharmacists are required to pull expiring medications three months before their expiration date. Although still useful, these medications are destroyed long before necessary causing waste and financial loss. Under an automated system, medications are pulled days before their due date resulting in a cost savings.

Project Components:
No core components are required for this initiative.

Milestones & Metrics:
Process Milestones and Metrics: P-X2, P-X2.1
Improvement Milestones and Metrics: I-X8, I-X8.1

Unique Community need identification numbers the project addresses:
CN.11 High rates of chronic disease and inadequate access to treatment programs and services for illnesses associated with chronic disease, including cancer, diabetes, obesity, cardiovascular disease, asthma and AIDS/HIV. The automated prescriptions filled at MMC are primarily refills for chronic disease conditions. The efficiencies gained with this project will allow the pharmacist on site, to focus on urgent need prescriptions, e.g. antibiotics, pain, seizure medications. On site pharmacist will also have more time to focus on clinical functions such as Medication Therapy Management (MTM).

MMC's primary service area is almost exclusive to the Port Lavaca zip code. The secondary service area includes the remainder of Calhoun County and the southwestern portion of adjacent Matagorda County. To better understand the community's needs and determine the steps MMC needs to take to adequately serve the region's patients, in 2010 MMC contracted with BR Healthcare Services, Inc. (BRHS) to conduct an analysis of MMC's current market, the primary and secondary service area, demographics, and outmigration.[240] The study found that 73% of patients served by MMC lived in the Port Lavaca zip code area, while 18% of patients lived in Calhoun County and Palacios. During the time period of the study, the patient population included 33.6% who are covered by Medicare; 16.4% who are covered by Medicaid; 31.1% who

[240] BR Healthcare Services, Inc., Memorial Medical Center Market & Service Area Development Report, October, 2010.

are insured by a commercial plan; and 18.9% who are uninsured, charity and indigent care patients.

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
The automation of a medication dispensing system significantly increases pharmacist and nursing staff time to spend on patient care and education. With hundreds of prescriptions filled per day an automated system also reduces pick errors for wrong medications increasing patient safety. In addition, an automated system facilitates cost savings due to the addition time allowed for pending expired medication to be disposed compared to the regulations for disposal via a manual model.

We will improve efficiencies by increasing the percentage of prescriptions filled by the automated dispensing system. There is currently no automation at Memorial Medical Center, therefore the baseline percentage of prescriptions filled via an automated system is 0%. The first partial year consisting of 4 months automated medication dispensing, ending in DY3, is expected to meet a goal of filling 20% of the total monthly prescription volume at the facility. We anticipate a cost savings in labor of $32,850 over baseline from implementation in the Emergency Department alone.

Approximately 50% of the total prescription volume is for chronic disease medications. In DY4, the percent of prescriptions filled through an automated system will increase by 70% to a goal of 90% over baseline with the addition of inpatient departments. We anticipate a cost savings in labor and supplies equal to $496,800. In DY5, the percent of automated prescriptions filled will remain at 90% over baseline. However, the recapture costs through tracking medication dispensed in the Emergency Department and the retention of expiring medication until their due date will add a total cost savings through the lifetime of the Waiver to $712,000.

Related Category 3 Outcome Measure(s):
OD-5 Cost of Care
IT-5.1 Improved cost savings: Demonstrate cost savings in care delivery
The automated dispensing redesign for pharmacy services at Memorial Medical Center will result in cost savings through increased efficiencies in the delivery of pharmaceutical services and availability of nursing staff to provide value added tasks for the patients. Automation will help keep labor costs in check while our frontline staff can focus on clinical efforts for our patients. The pharmacist will be readily available for counseling patients on medication adherence.

We will utilize the Cost Benefit Analysis to demonstrate costs and outcomes in monetary units. We propose incremental cost savings as the project goes from zero automation at baseline in DY2 to 90% automation by the end of DY5. We expect to decrease the average labor cost per prescription by 7% by the end of the initial DY3 implementation year. In DY4, we expect a 19% decrease from baseline in the average labor cost per prescription. In DY5, we expect a 31% decrease from baseline in the average labor cost per prescription. We will use a report to be generated from the new software operating system to determine the percentage of prescriptions filled through the automated system. The monthly operating statements will be used to show

comparative cost savings in total salaries and benefits and the total number of prescriptions filled at MMC. Projected cost savings are based on current 120,000 annual prescription volume.

Relationship to other Projects:
The increase of primary care and specialty care will naturally result in additional ambulatory care encounters for our region patient base. The ambulatory initiatives cover items such as laboratory, PT/OT, social work, etc. and are a necessity of our patients to ensure a comprehensive treatment for access as well as cost avoidance. The Region 3 initiative grid in the addendum reflects all ambulatory operations initiatives.

Plan for Learning Collaborative: We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system.

Project Valuation:
This project is a supporting pillar for one of the main objectives of the 1115 Waiver; increasing access to primary care for the underserved population in Calhoun County. The value of the project is based on cost avoidance, projecting savings associated with reducing the costs incurred in filling 120,000 current patient prescriptions on an annual basis. Based on the increase in primary care volumes addressed in another Memorial Medical Center Waiver project, further growth in volume to prescriptions is projected. Despite this increase in prescription volume, processing costs are projected to decrease in total with the addition of the automated medication dispensing function. The prompt availability of needed prescriptions for our underserved patients, particularly those with chronic disease that can be managed effectively with appropriate pharmaceuticals, will result in fewer emergency room visits for public and private hospitals located in the service area, and will also help to prevent future downstream inpatient admissions.

We value this project based upon labor costs for Pharmacist and Nursing staff. Further, cost savings generated by the elimination of labeling medications and destroying medications before their expiration date. In addition, the value associated with one-on-one patient care, medication counseling and the elimination of potentially fatal pick errors adds another layer of value to the patients we serve.

<table>
<tr><td>137909111.2.1</td><td>2.5.4</td><td>2.5.4</td><td colspan="2">MEDICATION DISPENSING SAFETY AND EFFICIENCY</td></tr>
<tr><td colspan="4">Memorial Medical Center</td><td>137909111</td></tr>
<tr><td>Related Category 3 Outcome Measure(s):</td><td>137909111.3.1.5</td><td>[3.IT-5.1.1]</td><td colspan="2">Improved cost savings: Demonstrate cost savings in care delivery</td></tr>
<tr><th>Year 2
(10/1/2012 – 9/30/2013)</th><th colspan="2">Year 3
(10/1/2013 – 9/30/2014)</th><th>Year 4
(10/1/2014 – 9/30/2015)</th><th>Year 5
(10/1/2015 – 9/30/2016)</th></tr>
<tr>
<td>Milestone 1
[P-X1]: Establish a baseline for percentage of prescriptions processed via automated dispensing system

Metric 1 [P-X1.1]: Baseline is 0% since there is no current automation)
Goal: Provide documentation of 0% baseline (current state)

Data Source: software operating system reports TBD

Milestone 1 Estimated Incentive Payment (maximum amount): $20,000

Milestone 2 [P-X2]:
Complete a planning process and submit a plan
Metric 1 [P-X2.1]: Implementation of Medication Dispensing System beginning with ED and expanding to inpatient services

Goals:
• Complete RFP & award contract to vendor
• Begin pharmacy operating system transition
• Begin build out

Milestone 2 Estimated Incentive</td>
<td colspan="2">Milestone 4 [P-X2]: Complete a planning process and submit a plan

Metric 1 [P-X2.1]: Implementation of Central Fill
Goals:
• Complete pharmacy operating system transition
• Complete automated medication dispensing build out
• Go-live with automated dispensing
• Fill 20% of total prescription volume via automated system

Data Source: project coordinators

Milestone 4 Estimated Incentive Payment: $93,593

Milestone 5 [P-1.1]: Quality Improvement Milestone: Participate in at least bi-weekly interactions (meetings, conference calls, or webinars) with other providers and the RHP to promote collaborative learning around shared or similar projects.
<u>Metric 1</u> P-1.1 Number of bi-weekly meetings, conference calls, or</td>
<td>Milestone 6
[I-X1]: Improved cost savings

Metric 1 [I-X1.1]: Demonstrate cost savings in care delivery

Goal: Decrease time from the time prescription is ordered to the time administered to patient by 10 minutes utilizing an automated dispensing system versus manual dispensing.

Data source: Software operating system reports TBD

Improvement Milestone 6 Estimated Incentive Payment: $95,873

Milestone 7 [P-X1.1]: Quality Improvement Milestone: Participate in at least bi-weekly interactions (meetings, conference calls, or webinars) with other providers and the RHP to promote collaborative learning around shared or similar projects.

<u>Metric 1</u> P-1.1 Number of bi-weekly meetings, conference calls, or webinars organized by RHP that the provider participated in.</td>
<td>Milestone 8
[I-X1]: Improved cost savings

Metric 1 [I-X1.1]: Demonstrate cost savings in care delivery

Goal: Decrease time from the time prescription is ordered to the time administered to patient by 30 minutes utilizing and automated dispensing system versus manual dispensing.

Data source: Software operating system reports TBD

Improvement Milestone 8 Estimated Incentive Payment: $80,389

Milestone 9 [P-1.1]: Quality Improvement Milestone: Participate in at least bi-weekly interactions (meetings, conference calls, or webinars) with other providers and the RHP to promote collaborative learning around shared or similar projects.

<u>Metric 1</u> P-1.1 Number of bi-weekly meetings, conference calls, or webinars organized by RHP that the provider participated in.</td>
</tr>
</table>

137909111.2.1	*2.5.4*	*2.5.4*	*MEDICATION DISPENSING SAFETY AND EFFICIENCY*
Memorial Medical Center			*137909111*
Related Category 3 Outcome Measure(s):	*137909111.3.1.5*	*[3.IT-5.1.1]*	*Improved cost savings: Demonstrate cost savings in care delivery*
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Payment *(maximum amount):* $47,445 **Milestone 3** [*P-X1.1]*: Quality Improvement Milestone: Participate in at least bi-weekly interactions (meetings, conference calls, or webinars) with other providers and the RHP to promote collaborative learning around shared or similar projects. Metric 1 P-1.1 Number of bi-weekly meetings, conference calls, or webinars organized by RHP that the provider participated in. Data Source: Documentation of weekly or bi-weekly phone meetings, conference calls, or webinars including agendas for phone calls, slides from webinars, and/or meeting notes. Metric 2 P-1.2: Share challenges and solutions successfully during this bi-weekly interaction. Milestone 3 Estimated Incentive Payment *(maximum amount):* $10,000	webinars organized by RHP that the provider participated in. Data Source: Documentation of weekly or bi-weekly phone meetings, conference calls, or webinars including agendas for phone calls, slides from webinars, and/or meeting notes. Metric 2 P-1.2: Share challenges and solutions successfully during this bi-weekly interaction. Milestone 5 Estimated Incentive Payment: $10,000	Data Source: Documentation of weekly or bi-weekly phone meetings, conference calls, or webinars including agendas for phone calls, slides from webinars, and/or meeting notes. Metric 2 P-1.2: Share challenges and solutions successfully during this bi-weekly interaction. Milestone 7 Estimated Incentive Payment *(maximum amount):* $10,000	Data Source: Documentation of weekly or bi-weekly phone meetings, conference calls, or webinars including agendas for phone calls, slides from webinars, and/or meeting notes. Metric 2 P-1.2: Share challenges and solutions successfully during this bi-weekly interaction. Milestone 9 Estimated Incentive Payment *(maximum amount):* $10,000

137909111.2.1	***2.5.4***	***2.5.4***	***MEDICATION DISPENSING SAFETY AND EFFICIENCY***
Memorial Medical Center			*137909111*
Related Category 3 Outcome Measure(s):	*137909111.3.1.5*	*[3.IT-5.1.1]*	*Improved cost savings: Demonstrate cost savings in care delivery*
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Year 2 Estimated Milestone Bundle Amount: $87,445	Year 3 Estimated Milestone Bundle Amount: $103,593	Year 4 Estimated Milestone Bundle Amount: $105,873	Year 5 Estimated Milestone Bundle Amount: $90,389
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:**$ 387,300			

Memorial Medical Center

Pass 3

Project Option 2.4.1- Improving the Patient Experience – The AIDET or similar project
Unique RHP Project ID: 137909111.2.2/Pass 3
Performing Provider Name/TPI: Memorial Medical Center / 137909111
Project Summary:
Provider:
Memorial Medical Center is a county-owned, 25 bed Critical Access Hospital and serves as the only hospital for Calhoun County. Located on the Gulf Coast, Memorial Medical Center serves 60% of the 21,382 County residents. With a tax base of $13,972,000, Memorial Medical Center was able to provide more than $8 million in charity care (includes uncompensated) during FY 2012.

Volume Statistics – 11 months Year to date 2011 - 2012	Patient Payer Mix	Patient/Community Demographics
Hospital admissions- 1056 Births (babies delivered)- 98 Emergency visits- 9084 Outpatient visits- 13,430 Laboratory procedures- 224,562	Medicaid and CHIP- 16.4% Medicare- 33.6% Commercial Insurance- 31.1% Uninsured, Charity, Indigent Care- 18.9%	Hispanic- 47.1% African American- 3.3% Caucasian- 44.4% Asian- 4.5% American Indian- 0.7%

Intervention(s):
Delay in seeking health care due to unsatisfactory patient experiences with customer service.

Need for the project:
The purpose of this project is to reduce patient anxiety and increase patient satisfaction. Process and measures will be implemented to measure and improve patient experiences resulting improved communication. With improved satisfaction, there is potential to increase the level of care integration and coordination of the patient/doctor relationship and lead to better health and better patient experience of care..

Target Population:
All patients within the system with may benefit from this project (Medicaid and CHIP-16.4% / Medicare- 33.6%), specifically those with chronic diseases.

Category 1 or 2 expected patient benefits:
Over the course of this project, 100% full time and part time employees will participate in a patient experience training to improve patient satisfaction. By the end of DY 5, patient data experience will be available internally and externally for general public access and accountability. By doing so, we will improve the health of our clients by providing more timely access to care and coordinating treatment and follow-up care that isn't available when patients seek treatment through the Emergency Department.

Category 3 outcomes:
OD-6: Because the community we serve has an insufficient number of providers and patients are often unable to obtain appointments in a timely manner, the priority goal for this project is ensuring patients receive care when they need it and without significant delays, which will result in improved health outcomes and patient satisfaction. In DY5, patient experience at the Hospital Based Clinic shall have improved in deficient areas of timely care, appointments and information by 10% by the end of the waiver.

Project Option 2.4.1 – Develop and implement a structured patient experience training program: Improving the Patient Experience – The AIDET or similar Project.

Unique RHP Project Identification Number: 137909111.2.2 /Pass 3
Performing Provider Name/TPI: Memorial Medical Center / 137909111

Project Description:
Memorial Medical Center will develop and implement a structured patient experience training program: Improving the Patient Experience – The AIDET Project.
Memorial Medical Center is a 25-bed rural critical access hospital located in Calhoun County. The population of Calhoun County is 21,381 per the 2010 Census. The community of Port Lavaca has a population of 11,500 per the 2010 Census. Memorial Medical Center is the only hospital within Calhoun County. We provide basic services including Emergency Room, Diagnostic Imaging, Laboratory, Rehabilitation, Swing Bed, Surgery, ICU and Obstetric services.
Memorial Medical Center plans to roll out The AIDET Project or similar training program to all new and existing full-time and part-time employees. The AIDET program was developed by the Studer Group. It is a powerful communication tool. AIDET is an acronym for Acknowledge, Introduce, Duration, Explanation and Thank You. When interacting with patients, gaining trust is essential for obtaining patient compliance and improving clinical outcomes. The project goal is to reduce patient anxiety and increase patient satisfaction which will result in positive outcomes for the patient.
We expect to incur scheduling difficulties amongst the targeted population; however, in addition to the live training program that will be conducted, we will also implement a self-study web-based program, so we can accommodate various schedules. By the end of the waiver, our expected outcome is to have 100% of our full-time and part-time employees trained on the patient experience training program, and for the employees and public to be educated on our efforts of improving patient satisfaction for our patients and their families. This project helps achieve the overall goals of the region by promoting positive healthcare experiences throughout the region which will ultimately improve the health of patients and decrease healthcare costs.

Starting Point/Baseline:
The starting point/baseline for this project will be the number of new full-time and part-time employees and the number of existing full-time and part-time employees. As of October 1, 2012, we are expecting to train 141 full-time employees and 60 part-time employees. The number of new full-time and part-time employees is unknown at this time. The time period for this baseline is one year from October 1, 2012 – September 30, 2013; however, we will continue to provide patient experience training even after this date in order to continue our quality improvement process.

Rationale:
Our rationale for selecting project option 2.4.1 Implement processes to measure and improve patient experience was a result of the need for improved communication between patients and healthcare providers. We believe if we can increase patient satisfaction, it has the potential to increase the level of care integration and coordination of the patient/doctor relationship and lead to better health and better patient experience of care.

Project Components:

All core components will be addressed in this project:

a) Organizational integration and prioritization of patient experience;

b) Data and performance measurement will be collected by utilizing patient experience of care measures from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) in addition to CAHPS and/or other systems and methodologies to measure patient experience;
c) Implementing processes to improve patient's experience in getting through to the clinical practice; and
d) Develop a process to certify independent survey vendors that will be capable of administering the patient experience of care survey in accordance with the standardized sampling and survey administration procedures,

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

We believe the need for this project could fall under several of the needs reported in the RHP #3 Community Needs Assessment list, but it best is categorized under CN.23 Lack of patient navigation, patient and family education and information programs. If a patient has a good experience, we believe they will continue to actively engage themselves in their future health related care which will ultimately lead to positive outcomes and lower overall healthcare costs. We are not aware of any related activities to this project that are funded by the US. Department of Health and Human Services currently ongoing or coming up in the future.

Related Category 3 Outcome Measure(s):

OD-6 Percent improvement over baseline of patient satisfaction scores.

Reasons/rationale for selecting the outcome measures:

We believe if we can decrease patient anxiety and improve patient satisfaction in the rural setting when the patient is referred to the urban setting for extended/expanded healthcare that they will be more receptive and compliant to their healthcare needs which will ultimately lead to positive outcomes, improved patient satisfaction and ultimately lower healthcare costs. When patients perceive healthcare as a positive process, they will practice healthy lifestyles which results in lower healthcare costs.

We will focus on the stand-alone measure that will monitor an increase in patient satisfaction scores for the measure - patient is getting timely care, appointments, and information. We believe this measure is very important to the overall patient experience. These outcomes are important to our hospital because we believe if patients felt comfortable with the timeliness of their care, they would be less anxious about healthcare processes and more open to working with the healthcare providers. We believe by improving the patient experience through our Category 2 project – developing and implementing a structured patient experience training program, the patient will feel optimistic about their healthcare experience and take care of themselves. Again, we believe by focusing on patient satisfaction for every patient, it will improve the health of low-income population as well as the total population.

Relationship to other Projects: 137909111 1.1 Hospital Based Clinic improving access to Primary and Specialty Care.

Relationship to Other Performing Providers' Projects in the RHP: Innovation is key to the transformation of healthcare in our community. The consistency of innovation in our region allows for increased improvements based on research trends, patient need, and provider availability. The waiver funding allows for innovation in specific areas and all innovative projects included in the plan are similar in the fact of program redesigns for historic treatments, and focus to chronic condition outcome measures such as central line infections. The Region 3 initiative grid in the addendum can provide a side by side comparison of all projects that directly relate to innovation.

Plan for Learning Collaborative: We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our region's healthcare system.

Project Valuation: We valued the project based on cost and benefits to our organization. We believe if we can reduce patient anxiety through education, the patient will have positive experiences and positive outcomes which will make them to want to take care of themselves by leading healthier lives, obtaining preventative healthcare and seeking medical help at appropriate times.

137909111.2.2	*2.4.1*	*A-D*	*IMPROVING THE PATIENT EXPERIENCE - THE AIDET PROJECT*
Memorial Medical Center			*137909111*
Related Category 3 Outcome Measure(s):	*137909111.3.3*	*[3.IT-6.1.1]*	*Patient Satisfaction*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-1]: Hire an executive accountable for experience performance and education. Metric 1 [P-1.1]: Documentation of an executive assigned responsibility experience performance and education. Data Source: Job description Milestone 1 Estimated Incentive Payment (*maximum amount)*: $35347 **Milestone 2** [P-15]: Develop a training program on patient experience. Metric 1 [P-15.1]: Submission of training program materials. Milestone 2 Estimated Incentive Payment: $35347 **Milestone 3** [P-4]: Integrate patient experience training into new employee orientation training. Metric 1 [P-4.1]: Percent of new full-time and part-time employees who received patient experience training as part of their new employee orientation. Baseline/Goal: Baseline = number of new full-time and part-time employees & Goal = 75% of new full-	**Milestone 5** [P-4]: Integrate patient experience training into new full-time and part-time employee orientation training. Metric 1 [P-4.1]: Percent of new full-time and part-time employees who received patient experience training as part of their new employee orientation. Baseline/Goal: Baseline = number of new full-time and part-time employees & Goal = 90% of new full-time and part-time employees receive patient experience training. Data Source: Human Resource Records Milestone 5 Estimated Incentive Payment (*maximum amount)*: $56475 **Milestone 6** [P-4} Integrate patient experience training into existing full-time and part-time employee training. Metric 1 [P-4.1]: Percent of existing full-time and part-time employees who received patient experience training. Baseline/Goal: Baseline = number of existing full-time and part-time employees & Goal = 90% of existing full-time and part-time employees receive patient experience training.	**Milestone 8** [P-6]: Include specific patient and/or employee experience objectives into employee job descriptions and work plans. Hold employees accountable for meeting them. Metric 1 [P-6.1]: Percent of employees who have specific patient and/or employee experience objectives in their job description and/or work plan. Baseline/Goal: Baseline = number of employees & Goal = 100% employees to have specific patient and/or employee experience objectives in their job description and/or work plan. Data Source: Job descriptions Milestone 8 Estimated Incentive Payment: $87430 **Milestone 9** [I-18]: Develop regular organizational display(s) of patient experience data (e.g., via a dashboard on the internal web) and provide updates to the employees on the efforts the organization is undertaking to improve the experience of it patients and their families. Metric 1 [I-18.1]: Number of organization-wide displays (can be	**Milestone 10** [I-19]: Make patient experience data available externally (e.g., via a dashboard on the external website) and provide updates to the general public on the efforts the organization is undertaking to improve the experience of it patients and their families. Metric 1 [I-19.1]: Number of external communications aimed at the general public's understanding of the organization's results and improvement efforts in the area of patient experience. Goal: TBD Data Source: External Communication Milestone 10 Estimated Incentive Payment: $149143

137909111.2.2	***2.4.1***	***A-D***	***IMPROVING THE PATIENT EXPERIENCE - THE AIDET PROJECT***
Memorial Medical Center			*137909111*
Related Category 3 Outcome Measure(s):	*137909111.3.3*	*[3.IT-6.1.1]*	*Patient Satisfaction*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
time and part-time employees receive patient experience training. Data Source: Human Resource Records Milestone 3 Estimated Incentive Payment (*maximum amount*): $35347 **Milestone 4** [P-4} Integrate patient experience training into existing full-time and part-time employee training. Metric 1 [P-4.1]: Percent of existing full-time and part-time employees who received patient experience training. Baseline/Goal: Baseline = number of existing full-time and part-time employees & Goal = 50% of existing of full-time and part-time employees receive patient experience training. Data Source: Human Resource Records Milestone 4 Estimated Incentive Payment: $35347	Data Source: Human Resource Records Milestone6 Estimated Incentive Payment: $56475 **Milestone 7** [P-6]: Include specific patient and/or employee experience objectives into employee job descriptions and work plans. Hold employees accountable for meeting them. Metric 1 [P-6.1]: Percent of employees who have specific patient and/or employee experience objectives in their job description and/or work plan. Baseline/Goal: Baseline = number of employees & Goal = 100% of employees to have specific patient and/or employee experience objectives in their job description and/or work plan. Data Source: Job descriptions Milestone 7 Estimated Incentive Payment: $56476	physical or virtual) about the organization's performance in the area of patient/family experience per year; and at least one example of internal CEO communication on the experience improvement work. Goal: TBD Data Source: Display and Internal Communication Milestone 9 Estimated Incentive Payment: $87430	
Year 2 Estimated Milestone Bundle Amount: $141,388	Year 3 Estimated Milestone Bundle Amount: $169,426	Year 4 Estimated Milestone Bundle Amount: $174,860	Year 5 Estimated Milestone Bundle Amount: $149,143
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:**$634,817			

Project Option 2.4.1- Improving the Patient Experience – Hospitalist Model
Unique RHP Project ID: 137909111.2.3/Pass 3
Performing Provider Name/TPI: Memorial Medical Center / 137909111
Project Summary:
Provider:
Memorial Medical Center is a county-owned, 25 bed Critical Access Hospital and serves as the only hospital for Calhoun County. Located on the Gulf Coast, Memorial Medical Center serves 60% of the 21,382 County residents. With a tax base of $13,972,000, Memorial Medical Center was able to provide more than $8 million in charity care (includes uncompensated) during FY 2012.

Volume Statistics – 11 months Year to date 2011 - 2012	Patient Payer Mix	Patient/Community Demographics
Hospital admissions- 1056 Births (babies delivered)- 98 Emergency visits- 9084 Outpatient visits- 13,430 Laboratory procedures- 224,562	Medicaid and CHIP- 16.4% Medicare- 33.6% Commercial Insurance- 31.1% Uninsured, Charity, Indigent Care- 18.9%	Hispanic- 47.1% African American- 3.3% Caucasian- 44.4% Asian- 4.5% American Indian- 0.7%

Intervention(s):
Due to the healthcare provider shortage, patients needing admission through the Emergency Department often experience delay in care.

Need for the project:
The purpose of this project is to eliminate the delay in care from the ER to inpatient services. MMC will research, design and implement if found to be effective a hospitalist model to increase productivity and access to care for patients involving both physicians and mid-level providers. Currently, patients are admitted to their primary care physician or the primary care physician on call for the ER. MMC works under contract with a team of rotating ER physicians resulting in issues with admitting patients and maintaining a care plan.

Target Population:
All patients within the system with may benefit from this project (Medicaid and CHIP-16.4% / Medicare- 33.6%), specifically those with chronic diseases.

Category 1 or 2 expected patient benefits:
Over the course of this project, the potential to yield improvements in the level of care integration and coordination for patients can ultimately lead to better health and better patient experience of care. Hospitalist will ensure patients' needs are met within a timely manner reducing complications, lengths of stay, and the costs providing care.

Category 3 outcomes:
OD-6: Because the community we serve has an insufficient number of providers and patients are often unable to obtain appointments in a timely manner, the priority goal for this project is ensuring patients receive care when they need it and without significant delays, which will result in improved health outcomes and patient satisfaction. Through a Hospitalist Model we anticipate a 10% decrease in admission times by the end of the waiver.

Project Option 2.4.1 – Redesign to Improved Patient Experience

Unique RHP Project Identification Number: 137909111.2.3/Pass 3
Performing Provider Name/TPI: Memorial Medical Center / 137909111

Project Description:
Hospitalist Model – Implementing processes to improve patient's experience

Memorial Medical Center is a 25-bed rural critical access hospital located in Calhoun County. The population of Calhoun County is 21,381 per the 2010 Census. The community of Port Lavaca has a population of 11,500 per the 2010 Census. Memorial Medical Center is the only hospital within Calhoun County. We provide basic services including Emergency Room, Diagnostic Imaging, Laboratory, Rehabilitation, Swing Bed, Surgery, ICU and Obstetric services.

Under this project, Memorial Medical Center will research, design, and implement (if found to be effective) a hospitalist model to increase productivity and access to care for patients, involving both physicians and mid-level providers. Under the current care model at our hospital, patient care is managed by individual primary care physicians who work in tandem with the hospital staff for their specific patients. Currently, there is a shortage of primary care physicians in Calhoun County and statewide that is causing lack of access to care. This lack of access is causing increased length of stay and decreased patient satisfaction. We would like to evaluate the possibility of implementing a hospitalist model, under which the hospital would have a staff of physicians and mid-level providers to treat hospital patients, in lieu of having primary care physicians make calls and visits on a fractured basis. Our research will determine if an all-physician hospitalist model would be appropriate or some type of mixed-model with mid-level providers is more effective. We expect to determine if and how much a hospitalist model will improve the patient experience by creating a more stable continuity of care during a hospital stay and providing easier access to doctors and nurses. Assuming the program is feasible and desirable, we expect that the move to a hospitalist model will improve patient satisfaction by reducing the wait time for treatment decisions, and will improve the documentation of patients' diagnoses, treatment, and outcomes. The model should also improve the quality of life for physicians as they would no longer have to be on call or round in the middle of the night. Challenges include: high cost of providing the nurses and physicians; determining whether the hospitalist model will make a positive impact for patients; convincing primary care physicians that this model is better for their patients; accurately measuring the change in patient satisfaction.

Starting Point/Baseline:
Currently, patients are admitted to their primary care physician or the primary care physician on-call for the emergency department. Memorial Medical Center currently works under contract with an Emergency Department team of doctors on rotation. With a rotation scenario, a patient admitted under one doctor may not have the same physician the next day delaying care. Further, due to the shortage of primary care physicians, our physicians are over-burdened with their practice and often do not see patients in a timely manner. This causes delays in treatments which can lead to poor outcomes and increased lengths of stay. Occasionally, patients have been transferred to other towns because no primary care physician was available to admit them which resulted in delay of care.

Rationale:
Implemented hospitalist projects have the potential to yield improvements in the level of care integration and coordination for patients and ultimately lead to better health and better patient experience of care. Currently, there is a shortage of primary care physicians in Calhoun County and statewide that is causing lack of access to care. This lack of access is causing increased lengths of stay and decreased patient satisfaction. We expect that the move to a hospitalist model will improve patient satisfaction by reducing the wait time for treatment decisions, and will improve the documentation of patients' diagnoses, treatment, and outcomes. Hospitalists will manage the acute care of patients and expedite the care of patients within the hospital setting. Hospitalists will ensure patients' needs are met within a timely manner. Because hospitalists are on duty 24 hours a day, they are fully available to patients from admission to discharge. This reduces complications, lengths of stay, and the costs of providing care. This model will relieve some primary care physicians from rounding in the hospital, thus enabling greater patient access to care as physicians will be able to spend more time in their practice.

Project Components:
All core components will be addressed in this project:

a) Organizational integration and prioritization of patient experience;

b) Data and performance measurement will be collected by utilizing patient experience of care measures from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) in addition to CAHPS and/or other systems and methodologies to measure patient experience;
c) Implementing processes to improve patient's experience in getting through to the clinical practice; and
d) Develop a process to certify independent survey vendors that will be capable of administering the patient experience of care survey in accordance with the standardized sampling and survey administration procedures,

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
We believe the need for this project could fall under several of the needs reported in the RHP #3 Community Needs Assessment list, but it best is categorized under CN.1 Inadequate access to primary care; CN2 Inadequate access to specialty care; CN6 Inadequate access to treatment and services designed for special needs populations, including disabled, homeless, children, elderly; and CN7 Insufficient access to care coordination practice management and integrated care treatment programs.

If a patient has a good experience, we believe they will continue to actively engage themselves in their future health related care which will ultimately lead to positive outcomes and lower overall healthcare costs. We are not aware of any related activities to this project that are funded by the US. Department of Health and Human Services currently ongoing or coming up in the future.

Related Category 3 Outcome Measure(s):
OD-6 Percent improvement over baseline of patient satisfaction scores.

Reasons/rationale for selecting the outcome measures:
We believe if we can decrease patient anxiety and improve patient satisfaction in the rural setting when the patient is referred to the urban setting for extended/expanded healthcare that they will be more receptive and compliant to their healthcare needs which will ultimately lead to positive outcomes, improved patient satisfaction and ultimately lower healthcare costs. When patients perceive healthcare as a positive process, they will practice healthy lifestyles which results in lower healthcare costs.

We will focus on the stand-alone measure that will monitor an increase in patient satisfaction scores for the measure - patient is getting timely care, appointments, and information. We believe this measure is very important to the overall patient experience. These outcomes are important to our hospital because we believe if patients felt comfortable with the timeliness of their care, they would be less anxious about healthcare processes and more open to working with the healthcare providers. We believe by improving the patient experience through our Category 2 project – Hospitalist Model, the patient will feel optimistic about their healthcare experience and take care of themselves. Again, we believe by focusing on patient satisfaction for every patient, it will improve the health of low-income population as well as the total population.

Relationship to other Projects: 137909111 1.1 Hospital Based Clinic improving access to Primary and Specialty Care.

Relationship to Other Performing Providers' Projects in the RHP: Innovation is key to the transformation of healthcare in our community. The consistency of innovation in our region allows for increased improvements based on research trends, patient need, and provider availability. The waiver funding allows for innovation in specific areas and all innovative projects included in the plan are similar in the fact of program redesigns for historic treatments, and focus to chronic condition outcome measures such as central line infections. The Region 3 initiative grid in the addendum can provide a side by side comparison of all projects that directly relate to innovation.

Plan for Learning Collaborative: We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our region's healthcare system.

Project Valuation: We valued the project based on cost and benefits to our organization. We believe if we can reduce patient anxiety through access to the right care at the right place and in the right setting, the patient will have positive experiences and positive outcomes which will make them to want to take care of themselves by leading healthier lives, obtaining preventative healthcare and seeking medical help at appropriate times.

The valuation of each Memorial Medical Center project takes into account the transformational impact of the project, the population served by the project (both number of people and complexity of patient needs), the alignment of the project with community needs, and the magnitude of costs avoided or reduced by the project. In particular, this project has been valued

based on the logistical work required to change patterns of care in the inpatient setting, as well as the potential for quality improvement and patient experience improvement resulting from a successfully implemented hospitalist program.

137909111.2.3	***2.4.1***	***A-D***	***EVALUATE HOSPITALIST MODEL***
Memorial Medical Center			*137909111*
Related Category 3 Outcome Measure(s):	*137909111.3.4*	*[3.IT-6.1.1]*	*Patient Satisfaction*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1: Establish baseline for metrics P-11.1 (better experience from ED to inpatient) and I-16.1 Metric 1: Establish baseline for future years. Milestone 1 Estimated Incentive Payment: $287212 **Milestone 2** [*P-1.1]*: Quality Improvement Milestone: Participate in at least bi-weekly interactions (meetings, conference calls, or webinars) with other providers and the RHP to promote collaborative learning around shared or similar projects. Metric 1 P-1.1 Number of bi-weekly meetings, conference calls, or webinars organized by RHP that the provider participated in. Data Source: Documentation of weekly or bi-weekly phone meetings, conference calls, or webinars including agendas for phone calls, slides from webinars, and/or meeting notes. Metric 2 P-1.2: Share challenges and solutions successfully during this bi-weekly interaction. Milestone 2 Estimated Incentive	**Milestone 3** [P-11]: Orchestrate improvement work on identified experience targets. Workgroups should be formed under the steering committee to work on experience targets. Detailed implementation plans should be created for each workgroup. Metric 1 [P-11.1]: Submission of implementation plan. Baseline/Goal: n/a Data Source: Implementation plans. Milestone 3 Estimated Incentive Payment: $346153 **Milestone 4** [*P-1.1]*: Quality Improvement Milestone: Participate in at least bi-weekly interactions (meetings, conference calls, or webinars) with other providers and the RHP to promote collaborative learning around shared or similar projects. Metric 1 P-1.1 Number of bi-weekly meetings, conference calls, or webinars organized by RHP that the provider participated in. Data Source: Documentation of weekly or bi-weekly phone meetings, conference calls, or webinars including agendas for	**Milestone 5** [I-16]: Improve patient satisfaction/experience scores. Metric 1 [I-16.1]: Percent improvement of patient satisfaction scores for a specific tool over baseline. Baseline/Goal: 5% increase over DY 2 baseline. Data Source: Patient satisfaction/experience surveys such as Clinician and Group Consumer Assessment of Health Care Providers and Systems (CG-CAHPS) and/or Hospital Quality Initiative Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) scores. Metric 2 [I-16.2]: Percent improvement of patient satisfaction scores for a subset of measures that the provider targets for improvement in a specific tool. Baseline/Goal: 5% increase over DY 2 baseline. Data Source: Patient satisfaction/experience survey and/or HCAHPS or CG-CAHPS scores. Milestone 5 Estimated Incentive Payment: $357573	**Milestone 7** [I-16]: Improve patient satisfaction/experience scores. Metric 1 [I-16.1]: Percent improvement of patient satisfaction scores for a specific tool over baseline. Baseline/Goal: 5% increase over DY 4. Data Source: Patient satisfaction/experience surveys such as Clinician and Group Consumer Assessment of Health Care Providers and Systems (CG-CAHPS) and/or Hospital Quality Initiative Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) scores. Metric 2 [I-16.2]: Percent improvement of patient satisfaction scores for a subset of measures that the provider targets for improvement in a specific tool. Baseline/Goal: 5% increase over DY 4. Data Source: Patient satisfaction/experience survey and/or HCAHPS or CG-CAHPS scores. Milestone 7 Estimated Incentive Payment: $303514

Payment *(maximum amount):* $10,000	phone calls, slides from webinars, and/or meeting notes. Metric 2 P-1.2: Share challenges and solutions successfully during this bi-weekly interaction. Milestone 4 Estimated Incentive Payment *(maximum amount):* $10,000	**Milestone 6** [*P-1.1*]: Quality Improvement Milestone: Participate in at least bi-weekly interactions (meetings, conference calls, or webinars) with other providers and the RHP to promote collaborative learning around shared or similar projects. Metric 1 P-1.1 Number of bi-weekly meetings, conference calls, or webinars organized by RHP that the provider participated in. Data Source: Documentation of weekly or bi-weekly phone meetings, conference calls, or webinars including agendas for phone calls, slides from webinars, and/or meeting notes. Metric 2 P-1.2: Share challenges and solutions successfully during this bi-weekly interaction. Milestone 6 Estimated Incentive Payment *(maximum amount):* $10,000	**Milestone 8** [*P-1.1*]: Quality Improvement Milestone: Participate in at least bi-weekly interactions (meetings, conference calls, or webinars) with other providers and the RHP to promote collaborative learning around shared or similar projects. Metric 1 P-1.1 Number of bi-weekly meetings, conference calls, or webinars organized by RHP that the provider participated in. Data Source: Documentation of weekly or bi-weekly phone meetings, conference calls, or webinars including agendas for phone calls, slides from webinars, and/or meeting notes. Metric 2 P-1.2: Share challenges and solutions successfully during this bi-weekly interaction. Milestone 8 Estimated Incentive Payment *(maximum amount):* $10,000
Year 2 Estimated Milestone Bundle Amount: $297,212	Year 3 Estimated Milestone Bundle Amount: $356,153	Year 4 Estimated Milestone Bundle Amount: $367,573	Year 5 Estimated Milestone Bundle Amount: $313,514
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:**$1,334,452			

Mental Health and Mental Retardation Authority of Harris County

Pass 1

Project Option 2.4.1- 2.15 INTEGRATE PRIMARY AND BEHAVIORAL HEALTH CARE SERVICES: COLLABORATIVE PRIMARY MEDICAL AND BEHAVIORAL HEALTH CARE

Unique RHP Project ID: 113180703.2.1/Pass 3

Performing Provider Name/TPI: MHMRA of Harris County / 113180703

Project Summary:

Provider**:** The Mental Health and Mental Retardation Authority (MHMRA) of Harris County is a public agency serving as the safety net provider for adults with serious mental illnesses, for children and adolescents with serious emotional disorders, for the developmentally delayed and for individuals experiencing acute psychiatric distress. MHMRA provides inpatient, residential and outpatient treatments, including psycho-therapy, case management and medication management for individuals. MHMRA serves more than 49,000 Harris County residents out of a culturally and ethnically diverse population of over 4.1 million. Of those individuals who received any agency service in FY12, 36.5% were medically indigent and 51.9% had Medicaid. Of those who received mental health services in FY12, such as those being proposed in this project, 55% were medically indigent and 34.9% had Medicaid.

Intervention(s): MHMRA will design, implement, and evaluate a care management program that integrates primary and behavioral health care services.

Need for the project: There is a significant connection between mental health conditions and physical health. In 2011, about 68% of MHMRA patients reported having a medical condition, including hypertension, cardiovascular disease and diabetes. Psychiatric medications exacerbate the problem because they are associated with weight gain leading to 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 for their chronic medical conditions.

Target population: MHMRA patients who are not already seen by a primary care physician. It is anticipated the program will provide service for about 1000 patients.

Category 1 or 2 expected patient benefits: MHMRA will

- Increase percent of individuals receiving both physical and behavioral health care at the established locations by 10% of baseline by DY5. [I-8.1]
- Increase percent of individuals with a treatment plan developed and implemented with primary care and behavioral health expertise by 5% over baseline by DY%. [I-9.1].

Category 3 outcomes: MHMRA expects to increase one domain of patient satisfaction (TBD) by 10% from baseline by DY5.

2.15.1 Integrate primary and behavioral health care services: Collaborative Primary Medical and Behavioral Health Care

RHP Project Number: 113180703.2.1
Performing Provider/TPI: Mental Health and Mental Retardation Authority of Harris County/ 113180703

Project Description:
The Mental Health and Mental Retardation Authority (MHMRA) of Harris County will design, implement, and evaluate a care management program that integrates primary and behavioral health care services.

The Mental Health and Mental Retardation Authority (MHMRA) of Harris County is a public agency serving as the safety net provider for adults with serious mental illnesses, for children and adolescents with serious emotional disorders, for the developmentally delayed and for individuals experiencing acute psychiatric distress. MHMRA serves more than 49,000 Harris County residents out of a culturally and ethnically diverse population of over 4.1 million. Of those who received mental health services in FY12, such as those being proposed in this project, 55% were medically indigent and 34.9% had Medicaid.

MHMRA proposes a collaborative primary and behavioral health program to address the needs of those patients with chronic physical and mental health problems. Over the past three decades, the importance of addressing both the physical and behavioral health needs of individuals has become an essential component of collaborative care delivery. In order to provide collaborative health care for the population served, MHMRA of Harris County proposes to integrate primary care and behavioral health care services in a total of 8 locations in Harris County. Four primary care teams will be placed within four of the MHMRA's mental health clinics; and four MHMRA mental health teams (psychiatrists, nurses, therapists, counselors, case managers, rehabilitation clinicians) will be placed in public health/safety net facilities (e.g., FQHCs, public health clinics, Harris Health System outpatient clinics etc) to provide integrated primary and behavioral health care services.

Goals and Relationship to Regional Goals:
Overall goals of the proposed program include improving mental health and medical treatment access for MHMRA patients via a collaborative treatment model. Specifically, there are several goals including mental and physical health outcomes for the proposed program. For the patient, the goals are improved health outcomes such as decreased blood pressure and blood sugar, preventative screenings for early disease detection, increased health literacy and increased adherence to medical treatment. Furthermore, goals related to mental health include improved adherence to psychiatric medications and treatment, early detection of relapses or non-compliance, improved medication adherence through better communication between different prescribers, hopefully reducing the side effects of psychotropic medications. A goal for the providers is a reduced no-show rate, increased collaboration between providers, improved patient input, making the patient a vested partner in improving health and behavioral health outcomes. Furthermore, both providers and the patient should see a reduction in costs through the collaborative efforts, the one-stop service provision and the increased kept appointments.

Regional Goals: Through the proposed program, MHMRA of Harris County will address areas of regional concern. The specific regional goal that will be addressed is increasing access to primary and specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their condition, regardless of where they live or their ability to pay with the outcome of reduced utilization of Emergency Centers as primary care providers for the seriously mentally ill.

Challenges:

Several challenges face the proposed implementation of collaborative teams, including patient issues, provider issues, and systemic problems. MHMRA patients are typically difficult to engage; have higher rates of mortality as compared to the general population; they frequently demonstrate treatment compliance issues, difficulties with follow-through, lack of resources, population diversity, and issues related to management of their psychiatric conditions.

As the A Performing Provider, MHMRA also faces several challenges to implementing a collaborative program, including attracting providers, developing a collaborative environment, incentivizing patients to use program and engaging and educating patients to improve health literacy and health seeking behaviors. Systemic issues will also present challenges to a collaborative approach, such as billing for two providers who may meet with a patient together, the high number of uninsured patients, limited access to primary care services resulting in subsequent over-utilization of ER for services, and systems for sharing health information with multiple care providers.

5 Year Expected Outcome:

MHMRA hopes that at the end of the 5 year DSRIP program there will be notable improvements in patient-centered collaborations, improved medical and mental health outcomes for patients, and a significant reduction in ER services utilization by this population in the region due to improved access to primary care services. The milestones and metrics attached will address yearly goals toward the five year outcomes.

Starting Point/Baseline:

Currently, a co-location program exists at El Centro De Corazon which has provided the opportunity to serve the medical needs of MHMRA patients who are also seen for psychiatric services in a mental health outpatient clinic. Current clinical space within the four locations will be assessed to determine if additional space will be needed to place the primary health care team. It is hopeful local FQHC programs will have available space for the four mental health teams proposed; however, additional space within these programs may need to be leased.

Rationale:

In 2011 about 68% of MHMRA patients reported having a medical condition, 19% had hypertension and 7% had diabetes; yet, though cardiovascular diseases, such as high blood pressure, are very prevalent amongst the mentally ill population, they are also widely left undetected. Psychiatric medications exacerbate the problem because they are associated with weight gain leading to 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 for their chronic medical conditions. About 34% of MHMRA patients do not report having a PCP upon admission to mental health and it is unknown how many who reported

having a PCP actually maintain regular appointments for their chronic health care problems. Because of the high rates of medically indigent within MHMRA and Houston, we can assume few patients maintain regular follow-up. By improving mental health and medical treatment access for MHMRA patients via a collaborative treatment model, chronic conditions can be treated before the need for emergency treatment is required.

The concept of a medical home that can address these needs is key to improving both access to care and continuity of care which, in turn, produces improved outcomes for patients. When coupled with protocols, training, technology and team delivery models, co-location has the potential to improve communications between providers and enhance coordination of care. Coordination of care has been shown to provide improved medical care at significantly lower costs. Additionally, access to care is enhanced because individuals do not have to incur the cost or burden of arranging transportation. By being able to address both physical and behavioral health needs at one facility reduces rates of disengagement and failure to follow through; this is because customers will be relieved of having to plan and co-ordinate transportation to multiple locations for different services.

To summarize, the rationale for the proposed program includes: 1) improved patient physical and mental health care, 2) reduced costs due to improved, collaborative and proactive care coordination and preventative care, 3) increased consumer satisfaction due to ease of receiving services and 4) improved medical outcomes in a mental health population who are typically underserved.

Project Components:
In order to accomplish this integrated program the following core components will be addressed:
a) MHMRA will identify sites for integrated care projects, which would have the potential to benefit a significant number of patients in the community.

- Both MHMRA clinics and FQHC locations will need to be identified and facility needs assessed

b) MHMRA will develop provider agreements to allow for co-scheduling and information sharing between physical health and behavioral health providers.
c) MHMRA will establish protocols and processes for communication, data-sharing, and referral between behavioral and physical health providers.
d) MHMRA will recruit physical health providers to provide services in the designated locations.
e) MHMRA will train physical and behavioral health providers in protocols, effective communication and team approach. A shared culture of treatment will be fostered by MHMRA and will include specific protocols and methods of information sharing, specifically as follows:

- 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.

(MHMRA will provide home visitation as needed for assigned clinic patients to support care coordination and improve physical health and behavioral health outcomes.
f) MHMRA will acquire data reporting, communication and collection tools (equipment) to be used in the integrated setting, which may include an integrated Electronic health record system or participation in a health information exchange.

g) MHMRA will explore the need for and develop any necessary legal agreements that may be needed in a collaborative practice.
h) MHMRA will arrange for utilities and building services for these settings as is appropriate
i) MHMRA will develop and implement data collection and reporting mechanisms and standards to track the utilization of integrated services as well as the health care outcomes of individual treated in these integrated service settings.
j) MHMRA will conduct quality improvement for project using methods such as rapid cycle improvement.
Through these core components, MHMRA hopes to address the mental and physical health needs of our patients who are at high risk for metabolic syndromes related to chronic medical conditions and poor health practices, both of which can be exacerbated by the use of psychotropic medications. In addition, because MHMRA serves an economically disadvantaged population, many patients often go without medical care.

Unique Community Need Identification numbers:

In addition, the proposed project addresses community needs:

- CN3-Inadequate access to Behavioral Health
- CN6- Inadequate access to treatment and services designed for special needs populations, including disabled, homeless, children and elderly
- CN9- High rates of preventable hospital readmissions
- CN10- High rates of preventable hospital admissions

The proposed program will meet several community needs by providing additional access to behavioral and physical health professionals. Furthermore, this service should help the community need to reduce reliance on ER services by engaging in more preventative care strategies.

Related Category 3 Outcome Measure(s):

IT-6.1 Percent improvement over baseline of patient satisfaction scores

Reasons/rationale for selecting the outcome measures:

Integration of primary and behavioral health care will provide the best opportunity to address the mental and physical health needs of our patients. Through collaboration and coordination of both behavioral and primary medical care we aim to significantly impact patient satisfaction within the targeted population.

Relationship to other Projects:

Currently, this is the only program proposed by MHMRA that addresses collaborative care between physical and mental health providers. Additional programs may be proposed by the RHP. The cohabitation of primary care and behavioral health is an important focus of our region in order to treat the patient base with comprehensive physical and behavioral healthcare issues. There are multiple initiatives in our RHP plan which addresses this need and all can be found on the Region 3 Initiative Grid in the addendums. The outcome measures focused to screening measures and access of the patient base.

Plan for Learning Collaborative:

In addition to participation in RHP collaborative programs we have included in the metrics and milestones, we will encourage collaboration between treatment providers in bi-weekly meetings.

Project Valuation:

In the effort to value the proposed project accurately, assistance was sought from H. Shelton Brown, Ph.D. of the UT Houston School of Public Health and Thomas Bohman, Ph.D. of the UT Austin Center for Social Work Research. Their consultation was limited to only the valuation section of this document.

The following valuation is aligned with the demonstration program goals. These goals are to develop programs that enhance access to health care, increase the quality of care, provide the cost-effectiveness of care, and serve the health of the patients and families. 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 Analyses: A review of the scientific literature identified several QALY-based estimates of the cost utility of providing collaborative mental health care in medical settings. One study examined collaborative care intervention for multi-symptom patients including depression, diabetes and coronary heart disease (Katon, Russo, Lin, Schmittdiel, Ciechanowski, Ludman & Von Korff, 2012). According to the authors, there was a 0.335 QALYs gained.

A second study focused on treatment of major depression in the primary practice setting; they found a QALY gain of 0.049 (Rost, Pyne, Dickinson & LoSasso, 2005). In addition, Pyne, Smith, Fortney, Zhang, Williams, & Rost (2003) reported the cost utility of collaborative care for major depression. Their estimates yielded a 0.123 QALY gained over treatment as usual for females and an estimate of a slight, non-significant loss for males (-0.073 QALY).

An average increment across the three reports can be calculated as (0.335, 0.049, 0.123, and -0.073), which produces 0.1085 QALYs gained. Assuming the program would serve 100 persons in a year, the following formula shows the total valuation:

100	(persons served)
0.1085	(QALY gained)
× $50,000	(life year value)
= $542,500	**QALY Value**

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. We identified three such studies. The first two studies assessed cost savings attributed to "depression free days." Rost and colleagues (2005) reported that a collaborative intervention for major depression produced a significant increment in days free of depression, resulting in 13.4 days between the first and second years of their study; whereas, Simon and colleagues (2012) reported a value of 47.7 depression-free days. Rost and colleagues also reported cost savings attributed to decreased medical costs. According to their findings, the intervention produced a savings of $777.20 (2012 dollars) per treated person. Assuming 100 people are served:

100	(persons served)
x $777.20	(health plan cost savings)
= $77,720	**Cost Savings: Health Costs**

Similarly, Dewa et al. (2009) found that collaborative care saved $545 (2012 US Dollars) per patient in disability benefits. Additional value can be calculated as:

100	(persons served)
x $545	(disability benefit savings)
= $54,500	**Cost Savings: Disability**

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 $**542,500 per 100 patients served per year.** Additional value in the form of depression-free days and reductions in disability payments are documented but not claimed.

Unique Identifier: 113180703.2.1	RHP PP Reference Number: 2.15.1	Project Components: 2.15.1a - j	Program Title: COLLABORATIVE PRIMARY MEDICAL AND BEHAVIORAL HEALTH CARE
RHP Performing Provider: Mental Health and Mental Retardation Authority of Harris County			**TPI: 113180703**
Related Category 3 Measure(s): Patient Satisfaction		**IT-6.1**	**Percent improvement over baseline of patient satisfaction scores**
Year 2	**Year 3**	**Year 4**	**Year 5**
(10/1/2012 – 9/30/2013)	**(10/1/2013 – 9/30/2014)**	**(10/1/2014 – 9/30/2015)**	**(10/1/2015 – 9/30/2016)**
Milestone 1: P-2: Identify existing clinics or other community-based settings where integration could be supported. **Metric 1: P-2.1** Discussions/Interviews with community healthcare providers (physical and behavioral), city and county governments, charities, faith-based organizations and other community based helping organizations. **Goal:** Identify sites for collaboration. **Data Source:** Information from persons interviewed	**Milestone 2 P-8** Participate in at least bi-weekly collaborative learning around shared or similar projects. **Metric 1** [P-8.1]: Number of bi-weekly meetings, conference calls, or webinars organized by the RHP that the provider participated in. **Goal:** increase collaboration, share goals, progress, challenges and solutions **Data Source:** Written documentation	**Milestone 4 [P-10]:** Participate in bi-annual, face-to-face learning, "raise the floor" activities with other providers and the RHP. **Metric 1** [P-10.1]: Participate in semi-annual face-to-face meetings and collaborate as described organized by the RHP. **Goal:** gain information from other programs that may assist current efforts, and improvements in process **Data Source:** Documentation of semiannual meetings including meeting	**Milestone 7 [I-8]:** Integrated Services **Metric 1** [I-8.1]: Percent of individuals receiving both physical and behavioral health care at the established locations. **Goal:** Increase integration by 10% of baseline **Data Source:** MHMRA records
Estimated Incentive Payment : $4,341,631.23	**Estimated Incentive Payment : $2,386,412.62**	**Estimated Incentive Payment : $1,700,091.39**	**Estimated Incentive Payment : $2,463,900.56**

Unique Identifier: 113180703.2.1	**RHP PP Reference Number: 2.15.1**	**Project Components: 2.15.1a - j**	**Program Title: COLLABORATIVE PRIMARY MEDICAL AND BEHAVIORAL HEALTH CARE**
RHP Performing Provider: Mental Health and Mental Retardation Authority of Harris County			**TPI: 113180703**
Related Category 3 Measure(s): Patient Satisfaction		**IT-6.1**	**Percent improvement over baseline of patient satisfaction scores**
Year 2	**Year 3**	**Year 4**	**Year 5**
(10/1/2012 – 9/30/2013)	**(10/1/2013 – 9/30/2014)**	**(10/1/2014 – 9/30/2015)**	**(10/1/2015 – 9/30/2016)**
N/A	**Milestone 3 [P-5]:** Designate/hire personnel or teams to support and/or manage the project/intervention **Metric 1** [P-5.1]: complete hiring for first team **Goal:** Identify number of staff needed and hire **Data Source:** personnel records	**Milestone 5 [I-8]: Integrated Services** **Metric 1** [I-8.1]: Percent of Individuals receiving both physical and behavioral health care at the established locations. **Goal:** increase integration by 5% of baseline **Data Source:** Project data; claims and encounter data; medical records	**Milestone 8: I-9** Care Coordination **Metric 8: I-9.1** Percent of Individuals with a treatment plan developed and implemented with primary care and behavioral health expertise Goal: increase 5% over baseline
N/A	**Estimated Incentive Payment : $2,386,412.63**	**Estimated Incentive Payment : $1,700,091.39**	**Estimated Incentive Payment : $2,463,900.56**
N/A	**N/A**	**Milestone 6: I-9** Coordination of Care **Metric 1**. I-9.1 Percent of individuals with a treatment plan developed/implement with primary care and behavioral health expertise **Data Source:** MHMRA records **Goal:** identify baseline	**N/A**
N/A	**N/A**	**Estimated Incentive Payment : $1,700,091.39**	**N/A**

DRAFT

Unique Identifier: 113180703.2.1		RHP PP Reference Number: 2.15.1	Project Components: 2.15.1a - j	Program Title: COLLABORATIVE PRIMARY MEDICAL AND BEHAVIORAL HEALTH CARE
RHP Performing Provider: Mental Health and Mental Retardation Authority of Harris County				TPI: 113180703
Related Category 3 Measure(s): Patient Satisfaction			IT-6.1	Percent improvement over baseline of patient satisfaction scores
Year 2	Year 3		Year 4	Year 5
(10/1/2012 – 9/30/2013)	(10/1/2013 – 9/30/2014)		(10/1/2014 – 9/30/2015)	(10/1/2015 – 9/30/2016)
Year 2 Estimated Milestone Bundle Amount: $4,341,631.23	Year 3 Estimated Milestone Bundle Amount: $4,772,825.25		Year 4 Estimated Milestone Bundle Amount: $5,100,274.17	Year 5 Estimated Milestone Bundle Amount: $4,927,801.12
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $19,142,531.77				

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Project Option 2.13 PROVIDE AN INTERVENTION FOR A TARGETED BEHAVIORAL HEALTH POPULATION TO PREVENT UNNECESSARY USE OF SERVICES IN A SPECIFIED SETTING: INTEGRATING SUBSTANCE ABUSE TREATMENT SERVICES INTO MENTAL HEALTH SERVICES

Unique RHP Project ID: 113180703.2.2/Pass 3

Performing Provider Name/TPI: MHMRA of Harris County / 113180703

Project Summary:

Provider**:** The Mental Health and Mental Retardation Authority (MHMRA) of Harris County is a public agency serving as the safety net provider for adults with serious mental illnesses, for children and adolescents with serious emotional disorders, for the developmentally delayed and for individuals experiencing acute psychiatric distress. MHMRA provides inpatient, residential and outpatient treatments, including psycho-therapy, case management and medication management for individuals. MHMRA serves more than 49,000 Harris County residents out of a culturally and ethnically diverse population of over 4.1 million. Of those individuals who received any agency service in FY12, 36.5% were medically indigent and 51.9% had Medicaid. Of those who received mental health services in FY12, such as those being proposed in this project, 55% were medically indigent and 34.9% had Medicaid.

Intervention(s): Substance abuse treatment services will be integrated and embedded into existing MHMRA mental health treatment services (psychosocial rehabilitation).

Need for the project: Presently, 31% of all MHMRA consumers have a documented substance abuse disorder, and the suspected number of individuals coping with substance abuse is much higher. National rates of comorbidity indicate that more than four million adults meet the criteria for both serious mental illness (SMI) and substance dependence and abuse (Office of Applied Studies, 2003b). According to the National Survey on Drug Use and Health (NSDUH) 23.2% of individuals with SMI were dependent or abused illicit drugs and alcohol compared to 8.2% of individuals without SMI.

Target population: MHMRA consumers with a co-morbid substance abuse diagnosis. It is anticipated the program will provide service for about 900 patients.

Category 1 or 2 expected patient benefits: MHMRA will:

- decrease county jail bookings by 10% from baseline by DY5(I-1.1)
- decrease PES/HCPC admissions by 10% from baseline by DY5 (I-X.1)

Category 3 outcomes: MHMRA expects to increase one domain of patient satisfaction (TBD) by 10% from baseline by DY5.

2.13.1 Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specified setting: Integrating substance abuse treatment services into mental health services

RHP Project Number: 113180703.2.2
Performing Provider/TPI: Mental Health and Mental Retardation Authority of Harris County/ 113180703

Project Description:
This Mental Health and Mental Retardation Authority (MHMRA) project will improve behavioral health care and reduce unnecessary use of emergency care by integrating substance abuse treatment services with existing mental health treatment services.

The Mental Health and Mental Retardation Authority (MHMRA) of Harris County is a public agency serving as the safety net provider for adults with serious mental illnesses, for children and adolescents with serious emotional disorders, for the developmentally delayed and for individuals experiencing acute psychiatric distress. MHMRA serves more than 49,000 Harris County residents out of a culturally and ethnically diverse population of over 4.1 million. Of those who received mental health services in FY12, such as those being proposed in this project, 55% were medically indigent and 34.9% had Medicaid. The purpose of this project is to improve behavioral health and reduce unnecessary use of emergency psychiatric services by integrating substance abuse treatment services with existing mental health treatment services (psychosocial rehabilitation). The program will consist of assessment, individual therapy, group therapy, and will be embedded into existing treatment teams, consisting of licensed counselors, case workers, psychiatrists and psychologists.

Goals and Relationship to Regional Goals:
Program goals include reduction in psychiatric emergency services, reduction in jail bookings, reduction and/or cessation of drug and alcohol use, increased outpatient treatment participation, and increased mental health functioning. Additionally, consumer satisfaction will be assessed. These goals are compatible with the selected core components and the milestone and metrics addendum.
Regional goals:
It is important to note this project directly meets four broad goals identified by the region. First, it improves on existing programs and infrastructure by adding a component of treatment to existing community mental health clinics. Second, it increases access to specialty care services by providing empirically based substance abuse treatment to individuals who otherwise, may not be able to afford this type of intervention. Next, the recovery model of substance abuse is inherently a patient-centered approach that moves away from the historical "disease" focused model of substance dependence. The proposed program will also complement the regional goal to develop a culture of "best practices" whereby the patient/consumer plays a more active role as a stakeholder by completing consumer satisfaction surveys. Finally, this program would provide empirically validated substance abuse treatment using national standards.

Challenges:

Patients with co-morbid disorders may be more reticent to engage in treatment and may have a higher early-termination rate than non-dually diagnosed consumers; MHMRA will utilize empirically based treatments, such as motivational interviewing to combat these challenges. In order to ameliorate any difficulties related to hiring staff, MHMRA plans to contract with the Houston Council on Alcohol and Drugs to provide this service inside the MHMRA Clinics.

5 year expected outcome:
The expected five-year outcome is to have a fully functioning, integrated substance abuse treatment program embedded in outpatient mental health services.

Starting Point/Baseline:
Although MHMRA offers substance abuse treatment within the context of assertive community treatment, outpatient substance abuse treatment is virtually non-existent in other treatment programs. In order to accomplish this project, MHMRA plans to contract to hire 30 licensed clinical dependency counselors (LCDCs) to provide outpatient substance abuse treatment among existing MHMRA mental health clinics.

Rationale:
MHMRA of Harris County is an ideal agency to host this intervention given the rate of co-morbid drug and alcohol use among the severely mentally ill. Presently, 31% of all MHMRA consumers have a documented substance abuse disorder, and the suspected number of individuals coping with substance abuse is much higher. National rates of comorbidity indicate that more than four million adults meet the criteria for both serious mental illness (SMI) and substance dependence and abuse (Office of Applied Studies, 2003b). According to the National Survey on Drug Use and Health (NSDUH) 23.2% of individuals with SMI were dependent or abused illicit drugs and alcohol compared to 8.2% of individuals without SMI.

Not only is there a high base rate of co-occurring disorders in outpatient treatment, but the outpatient population accesses acute services at a higher rate. The Texas Health and Human Services Commission conducted a study in 2010 that examined inpatient admissions, mental health and substance abuse; results revealed that of those hospitalized for a mental health or substance abuse issue, 24% have a potentially preventable admission. Furthermore, this study noted the increased rates of potentially preventable admission for any patient initially hospitalized for any issue if they have a co-morbid mental health or substance abuse diagnosis.

Integration of treatment may provide an opportunity to identify more consumers who cope with substance abuse and mental illness and offer appropriate treatment. Additionally, it is hoped that integration will promote better outcomes and sustainable recovery among program participants. It is also expected that with preventative care, readmission rates to inpatient and psychiatric emergency services will be reduced.

Project Components:
In order to develop the proposed program the following core components (2.13) will be utilized:

a) Assess size, characteristics and needs of target population(s)
    - Completed. MHMRA currently completes the Adult Texas Recommended Assessment (TRAG) to establish a treatment plan for each consumer. Section Seven of the TRAG addresses co-occurring substance abuse and clinicians are required to rate consumer on this index using a Likert scale (1-5; 5 is synonymous

with drug dependence. This data is available in the current electronic medical record and charts
  - Secondly, MHMRA clinicians and psychiatrists assess substance abuse disorders as part of their intake assessment. If a consumer meets criteria for drug abuse or dependence, they render an appropriate diagnosis.

b) Review literature / experience with populations similar to target population.
  - To be completed. MHMRA will look to expert authorities within the agency and national resources, such as SAMHSA an NIDA prior to implementing specific treatment approaches or adopting specific manuals/materials.

c) Develop project evaluation plan using qualitative and quantitative metrics to determine outcomes.
  - To be completed. MHMRA will develop a program evaluation that includes qualitative and quantitative metrics (e.g., pre/post assessment of program participants, use of psychiatric emergency services, jail bookings, patient satisfaction surveys, etc.)

d) Design models which include an appropriate range of community-based services and residential supports.
  - To be completed. MHMRA currently offers residential treatment for individuals with co-morbid disorders. If this project is expanded, the agency will have community-based treatment as well. In addition, MHMRA will develop a toolkit that is interdisciplinary (mental health and substance abuse) and addresses key areas that impact the success of consumers. For example, consumers often need assistance with transportation, housing, and medical needs. MHMRA case workers and clinicians can address these needs using existing psycho-educational material.

e) Assess the impact of interventions based on standardized quantitative measures and qualitative analysis relevant to the target population.
  - To be completed. MHMRA will work with the outcomes department to identify pre/post measures and patient satisfaction surveys that are empirically validated for individuals who are diagnosed with co-morbid conditions. See Category 3 Outcome for more details.

f) Community-based interventions should be comprehensive and multispecialty.
  - As mentioned above, this program will integrate substance abuse treatment services with existing mental health treatment services (psychosocial rehabilitation). Additionally, consumers will have access to nursing services and medication management.

Milestones and Metrics:
The program goals are consistent with the regional goals and community needs discussed above. Furthermore, the improvement metrics chosen to evaluate the performance of the program were specifically chosen to determine the impact the program will have on the community: (I-1, I-1.1 - % decrease in preventable admissions and readmissions into county jail bookings and I-X, I-X.1 - % decrease from baseline in PES/HCPC).

Unique community need identification number the project addresses:

In addition to the regional goal, the following community needs are addressed with the proposed program:

- CN3-Inadequate access to Behavioral Health
- CN6- Inadequate access to treatment and services designed for special needs populations, including disabled, homeless, children and elderly
- CN9- High rates of preventable hospital readmissions

Related Category 3 Outcome Measure(s):
IT- 6.1 Percent improvement over baseline of patient satisfaction scores
Through integrating substance abuse treatment services into mental health services we will increase enrollment and serve more individuals with co-morbid mental illness and substance abuse disorders. The transformed system is proposed to be a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes.

Relationship to other Projects:
This program would enhance other MHMRA DSRIP proposals, such as expansion of outpatient behavioral services.

The behavioral health crisis in Region 3 is considerable and the proposed initiatives in our RHP plan will only imply a small impression into the overall community need for treatment, but is a good start. The outpatient focus of many RHP Plan initiatives will help numerous facilities focus to treating the patients in an ambulatory setting as well as continued navigation of services with a focus to keeping patients from the inpatient unit. This initiative is similar to many others in the sense of the category of behavioral health. The Region 3 Initiative Grid attached in the addendum will show the relationship to other programs.

Plan for Learning Collaborative:
The project has no plans to establish a Learning Collaborative at this time but is open to doing so if another similar project is approved. Historically, MHMRA has worked informally and contractually with other providers in the community who are experts in substance abuse treatment, such as the Council on Drugs and Alcohol— Houston.

Project Valuation:
In the effort to value the proposed project accurately, assistance was sought from H. Shelton Brown, Ph.D. of the UT Houston School of Public Health and Thomas Bohman, Ph.D. of the UT Austin Center for Social Work Research. Their consultation was limited to only the valuation section of this document. 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 quality-adjusted 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 threshold. The number of life-years added is based on a review of the scientific literature.

Cost-Utility Analysis: One highly applicable cost utility study was identified that assessed the implementation motivational enhancement for substance abuse cessation. In 2001, Sellman, Sullivan, Dore, Adamson and MacEwan reported a randomized control trial for Motivational Enhancement Therapy (MET) for mild to moderate alcohol dependence. The study revealed that those who completed MET treatment (with mild to moderate dependence) showed a 0.116 QALY gain. These findings are relevant because MHMRA employees are trained in motivational interviewing techniques.

100	(persons served)
0.116	(QALY gained)
× $50,000	(life year value)
= $580,000	QALY Value

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. We identified one benefit-cost study that is related. As mentioned previously, Mangrum and colleagues investigated the utility of integrated versus parallel treatment of co-occurring psychiatric and substance use disorders in Houston (2006). They reported an 8.9 percentage point decrease in the incidence of hospitalization for the integrated care treatment group. The parallel treatment group had a non-significant change in hospitalization. The cost savings per 100 persons treated associated with the avoidance of hospitalizations can be calculated as follows:

100	(persons treated)
0.089	(hospitalizations avoided)
10.25	(local average length of stay)
x $700	(local cost per public psychiatric hospital bed day)
$63,857.50	Total Hospital Costs Avoided

These authors also reported a parallel reduction of 4.1% in jail events for their integrated treatment group. This group would have averted cots at the following rate:

100	(persons treated)
0.041	(bookings avoided)
40.5	(local average length of stay)
x $130	(local cost per county jail bed day with mental health treatment)
$21,586.50	Total Jail Costs Avoided

Summary and Total Valuation: This valuation shows the proposed program will have a positive value for participants who receive the intervention(s). The combined QALY-based valuation ($580,000) plus psychiatric hospital cost avoidance ($63,857) plus jail cost avoidance ($21,586.50) valuation equals $685,444 per 100 treated persons served per year. Although further savings have been documented, **only the QALY-based estimate of $580,000 per 100 treated person s is claimed**. This concludes the valuation for the proposed project. The cited references for this section are included in the attached addendum.

<table>
<tr><td>Unique Identifier:
113180703.2.2</td><td>RHP PP Reference Number: 2.13.1</td><td>Project Components:
2.13.1a; 2.13.1b; 2.13.1c; 2.13.1d; 2.13.1e</td><td colspan="2">Program Title: INTEGRATING SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES</td></tr>
<tr><td colspan="4">RHP Performing Provider: Mental Health and Mental Retardation Authority of Harris County</td><td>TPI: 113180703</td></tr>
<tr><td colspan="2">Related Category 3 Measure(s): Patient Satisfaction</td><td>IT-6.1</td><td colspan="2">Percent improvement over baseline of patient satisfaction scores</td></tr>
</table>

Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Milestone 1: P-2: Design community-based specialized interventions. Design treatment program for co-morbid mental illness and substance abuse disorders. **Metric 1: P-2.1** Project plans will be based on empirically based treatment approaches such as those proffered by NIDA and SAMHSA **Data Source:** Written plan, project documentation	**Milestone 2: P-3.** Enroll and serve individuals who with co-morbid mental illness and substance abuse disorders. **Metric 1: P-3.1** **E**nroll 300 individuals in substance abuse treatment **Data Source:** Project documentation	**Milestone 5: P-3** Enroll and serve individuals who with co-morbid mental illness and substance abuse disorders. **Metric 1: P-3.1** Enroll 300 more individuals (over DY3) in substance abuse treatment (total of 600 served per year) **Data Source**: Project documentation	**Milestone 8: P-3** Enroll and serve individuals who with co-morbid mental illness and substance abuse disorders. **Metric 1: P-3.1** Enroll 300 more individuals (over DY4) in substance abuse treatment (total of 900 served per year) **Data Source**: Project documentation
Estimated Incentive Payment: $4,177,569.59	**Estimated Incentive Payment: $1,530,823.20**	**Estimated Incentive Payment: $1,635,848.30**	**Estimated Incentive Payment: $1,580,529.76**

Unique Identifier: 113180703.2.2	RHP PP Reference Number: 2.13.1	Project Components: 2.13.1a; 2.13.1b; 2.13.1c; 2.13.1d; 2.13.1e	Program Title: INTEGRATING SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES
RHP Performing Provider: Mental Health and Mental Retardation Authority of Harris County			TPI: 113180703
Related Category 3 Measure(s): Patient Satisfaction		IT-6.1	Percent improvement over baseline of patient satisfaction scores

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
N/A	**Milestone 3: I-1.** Criminal justice admissions/readmissions - Jail Bookings **Metric 1: I-1.1.** Establish a baseline of criminal justice admissions among consumers with co-morbid mental illness and substance abuse. **Data Source:** MHMRA and jail records.	**Milestone 6: I-1** Criminal justice admissions/readmissions -Jail Bookings **Metric 1: I-1.1** A 5% decrease from baseline in county jail bookings **Data Source:** MHMRA and jail records.	**Milestone 9: I-1** Criminal justice admissions/readmissions -Jail Bookings **Metric 1: I-1.1** A 10% decrease from baseline in county jail bookings **Data Source:** MHMRA and jail records.
N/A	**Estimated Incentive Payment: Payment: $1,530,823 .21**	**Estimated Incentive Payment: Payment $$1,635,848.30**	**Estimated Incentive Payment: Payment $1,580,529.76**

Unique Identifier: 113180703.2.2	RHP PP Reference Number: 2.13.1	Project Components: 2.13.1a; 2.13.1b; 2.13.1c; 2.13.1d; 2.13.1e	Program Title: INTEGRATING SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES
RHP Performing Provider: Mental Health and Mental Retardation Authority of Harris County			**TPI: 113180703**
Related Category 3 Measure(s): Patient Satisfaction		**IT-6.1**	**Percent improvement over baseline of patient satisfaction scores**

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
N/A	**Milestone 4: I-X** Psychiatric Emergency Service (PES) /Inpatient psychiatric hospitalizations **Metric 1: I-X.1** Establish a baseline of Integrated substance abuse patients' PES/inpatient admissions. **Data Source:** PES records are part of the MHMRA electronic record. Harris County Psychiatric Center (HCPC) is the local public psychiatric inpatient unit which maintains separate records	**Milestone 7: I-X** PES and Inpatient Public Hospital Admissions **Metric 1: I-X.1** A 5% decrease from baseline in PES/HCPC a. Numerator: Percent of patients receiving Interim Care admitted to PES/HCPC during measurement period. b. Denominator: The number of patients receiving Interim Care **Data Source:** MHMRA and HCPC records	**Milestone 10: I-X** PES and Inpatient Public Hospital Admissions **Metric 1: I-X.1** A 10% decrease from baseline in PES/HCPC a. Numerator: Percent of patients receiving Interim Care admitted to PES/HCPC during measurement period. b. Denominator: The number of patients receiving Interim Care **Data Source:** MHMRA and HCPC records
N/A	**Estimated Incentive Payment: Payment: $1,530,823.21**	**Estimated Incentive Payment: $1,635,848.31**	**Estimated Incentive Payment: $1,580,529.76**
Year 2 Estimated Milestone Bundle Amount: $4,177,569.59	**Year 3 Estimated Milestone Bundle Amount: $4,592,469.64**	**Year 4 Estimated Milestone Bundle Amount: $4,907,544.91**	**Year 5 Estimated Milestone Bundle Amount: $4,741,589.28**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $18,419,173.42			

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Sellman, J., Sullivan, P., Dore, G., Adamson, S. & MacEwan, I. (2001) A randomized control trial for Motivational Enhancement Therapy (MET) for mild to moderate alcohol dependence. *Journal of Studies on Alcohol, 62*, 389–396.

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Project Option 2.17 ESTABLISH IMPROVEMENTS IN CARE TRANSITION FROM THE INPATIENT SETTING FOR INDIVIDUALS WITH MENTAL HEALTH DISORDERS: REDESIGN OF THE TRANSITION FROM HCPC HOSPITALIZATION TO MHMRA OUTPATIENT AFTERCARE

Unique RHP Project ID: 113180703.2.3/Pass 3

Performing Provider Name/TPI: MHMRA of Harris County / 113180703

Project Summary:

Provider**:** The Mental Health and Mental Retardation Authority (MHMRA) of Harris County is a public agency serving as the safety net provider for adults with serious mental illnesses, for children and adolescents with serious emotional disorders, for the developmentally delayed and for individuals experiencing acute psychiatric distress. MHMRA provides inpatient, residential and outpatient treatments, including psycho-therapy, case management and medication management for individuals. MHMRA serves more than 49,000 Harris County residents out of a culturally and ethnically diverse population of over 4.1 million. Of those individuals who received any agency service in FY12, 36.5% were medically indigent and 51.9% had Medicaid. Of those who received psychiatric emergency services in FY12, such as those being proposed in this project, 59.3% were medically indigent and 28.7% had Medicaid.

Intervention(s): The HCPC transition program will hire licensed mental health professionals to engage patients pre-discharge from HCPC and assist with successfully linking them to community mental health treatment.

Need for the project: Only 49% of individuals discharged from HCPC attend an outpatient appointment within 30 days. Additionally, data analysis indicates that 5% of patients who are discharged from HCPC account for a significant proportion of readmissions to ER services.

Target population: Individuals being discharged from state psychiatric hospitals and the local, public psychiatric facility, Harris County Psychiatric Center (HCPC). It is anticipated the program will provide service for about 1375 patients.

Category 1 or 2 expected patient benefits: MHMRA will

- Demonstrate a 10% increase from baseline in warm handoffs by DY5
- Demonstrate a 5% increase in outpatient follow-up after HCPC discharge within 7 and 30 days from baseline.

Category 3 outcomes: MHMRA expects to increase one domain of patient satisfaction (TBD) by 10% from baseline by DY5.

Project Option 2.17.1 Establish improvements in care transition from the inpatient setting for individuals with mental health disorders: redesign of the transition from HCPC hospitalization to MHMRA outpatient aftercare

Unique RHP Project Identification Number: 113180703.2.3
Performing Provider Name/TPI: Mental Health and Mental Retardation Authority of Harris County/113180703

Project Description:
The Mental Health and Mental Retardation Authority (MHMRA) of Harris County proposes to establish improvements in care transition from the inpatient setting for individuals with mental health disorders by redesigning the transition from HCPC hospitalization to MHMRA outpatient aftercare.

The Mental Health and Mental Retardation Authority (MHMRA) of Harris County is a public agency serving as the safety net provider for adults with serious mental illnesses, for children and adolescents with serious emotional disorders, for the developmentally delayed and for individuals experiencing acute psychiatric distress. MHMRA serves more than 49,000 Harris County residents out of a culturally and ethnically diverse population of over 4.1 million. Of those who received mental health services in FY12, such as those being proposed in this project, 55% were medically indigent and 34.9% had Medicaid. MHMRA is also responsible for providing outpatient aftercare services to individuals being discharged from state psychiatric hospitals and the local, public psychiatric facility, Harris County Psychiatric Center (HCPC), within 10 days of discharge. The objective of this new program is to improve the transition from HCPC to MHMRA community mental health outpatient treatment settings (2.17).

Goals and Relationship to Regional Goals:
The proposed program seeks to improve outpatient treatment adherence while decreasing subsequent readmission rates at HCPC. In order to decrease HCPC readmission, the program will assess the factors that are associated with low utilization of outpatient treatment after hospitalization and employ empirically based practices to increase utilization. For example, the program will employ "warm handoffs" or improved communication among treatment professionals across different treatment settings. Additional interventions will be assessed and prioritized following a literature review of empirically based approaches. Another emphasis of the program will be on improving patients' involvement in discharge planning and outpatient treatment planning, using a person-centered approach. It is hoped that patients will be more likely to adhere to treatment plans if they are provided with more choices and autonomy in the treatment planning stage.

Challenges:
This project will examine barriers faced by individuals as they are discharged from HCPC inpatient care and referred to MHMRA for outpatient services. Influences of personal resources, attitudes about mental health and recovery, and the importance of ongoing care will be reviewed; strategies will then be designed to address each identified barrier, which may include motivational interviewing, providing transportation or other material resources, and addressing patient choice.

5-Year Expected Outcome for Provider and Patients:

Our ultimate goal (e.g., five year goal), is that nearly all patients will attend outpatient mental health treatment within 30 days of discharge from HCPC to include MHMRA outpatient community option.

In order to enhance the transition from inpatient to develop such a program, the following option and core components were chosen: 2.17.1, Design, implement, and evaluate interventions to improve care transitions from the inpatient setting for individuals with mental health disorders. These components have also been imbedded in the program process and improvement milestones (See milestone and metric chart for further details). The status of each component is noted, if that activity is currently underway:

a. Develop a team comprised of clinical and administrative representatives from acute care, ambulatory care, behavioral health and community-based non-medical supports
    - To be developed. The proposed program will consist of two additional mental health professionals (LPHAs) who interface with HCPC staff and existing MHMRA programs to facilitate improved transitions to community based mental health treatment.
b. Conduct an analysis of the key drivers of 30-day hospital readmissions for behavioral health conditions using a chart review tool
    - In progress. The MHMRA Outcomes Management Department is reviewing hospital re-admission data for predictors of rapid readmission.
c. Identify baseline mental health and substance abuse conditions at high risk for readmissions, (example include schizophrenia, bipolar disorder, major depressive disorder, chemical dependency).
    - In progress. The MHMRA Outcomes Management Department recently completed an analysis of psychiatric emergency service use among existing consumers.
d. Review best practices for improving care transitions from a range of evidence-based or evidence-informed models
    - To be completed. A literature review will be conducted to identify and assess evidence-based practices to improve transitions from inpatient to community treatment.
e. Identify and prioritize evidence-based strategies and clinical protocols that support seamless care transitions and reduce preventable 30-day readmissions.
    - To be completed. Following the literature review, administrators will review potential protocols and practices to improve transition.
f. Implement two or more pilot intervention(s) in care transitions targeting one or more patient care units or a defined patient population.
    - To be completed. Administration and management will select a pilot intervention and employ the strategy.
g. Conduct quality improvement for project using methods such as rapid cycle improvement. Activities may include, but are not limited to, identifying project impacts, identifying "lessons learned," opportunities to scale all or part of the project to a broader patient population, and identifying key challenges associated with expansion of the project, including special considerations for safety-net populations.

Starting Point/Baseline:

Patients who are admitted to inpatient treatment at HCPC are given an appointment at MHMRA's outpatient clinics within 10- days of their discharge window. Patients are provided with an MHMRA appointment reminder form and the MHMRA crisis number should they need this prior to their MHMRA outpatient appointment. The patient also receives a reminder telephone call twenty-four (24) hours prior to the appointment and will receive follow up calls from the outpatient clinic if they fail to appear for services. Patients who are prescribed psychotropic medication are given five (5) days of medication with a prescription for a ten (10) day refill. It is well known that non-adherence to psychotropic medication is a key factor in relapse, and subsequently hospital readmission for individuals with severe mental illness.

Rationale:

Until recently, all new patients were required to visit MHMRA's Eligibility Center before obtaining an appointment at one of MHMRA's outpatient clinics. In June of 2011, MHMRA amended the intake procedures for patients who were hospitalized at HCPC. Although the Eligibility Center is centrally located, having to be screened at the Eligibility Center post-hospitalization was conceptualized as a barrier to access to care. Because of this theory, the intake procedure was changed; HCPC patients were given follow-up appointments while in the hospital, without having to go to the Eligibility Center first. This change was made to improve the rate of outpatient treatment among recently discharged patients from HCPC. The rate of increase went from approximately 47% to 65% during this period of time and is currently at around 59%; we do not have figures on the connectivity rate after attempts to reengage by outpatient staff as a result of a missed initial appointment. The National Quality Forum and HEDIS averages are 43 and 42% respectively for seven (7) day aftercare appointments; 60% after thirty (30) days. Additionally, data analysis indicates that 5% of patients who are discharged from HCPC account for a significant proportion of readmissions.

It is hypothesized that linkage to outpatient treatment will increase due to implementation of this program. This theory is consistent with research conducted by Boyer, McAlpine, Pottick, and Olfson (2000) using an inpatient psychiatric sample. They reported that three specific clinical interventions tripled the odds of successful linkage to outpatient care: communication about patients' discharge plans between inpatient staff and outpatient clinicians; patients' starting outpatient programs before discharge; and family involvement during the hospital stay.

Unique community need identification number the project addresses:

This project directly meets broad goals identified by the regional needs assessment. First, it improves on existing programs. Second, it increases access to specialty care services by providing a novel treatment approach to a pervasive problem. The program also offers a preventative, patient-centered approach that provides individualized care to prospective outpatient consumers. The proposed program will also complement the regional need to develop a culture of "best practices" whereby the patient/consumer plays a more active role in treatment planning, and also by completing patient satisfaction surveys.

Redesign of the transition from HCPC hospitalization to MHMRA outpatient aftercare will address the following community needs:

- CN3-Inadequate access to Behavioral Health
- CN6- Inadequate access to treatment and services designed for special needs populations, including disabled, homeless, children and elderly
- CN9- High rates of preventable hospital readmissions

Relationship to Other Projects:

At this time there is not enough information available from the RHP to describe how this project may or may not be related to other RHP DSRIP proposals. However, this project will interface with the expansion of the collaborative primary medical and behavioral health care and expansion of outpatient treatment teams.

The behavioral health crisis in Region 3 is considerable and the proposed initiatives in our RHP plan will only imply a small impression into the overall community need for treatment, but is a good start. The outpatient focus of many RHP Plan initiatives will help numerous facilities focus to treating the patients in an ambulatory setting as well as continued navigation of services with a focus to keeping patients from the inpatient unit. This initiative is similar to many others in the sense of the category of behavioral health. The Region 3 Initiative Grid attached in the addendum will show the relationship to other programs.

Plan for Learning Collaborative:

MHMRA plans to participate in region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other performing providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our region's healthcare system.

Project Valuation:

In the effort to value the proposed project accurately, assistance was sought from H. Shelton Brown, Ph.D. of the UT Houston School of Public Health and Thomas Bohman, Ph.D. of the UT Austin Center for Social Work Research. Their consultation was limited to only the valuation section of this document. 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 is a worthy value. The number of life-years added is based on a review of the scientific literature.

Cost-Utility Analysis: As mentioned above, QALYs represent relative improvements in quality of life years subsequent to a particular intervention. A thorough literature review revealed two studies that are relevant to the HCPC population. The first study, conducted by Chouinard and Albright (1997) provided a QALY gained of (0.125) when schizophrenic patients were treated with psychotropic medication (Risperdone) compared to those who received a placebo (-0.021). This study is relevant to the proposed population because individuals with schizophrenia represent a significant portion of MHMRA's priority population, and many of the individuals who are discharged from HCPC do not have ongoing psychiatric care, making them similar to a waitlist or placebo control group. Using the QALY of 0.125, we can estimate a QALY value per 100 people:

100	(persons served)
0.05	(percent of high utilizers)
0.125	(QALY gained)
$50,000	(life year value)
$31,250	**QALY Value per 100**

Cost Savings: A second way to value this proposal is to assess cost avoidance. Dixon et al. (2009) assessed the effectiveness of a brief intervention to improve continuity of psychiatric outpatient care for patients who were discharged from inpatient psychiatric hospitals. Compared to the control group, the intervention group had significantly fewer days between their hospital discharge and their first outpatient appointment (3.5 days versus 15.0 days, $p<0.001$); were more likely to schedule their outpatient follow up (78% versus 38%, $p<.001$); to have kept their outpatient appointment 180 days post discharge (100% versus 86%, $p<0.001$). The intervention group had fewer hospitalizations ($.2\pm.5$ versus $.6\pm1.0$, $\chi2=4.14$, $df=1$, $p=.042$) than the control group.

We can use the reduction of 40% between the control group and the intervention group to estimate cost savings relative to hospital admissions within the Houston area. Assuming the program serves 100 people, and 5% of the patients are at high risk of readmission as discussed in the program description, cost savings can be tallied. Using local data about HCPC costs and average length of stay among MHMRA consumers, the following cost savings is proposed:

100	(persons served)
0.05	(percent of high utilizers)
0.40	(reduced hospitalizations)
10.25	(average length of stay)
x $700	(average cost per diem)
$14,350	**Cost Savings**

Summary and Total Valuation: This valuation analysis shows that the intervention will have a positive value for participants. The combined estimates of $31,250 QALY gained and

$14,350 Cost Savings yield a total valuation of $45,600 per 100 people served per year. It is hoped the proposed program could benefit 1,375 people per year, for a valuation of $627,000 per 1,375 people served per year. This concludes the valuation for the proposed project. The cited references for this section are included in the attached addendum.

Unique Identifier: 113180703.2.3	*2.17.1*	*2.17.1a, 2.17.1b., 2.17.1c., 2.17.1d., 2.17.1e., 2.17.1f., 2.17.1g*	*HCPC transition*
Mental Health and Mental Retardation Authority of Harris County			*113180703*
Related Category 3 Measure(s):	*IT-6.1*		*Percent improvement over baseline of patient satisfaction scores*
Year 2 (10/1/2012 – 9/30/2013)	**Year 3** (10/1/2013 – 9/30/2014)	**Year 4** (10/1/2014 – 9/30/2015)	**Year 5** (10/1/2015 – 9/30/2016)
Milestone 1: P-28: Gap analysis regarding patient communication with providers and/or discharge information **Metric 1: P-28.1** Complete analysis **Data Source:** Written Report	**Milestone 4: P-4.** Hire 2 clinicians with care transition expertise **Metric 4: P-4.1** Position offer letters **Data Source:** Human Resource records	**Milestone 7: I-31.** Warm Handoffs **Metric 7. I-31.1** Measure use of warm handoffs **Data Source:** MHMRA clinical records and HCPC records. **Goal: 5%** increase from baseline in warm handoffs	**Milestone 9: I-31.** Warm Handoffs **Metric 9: I-31.1** Measure use of warm handoffs **Data Source:** MHMRA clinical records and HCPC records. **Goal:**10% increase from baseline in warm handoffs
Estimated Incentive Payment:$167,262.85	**Estimated Incentive Payment:$183,874.74**	**Estimated Incentive Payment:$294,734.74**	**Estimated Incentive Payment:$284,767.86**

Unique Identifier: 113180703.2.3	***2.17.1***	***2.17.1a, 2.17.1b., 2.17.1c., 2.17.1d., 2.17.1e., 2.17.1f., 2.17.1g***	***HCPC transition***
Mental Health and Mental Retardation Authority of Harris County			*113180703*
Related Category 3 Measure(s):	*IT-6.1*		*Percent improvement over baseline of patient satisfaction scores*
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 2: P-2. Collect and analyze data on factors contributing to readmissions to HCPC within 30 days of discharge **Metric 2: P-2.7** Identification of key factors that increase the likelihood of preventable 30 day readmissions for individuals with mental health disorders **Data Sources:** Report on readmission data	**Milestone 5: P-8.** Pilot test intervention approaches at HCPC sites **Metric 5: P-8.1** Implementation of evidence-based interventions on a pilot inpatient unit, including number of patients served **Data Sources:** Detailed implementation plan; program records	**Milestone 8: I-42.** Follow-up after Hospitalization **Metric 8: I-42.1** Baseline for patients receiving Follow-Up After HCPC discharge within 7 and 30 days (NQF#-576) a. Numerator: Number of patients who were hospitalized at HCPC then went to outpatient appt. visit 7 -30 days after discharge. b. Denominator: Number of patients discharged from HCPC **Data Source:** MHMRA records **Goal:** Establish baseline	**Milestone 10: I-42.** Follow-up after Hospitalization **Metric 10: I-42.1** Outpatient Follow-Up After HCPC discharge within7 and 30 days **Data Source:** MHMRA and HCPC Records Goal: 5% increase from baseline
Estimated Incentive Payment:$167,262.84	**Estimated Incentive Payment:$183,874.75**	**Estimated Incentive Payment:$294,734.74**	**Estimated Incentive Payment:$284,767.86**

Unique Identifier: 113180703.2.3	*2.17.1*		*2.17.1a, 2.17.1b., 2.17.1c., 2.17.1d., 2.17.1e., 2.17.1f., 2.17.1g*	*HCPC transition*
Mental Health and Mental Retardation Authority of Harris County				*113180703*
Related Category 3 Measure(s):	*IT-6.1*		*Percent improvement over baseline of patient satisfaction scores*	

Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Milestone 3: P-6: Identify evidence-based frameworks that support seamless care transitions and impact preventable 30-day readmissions **Metric 3: P-6.1.** Selection of an evidence based framework **Data Source:** Meeting minutes displaying the selection of evidence based framework	**Milestone 6: I-31.** Warm Handoffs **Metric 6. I-31.1** Measure baseline of the use of warm handoffs for adult inpatients being discharged to the community **Data Source:** MHMRA clinical records and HCPC records. Percent of people who received warm handoffs **Goal:** Measure baseline	**N/A**	**N/A**
Estimated Incentive Payment: $167,262.84	**Estimated Incentive Payment:$183,874.74**	**N/A**	**N/A**
Year 2 Estimated Outcome Amount: $501,788.53	**Year 3 Estimated Outcome Amount: $551,624.23**	**Year 4 Estimated Outcome Amount: $589,469.48**	**Year 5 Estimated Outcome Amount: $569,535.72**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $2,212,417.96			

REFERENCES

Boyer, C., McAlpine, D., Pottick, K., & Olfson, M. (2000). Identifying risk factors and key strategies in linkage to outpatient psychiatric care. *The American Journal of Psychiatry*, *157,* 1592-1598.

Chouinard, G. & Albright, P. (1997). Economic and health state utility determinations for schizophrenic patients treated with risperidone or haloperidol. *Journal of Clinical Psychopharmacology, 17,* 298-307.

Dixon, L., Goldberg, R., Lannone, V., Lucksted, A., Brown, C., Kreyenbuhl, J., & ... Potts, W. (2009). Use of a critical time intervention to promote continuity of care after psychiatric inpatient hospitalization. *Psychiatric Services*, *60,* 451-458.

Project Option 2.13 PROVIDE AN INTERVENTION FOR A TARGETED BEHAVIORAL HEALTH POPULATION TO PREVENT UNNECESSARY USE OF SERVICES IN A SPECIFIED SETTING: EXPAND CHRONIC CONSUMER STABILIZATION INITIATIVE

Unique RHP Project ID: 113180703.2.4/Pass 3

Performing Provider Name/TPI: MHMRA of Harris County / 113180703

Project Summary: Provider**:** The Mental Health and Mental Retardation Authority (MHMRA) of Harris County is a public agency serving as the safety net provider for adults with serious mental illnesses, for children and adolescents with serious emotional disorders, for the developmentally delayed and for individuals experiencing acute psychiatric distress. MHMRA provides inpatient, residential and outpatient treatments, including psycho-therapy, case management and medication management for individuals. MHMRA serves more than 49,000 Harris County residents out of a culturally and ethnically diverse population of over 4.1 million. Of those individuals who received any agency service in FY12, 36.5% were medically indigent and 51.9% had Medicaid. Of those who received psychiatric emergency services in FY12, such as those being proposed in this project, 59.3% were medically indigent and 28.7% had Medicaid.

Intervention(s): MHMRA plans to expand the Chronic Consumer Stabilization Initiative (CCSI), an interagency collaboration with the Houston Police Department (HPD). Staff members provide intensive case management and work directly with individuals, family members, health providers, and/or staff at living facilities. MHMRA provides family and community education about mental illness, outreach and engagement, intensive case management, Mental Health First Aide (an evidence-based mental health awareness program for community members), navigation to address physical health, housing and other social needs, crisis intervention and advocacy typically for several months, longer than other crisis diversion programs.

Need for the project: There are at least 70 more individuals that have been identified who meet the target population than can be served within the current capacity of the program.

Target population: The program will target individuals who have been diagnosed with a serious and persistent mental illness, have frequent admissions to emergency and crisis services, and have frequent encounters with HPD. It is anticipated that the program will provide services for about 60 patients.

Category 1 or 2 expected patient benefits: MHMRA will:

- Enroll 10 additional individuals yearly starting in DY 3 who chronically access PES services.
- Reduce emergency detention orders, law enforcement calls for service, arrests, and jail by 10% decrease from baseline by DY5
- Reduce PES/HCPC admissions by 10% decrease from baseline by DY5.

Category 3 outcomes: MHMRA expects to increase one domain of patient satisfaction (TBD) by 10% from baseline by DY5.

Project Option 2.13.1 Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specified setting: expand chronic consumer stabilization initiative

Unique RHP Project Identification Number: 113180703.2.4
Performing Provider Name/TPI: Mental Health and Mental Retardation Authority of Harris County/113180703

Project Description:
The Mental Health and Mental Retardation Authority (MHMRA) of Harris County proposes to provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specified setting by expanding a chronic consumer stabilization initiative.

The Mental Health and Mental Retardation Authority (MHMRA) of Harris County is a public agency serving as the safety net provider for adults with serious mental illnesses, for children and adolescents with serious emotional disorders, for the developmentally delayed and for individuals experiencing acute psychiatric distress. MHMRA serves more than 49,000 Harris County residents out of a culturally and ethnically diverse population of over 4.1 million. Of those who received mental health services in FY12, such as those being proposed in this project, 55% were medically indigent and 34.9% had Medicaid. MHMRA seeks to expand the Chronic Consumer Stabilization Initiative (CCSI), an interagency collaboration with the Houston Police Department (HPD). The purpose of this project is to improve behavioral health and reduce unnecessary use of emergency psychiatric services by identifying individuals who are frequent users of psychiatric emergency services (PES) and police.

Goals and Relationship to Regional Goals:

The primary goal of the program is to identify, engage and provide services to individuals who have been diagnosed with a serious and persistent mental illness, have frequent admissions to emergency and crisis services, and have frequent encounters with HPD either through their own initiative or by family and/or collateral contact. Staff members provide intensive case management and work directly with individuals, family members, health providers, and/or staff at living facilities. Familial and community education about mental illness is a key component. CCSI provides outreach and engagement, intensive case management, Mental Health First Aide (an evidence-based mental health awareness program for community members), navigation to address physical health, housing and other social needs, crisis intervention and advocacy. It is also important to note the length of stay for individuals open to CCSI is several months, compared to other crisis diversion services in the area.

The goal of this project is to avert outcomes such as potentially avoidable inpatient admission and readmissions 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. This can be done by providing community based interventions for individuals to prevent them from cycling through multiple systems, such as the criminal justice system; the general acute and specialty psychiatric inpatient system; and the mental health system. The five year goal of this project is to expand capacity in the program from 30 to 60 individuals and

reduce the number of law enforcement interactions, psychiatric crisis interventions, and psychiatric hospital admission for this cohort.

Challenges:

Challenges to implementation include motivating these individuals to accept and engage in care and to provide adequate education and information to family members and/or staff at their living facilities. These challenges will be addressed through intensive engagement activities, motivational interviewing, providing education, and collaborating with law enforcement to divert the participants away from intensive crisis services.

Starting Point/Baseline: CCSI is an existing MHMRA program that serves 30 individuals. The proposed project will expand the number of individuals served to 60.

Rationale:

There is a cohort of individuals within the region who have been identified by HPD as having multiple admissions to psychiatric emergency services involuntarily, brought in by law enforcement. MHMRA and Houston Police Department have collaborated in a project to provide specialized interventions for 30 of these individuals. However, at least 70 more individuals have been identified who meet the target population than can be served within the current capacity of the program.

Outcomes from the existing program reveal a significant reduction in criminal justice involvement, and psychiatric emergency care and hospitalizations. If this program averted only one PES service per patient per year, the savings would be more than $7,000 per patient ($700 per bed x 10.25 average length of stay in Harris County public psychiatric hospital). Because many of these individuals have multiple admissions per year, the savings would be considerably higher. For example, data from existing program revealed a 28% decrease in psychiatric emergency services and public psychiatric hospitalizations among existing CCSI consumers (MHMRA, 2010: Pilot Project Final Report). Additionally, all patients have a right to be served in the least restrictive environment possible. Lastly, the program has met with much success and has received recognition nationally, including nomination for Herman Goldstein Problem Oriented Policing award and an International Chiefs of Police Award.

Project Components:

a) Assess size, characteristics and needs of target population(s)
   - In progress. MHMRA and the Houston police department are continuously compiling a list of potential consumers who would benefit from the program. Demographic data, criminal justice involvement, and psychiatric emergency services are also gathered to better understand the needs of this population. MHMRA and HPD will continue to conduct this analysis as needed.

b) Review literature / experience with populations similar to target population.
   - To be completed. MHMRA will look to expert authorities and national resources, such as SAMHSA, prior to implementing specific treatment approaches or adopting specific manuals/materials.

c) Develop project evaluation plan using qualitative and quantitative metrics to determine outcomes.

- To be completed. MHMRA will develop a program evaluation that includes qualitative and quantitative metrics (e.g., pre/post assessment of program participants, use of psychiatric emergency services, jail bookings, patient satisfaction surveys, etc.)

d) Design models which include an appropriate range of community-based services and residential supports.
   - To be completed. MHMRA consumers often need assistance with transportation, housing, and medical needs. MHMRA clinicians can address these needs using existing psychoeducational material. Additionally, MHMRA has a residential step-down program that may be used by CCSI consumers if they need transitional housing post-hospitalization before returning to the community.

e) Assess the impact of interventions based on standardized quantitative measures and qualitative analysis relevant to the target population.
   - To be completed. MHMRA will work with the outcomes department to identify pre/post measures and patient satisfaction surveys that are empirically validated for individuals who are diagnosed with co-morbid conditions. See Category 3 Outcome for more details.

f) Community-based interventions should be comprehensive and multispecialty.
   - As mentioned above, this program is inherently multidisciplinary and uses resources provided both by the local mental health authority and the local police.

Milestones and Metrics:

The goals are consistent with the regional goals and community needs discussed above. Furthermore, the improvement metrics chosen for this project (I-10.1: % decrease in emergency detention orders, law enforcement calls for service, arrests, and jail, and I-X.1: % decrease from baseline in PES/HCPC) will determine the progress MHMRA is making to meet our stated goals. Both measure the success in reducing the use of jail services and ER services through the proposed program.

Relationship to other Projects: At this time there is not enough information available from the RHP to describe how this project may or may not be related to other RHP DSRIP proposals. However, the proposed project is similar to several MHMRA DSRIP proposals, including the expansion of the Crisis Residential Unit, and the Interim Care Clinic. All three proposals seek to expand psychiatric stabilization while reducing inpatient admissions and criminal justice involvement. It is hoped that many of the CCSI patients could access these less restrictive and more appropriate care levels in lieu of hospitalization, or civil commitment.

The behavioral health crisis in Region 3 is considerable and the proposed initiatives in our RHP plan will only imply a small impression into the overall community need for treatment, but is a good start. The outpatient focus of many RHP Plan initiatives will help numerous facilities focus to treating the patients in an ambulatory setting as well as continued navigation of services with a focus to keeping patients from the inpatient unit. This initiative is similar to many others in the sense of the category of behavioral health. The Region 3 Initiative Grid attached in the addendum will show the relationship to other programs.

Unique community need identification number the project addresses:

This project directly meets broad goals identified by the regional needs assessment. First, it improves on existing programs and infrastructure by adding a component of treatment to existing community mental health service array. Second, it increases access to specialty care services by providing treatment to individuals who otherwise, may not be able to afford this type of intervention. Finally, this program is inherently a patient-centered approach that moves away from the historical "disease" focused model of repeated hospitalizations. The proposed program will also complement the regional need to develop a culture of "best practices" whereby the patient/consumer plays a more active role as a stakeholder by completing consumer satisfaction surveys.

CCSI addresses the following community needs:

- CN3-Inadequate access to Behavioral Health
- CN6- Inadequate access to treatment and services designed for special needs populations, including disabled, homeless, children and elderly
- CN9- High rates of preventable hospital readmissions

Plan for Learning Collaborative:

MHMRA plans to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system.

Project Valuation:

In the effort to value the proposed project accurately, assistance was sought from H. Shelton Brown, Ph.D. of the UT Houston School of Public Health and Thomas Bohman, Ph.D. of the UT Austin Center for Social Work Research. Their consultation was limited to only the valuation section of this document. 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 literature reviewed one QALY that is highly relevant to this population. This 2012 study reported the QALY gains associated of assertive community treatment (ACT) compared to standard case management care in patients with schizophrenia (Karow, Reimer, König, Heider, Bock & Huber ...2012). ACT is highly similar to the proposed intervention in that it seeks to identify high utilizers of psychiatric emergency services and provide intensive case management to reduce psychiatric inpatient admissions and jail detentions. According to the Karow et al. study, the ACT intervention yielded a QALY of 0.76, whereas the treatment as usual group resulted in a QALY of 0.66; therefore, the incremental QALY for the ACT group was 0.10.

Applying this estimate to the current population the value of enhancing services for these underserved individuals from Level Four can be calculated as follows:

60	(persons served)
0.10	(QALY gained)
× $50,000	(life year value)
= $300,000	Level 4 QALY Value

Cost Savings: In addition to quality of life years adjusted, we obtained local data that supports the notion that ongoing treatment in the form of medication management and case management reduces hospital admissions. Specifically, individuals who are deemed "psychiatrically underserved" in Harris County require higher levels of public psychiatric hospital care. (Underserved means individuals received less services than their treatment plan and history indicates is necessary for recovery from mental illness.) In a sample of 6,275 consumers studied over seven years, underserved MHMRA consumers logged 0.819 additional hospital bed days per year. The increment in costs that could be averted with these interventions can be calculated as:

60	(persons served)
0.819	(psychiatric bed days gained)
× $700	(local bed day value)
= $ 34,398	Cost Savings

Summary and Total Valuation: This valuation analysis shows that the intervention will have a positive value for participants who receive the intervention(s).The expected value of this proposal is $334,398 ($300,000 and $34,398) per 60 people served per year. (If 100 people were served per year, the estimated savings would be $557,330). Additional cost savings in the form of diverted jail detentions is also expected.

113180703.2.4	*2.13.1*	*2.13.1a, 2.13.1b, 2.13.1c, 2.13.1d, 2.13.1e*	*Chronic consumer stabilization initiative*
Mental Health and Mental Retardation Authority of Harris County			*113180703*
Related Category 3 Measure(s):	*IT-6.1*	*Percent improvement over baseline of patient satisfaction scores*	

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1: P-2. Re-design treatment program to provide empirically based services to chronic Psychiatric Emergency Service (PES) and Criminal Justice (CJ) users **Metric 1:** P-2.1 Project plans will be based on empirically based treatment approaches such as those proffered by SAMHSA **Data Source:** Written plan	**Milestone 2:** P-3. Identify and enroll individuals who are chronic PES/CJ users **Metric 2:** P-3.1 Enroll 10 individuals who chronically access PES services (from baseline of 30, 40 people will be served) **Data Source:** Project documentation	**Milestone 5:** P-3. Enroll and serve individuals who are chronic PES/CJ users **Metric 5:** P-3.1 Enroll 10 more individuals who chronically access PES services (from baseline of 30, 50 people will be served) **Data Source:** Project documentation	**Milestone 8:** P-3. Enroll and serve individuals who are chronic PES/CJ users **Metric 8:** P-3.1 Enroll 10 more individuals who chronically access PES services (from baseline of 30, 60 people will be served) **Data Source:** Project documentation
Estimated Incentive Payment: $267,618.95	**Estimated Incentive Payment: $98,065.94**	**Estimated Incentive Payment: $104,793.94**	**Estimated Incentive Payment: $101,250.19**

113180703.2.4	*2.13.1*	*2.13.1a, 2.13.1b, 2.13.1c, 2.13.1d, 2.13.1e*	*Chronic consumer stabilization initiative*
Mental Health and Mental Retardation Authority of Harris County			*113180703*
Related Category 3 Measure(s):		*IT-6.1*	*Percent improvement over baseline of patient satisfaction scores*

Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
N/A	**Milestone 3**: I-10. Law Enforcement Interactions**Metric 3:** I-10.1Establish a baseline of CCSI consumers' emergency detention orders, law enforcement calls for service, arrests, and jail bookings/admission **Data Source:** Harris County Police Department Records, County Jail, and MHMRA records	**Milestone 6:** I-10. Law Enforcement Interactions **Metric 6:** I-10.1A 5% decrease from baseline in emergency detention orders, law enforcement calls for service, arrests, and jail bookings/admissiona. Numerator: Percent of individuals receiving CCSI who have emergency detention orders, law enforcement calls for service, arrests, and jail bookings/admission during measurement period.b. Denominator: The number of individuals receiving CCSI **Data Source:** Harris County Police Department Records, County Jail, and MHMRA record**s**	**Milestone 9:** I-10. Law Enforcement Interactions **Metric 9:** I-10.1A 10% decrease from baseline in emergency detention orders, law enforcement calls for service, arrests, and jail bookings/admission a. Numerator: Percent of individuals receiving CCSI who have emergency detention orders, law enforcement calls for service, arrests, and jail bookings/admission during measurement period.b. Denominator: The number of individuals receiving CCSI **Data Source:** Harris County Police Department Records, County Jail, and MHMRA records
N/A	**Estimated Incentive Payment: $98,065.94**	**Estimated Incentive Payment: $104,793.95**	**Estimated Incentive Payment: $101,250.19**

113180703.2.4	*2.13.1*	*2.13.1a, 2.13.1b, 2.13.1c, 2.13.1d, 2.13.1e*	*Chronic consumer stabilization initiative*
Mental Health and Mental Retardation Authority of Harris County			*113180703*
Related Category 3 Measure(s):	*IT-6.1*	*Percent improvement over baseline of patient satisfaction scores*	

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
N/A	**Milestone 4**: I-X. Psychiatric Emergency Service (PES) Readmissions and Inpatient Public Hospital Admissions **Metric 4**: I-X.1. Establish a baseline of CCSI consumers' PES/inpatient admissions. **Data Source**: PES records are part of the MHMRA electronic record. Harris County Psychiatric Center (HCPC) is the local public psychiatric inpatient unit which maintains separate records	**Milestone 7:** I-X. Psychiatric Emergency Service (PES) Readmissions and Inpatient Public Hospital Admissions **Metric 7:** I-X.1 A 5% decrease from baseline in PES/HCPC a. Numerator: Percent of patients receiving CCSI services admitted to PES/HCPC during measurement period. b. Denominator: The number of patients receiving CCSI services **Data Source**: MHMRA and HCPC records	**Milestone 10:** I-X. Psychiatric Emergency Service (PES) Readmissions and Inpatient Public Hospital Admissions **Metric 10:** I-X.1 A 10% decrease from baseline in PES/HCPC a. Numerator: Percent of patients receiving CCSI services admitted to PES/HCPC during measurement period. b. Denominator: The number of patients receiving CCSI services **Data Source:** MHMRA and HCPC records
N/A	**Estimated Incentive Payment: $98,065.95**	**Estimated Incentive Payment: $104,793.95**	**Estimated Incentive Payment: $101,250.19**
Year 2 Estimated Milestone Bundle Amount: $267,618.95	**Year 3 Estimated Milestone Bundle Amount: $294,197.83**	**Year 4 Estimated Milestone Bundle Amount: $314,381.84**	**Year 5 Estimated Milestone Bundle Amount: $303,750.57**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $1,179,949.19			

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Project Option 2.13 PROVIDE AN INTERVENTION FOR A TARGETED BEHAVIORAL HEALTH POPULATION TO PREVENT UNNECESSARY USE OF SERVICES IN A SPECIFIED SETTING: EXPANSION OF MOBILE CRISIS OUTREACH TEAM

Unique RHP Project ID: 113180703.2.5/Pass 3

Performing Provider Name/TPI: MHMRA of Harris County / 113180703

Project Summary:

Provider**:** The Mental Health and Mental Retardation Authority (MHMRA) of Harris County is a public agency serving as the safety net provider for adults with serious mental illnesses, for children and adolescents with serious emotional disorders, for the developmentally delayed and for individuals experiencing acute psychiatric distress. MHMRA provides inpatient, residential and outpatient treatments, including psycho-therapy, case management and medication management for individuals. MHMRA serves more than 49,000 Harris County residents out of a culturally and ethnically diverse population of over 4.1 million. Of those individuals who received any agency service in FY12, 36.5% were medically indigent and 51.9% had Medicaid. Of those who received psychiatric emergency services in FY12, such as those being proposed in this project, 59.3% were medically indigent and 28.7% had Medicaid.

Intervention(s): MHMRA proposes to expand the current Mobile Crisis Outreach Team (MCOT), which provides mobile crisis outreach and follow-up to adults and children who are unable or unwilling to access traditional psychiatric services. When a consumer initiates an MCOT intervention, two trained MCOT staff responds to the consumers' needs, meeting them in a variety of settings including in the consumer's community, home, or school and provide assessment, intervention, education, and linkage to other services to address identified needs.

Need for the project: MCOT has grown by more than 52% since inception in 2004, from 1,224 episodes of care to 1,861 episodes in 2011. The program reached its current peak capacity in 2010 after its most recent expansion in 2008. Over the past twelve years, MHMRA's psychiatric emergency services have nearly doubled, logging an 88% increase in the volume of service episodes from 12,899 in 2000 to 24,365 in 2011.

Target population: Individuals in need of mental health services. It is anticipated that the program will provide services for about 720 patients.

Category 1 or 2 expected patient benefits: MHMRA will:

- Provide 720 more initial interventions from baseline by DY5
- Increase percent of MCOT patients who follow up at MHMRA outpatient clinic within 30 days of discharge from MCOT by 10% from baseline by DY5.
- Reduce PES/HCPC admissions by 10% from baseline by DY5.

Category 3 outcomes: MHMRA expects to increase one domain of patient satisfaction (TBD) by 10% from baseline by DY5.

Project Option 2.13.1 Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specified setting: expansion of mobile crises unit

Unique RHP Project Identification Number: 113180703.2.5
Performing Provider Name/TPI: Mental Health and Mental Retardation Authority of Harris County/113180703

Project Description:
The Mental Health and Mental Retardation Authority (MHMRA) of Harris County proposes to provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specified setting by expansion of a mobile crises unit.

The Mental Health and Mental Retardation Authority (MHMRA) of Harris County is a public agency serving as the safety net provider for adults with serious mental illnesses, for children and adolescents with serious emotional disorders, for the developmentally delayed and for individuals experiencing acute psychiatric distress. MHMRA serves more than 49,000 Harris County residents out of a culturally and ethnically diverse population of over 4.1 million. Of those who received mental health services in FY12, such as those being proposed in this project, 55% were medically indigent and 34.9% had Medicaid.

MHMRA proposes to expand the current Mobile Crisis Outreach Team (MCOT), which provides mobile crisis outreach and follow-up to adults and children who are unable or unwilling to access traditional psychiatric services.

MCOT adopts a multidisciplinary approach to mental health treatment. When a consumer initiates an MCOT intervention, two trained MCOT staff respond to the consumers' needs. Teams may meet with the patient in a variety of settings including in the consumer's community, home, or school. MCOT provides assessment, intervention, education, and linkage to other services to address identified needs. For example, MCOT may facilitate a referral to a medical provider, nurse, outpatient psychiatric clinic, or inpatient psychiatric hospital. MCOT also provides nursing and medication management for consumers who are in need of this type of care. Additionally, the program may assist local medical emergency rooms that do not have a psychiatric presence by screening patients who may be in need of psychiatric emergency services.

MCOT provides case coordination services similar to MHMRA's Chronic Consumer Stabilization Initiative (CCSI); however, MCOT provides short-term (4-6 weeks) stabilization interventions to consumers in need, whereas the CCSI is a long-term program. MHMRA's Crisis Intervention Response Team (CIRT) is also a variation of mobile response, except that it provides only one initial crisis intervention by a team composed of a mental health professional and law enforcement officer and the CIRT team responds to police dispatch in an unmarked police car. CIRT interventions typically last several hours, compared to MCOT, which may last several weeks. It is also important to note that police officers are not part of the MCOT multidisciplinary team. There are times when a CIRT crisis response results in a referral to MCOT for follow-up and continued interventions.

Goals and Relationship to Regional Goals:

The primary goal of the program is to reduce preventable psychiatric hospital admissions among MCOT recipients. The second goal is to improve linkage to outpatient treatment. By

accomplishing these goals, cost savings will be accrued. Finally, we seek to provide high quality services as reflected by patient satisfaction surveys. Process goals have been identified to ensure the program is well designed and reflects best practices.

Challenges:

The challenges include identifying appropriate ongoing service providers for linkage. This challenge will be addressed through expansion of outpatient behavioral health services for individuals with severe psychiatric conditions.

Starting Point/Baseline:

The existing MCOT program provides clinical intervention to approximately 1400 unduplicated individuals per year. The proposed program will expand the number of cases from 1,400 to about 2,100 per year.

Rationale:

Mobile crisis services offer several advantages, including decreased psychiatric emergency services, decreased service costs, increased community treatment, increased patient autonomy, and decreased burden on the community to expand emergency services.

Mobile crisis services are well studied in the behavioral sciences literature. The most common outcome of mobile services is the reduction in preventable psychiatric hospitalizations. For example, Scott (2000) reported a 27% reduction in hospitalization rates, coupled with a 23% decrease in costs. Similarly, Hugo, Smout, and Bannister (2002) reported a 30% decrease in hospitalization rates when mobile crisis services were utilized. Our own program evaluation indicated MCOT interventions rarely result in inpatient admissions (e.g., less than 5% of service calls). The cost savings that result from preventable admissions is discussed below in the valuation section.

Mobile crisis services also seek to improve access to appropriate levels of treatment, such as linkage to community outpatient services. By engaging a consumer via mobile services, and successfully linking them to community treatment, our agency ensures the consumer is treated in the least restrictive environment possible. Again, MHMRA data indicates the longer a consumer is engaged in MCOT services (e.g., 3-4 weeks versus 1-2 weeks), the less likely the consumer is to return to the hospital immediately and the more likely the consumer is to access outpatient treatment.

Finally, Houston is a large city with a population of over 4.2 million. State and local data indicates an increased demand for mental health services. MHMRA data also supports this theory. For example, MCOT has grown by more than 52% since inception in 2004, from 1,224 episodes of care to 1,861 episodes in 2011. The program reached its current peak capacity in 2010 after its most recent expansion in 2008. Over the past twelve years, MHMRA's psychiatric emergency services have nearly doubled, logging an 88% increase in the volume of service episodes from 12,899 in 2000 to 24,365 in 2011. Further expansion is likely limited primarily by capacity.

Project Components:

In order to enhance the transition from inpatient to develop such a program, the following option and core components were chosen: 2.13.1, Design, implement, and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population. These components have also been imbedded in the program process and improvement milestones

(See milestone and metric chart for further details). The status of each component is noted, if that activity is currently underway:

a) Assess size, characteristics and needs of target population(s)
    - In progress. MHMRA is in the process of completing a needs assessment to determine the number of consumers who may benefit from this expansion and the treatment needs of these consumers.
b) Review literature / experience with populations similar to target population.
    - To be completed. MHMRA will look to expert authorities and national resources, such as SAMHSA, prior to implementing specific treatment approaches or adopting specific manuals/materials.
c) Develop project evaluation plan using qualitative and quantitative metrics to determine outcomes.
    - To be completed. MHMRA will develop a program evaluation that includes qualitative and quantitative metrics (e.g., pre/post assessment of program participants, use of psychiatric emergency services, jail bookings, patient satisfaction surveys, etc.)
d) Design models which include an appropriate range of community-based services and residential supports.
    - In progress. MHMRA consumers often need assistance with transportation, housing, and medical needs. MHMRA clinicians currently address these needs using existing psychoeducational material. Additionally, MHMRA has a residential program that may be used by consumers if they need transitional housing.
e) Assess the impact of interventions based on standardized quantitative measures and qualitative analysis relevant to the target population.
    - To be completed. MHMRA will work with the outcomes department to identify pre/post measures and patient satisfaction surveys that are empirically validated for individuals who are diagnosed with co-morbid conditions. See Category 3 Outcome for more details.
f) Community-based interventions should be comprehensive and multispecialty.
    - As mentioned above, this program is inherently multidisciplinary.

Unique community need identification number the project addresses:

This project directly meets broad goals identified by the regional needs assessment. First, it improves on existing programs and infrastructure by filling a void that is unmet by existing psychiatric outpatient clinics and psychiatric emergency services. Second, it increases access to specialty care services by providing mobile treatment. The program also offers a preventative, patient-centered approach that provides short-term mental health treatment to those in urgent need. The proposed program will also complement the regional need to develop a culture of "best practices" whereby the patient plays a more active role as a stakeholder by completing patient satisfaction surveys.

The MCOT Expansion will address the following community needs: CN2-Insuffcient Access to Behavioral Health; CN5- Integrated Care for Behavioral Health; CN12- Improved Access to Patient Education; and CN14-Reduction of ER Services.

Relationship to other Projects: At this time there is not enough information available from the RHP to describe how this project may or may not be related to other RHP DSRIP proposals. However, the proposed project complements several MHMRA DSRIP proposals, including the expansion of the Crisis Residential Unit and expansion of the Chronic Consumer Stabilization Initiative. All three proposals seek to expand psychiatric stabilization while reducing inpatient admissions.

Numerous community needs assessments reflect an extreme need for behavioral health services to include outpatient treatment centers, crisis stabilization units, inpatient beds, and much more. The lack of funding as well as complexity of the regions patient base has limited the amount of behavioral health treatments available to our region and continues to drive cost in emergent and inpatient situations. The Crisis Stabilization Unit has a direct correlation to all behavioral health programs recommended in the RHP plan and will be a focus of two of the largest Local Mental Health Authorities of our region. Both CSU's share the outcome measures of mental health admissions & readmissions, and improvement of patient satisfaction scores. The Region 3 Initiative Grid attached in the addendum reflects the direct relationships of this initiative.

The specific community needs that the proposed program addresses include:

- CN3-Inadequate access to Behavioral Health
- CN6- Inadequate access to treatment and services designed for special needs populations, including disabled, homeless, children and elderly
- CN9- High rates of preventable hospital readmissions

Plan for Learning Collaborative: We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system.

Project Valuation:

In the effort to value the proposed project accurately, assistance was sought from H. Shelton Brown, Ph.D. of the UT Houston School of Public Health and Thomas Bohman, Ph.D. of the UT Austin Center for Social Work Research. Their consultation was limited to only the valuation section of this document. 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.

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 intervention is cost effective. The number of life-years added is based on a review of the scientific literature.

Cost-Utility Analysis: After an exhaustive review of the literature, no studies were located that contained a QALY for mobile crisis services; therefore the valuation proposed is limited to cost savings studies.

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. We did identify a benefit-cost study that is related.

As previously discussed, Scott (2000) showed that people with mental illness using mobile crisis services avoided hospitalizations in 55% of the cases in Alabama compared those who received police intervention (28%) resulting in a net reduction of 27% in hospitalization. Additionally, MCOT services were 23% less costly per person ($2,295, 2012 US Dollars) compared to those served by the police department ($2,964). These costs include both program costs and hospitalization costs. Similar results were found in a study that compared mobile crisis assessment to emergency room assessment (Hugo, Smout & Bannister 2002). Their study showed that the 298 individuals receiving MCOT were 30% less likely to be admitted to a psychiatric inpatient unit compared to individuals served within an emergency room, regardless of their clinical characteristics.

The average reduction in hospitalization rate between these two studies is 28.5% (27+30/2). It is important to note the average cost of inpatient hospitalization in the Harris County Hospital District is $700 per day, with an average length of stay of 10.25 days (SD=7.23, N=33,680).

100	(People served)
.285	(Reduction in inpatient admissions, or 28.5%)
$700	(Average cost per hospital day)
x 10.25	(Average psychiatric hospital length of stay)
= $204,487.50	**Total Valuation**

Additional Costs: Hickey, Strang & Cantu (2012) reported that MHMRA of Harris County adult outpatient care reduced the annual percentage of individuals booked into the County Jail by 5% during an average 1.33 year treatment episode when compared to the rate in the year prior to admission to outpatient services. An average length of incarceration for mentally ill offenders in the County Jail is 40.73 days (Nguyen, Hickey & Farenthold, 2005). At a cost of $130/day for individuals receiving mental health care inside the jail, the cost savings can be estimated as (5% reduction x 40.73 days x $130/day x 100 served) $264,949 per 100 served.

Valuation: This valuation analysis shows that the intervention will have a positive value for participants who receive the intervention(s). All valuations used 100 individuals that would receive all components of the program. Assuming a reduction of 28.5% in hospitalization rates, an average length of stay of 10.25 days, and $700 per day, the total valuation is estimated at nearly $205,000 per 100 individuals served. With the addition of jail avoidance costs ($264,949) the **total valuation would be $469,949 per 100 served**. Since the project aims to serve 720 patients, the total valuation ($469,949 X 720/100) is $3,383,632.80.

113180703.2.5	*2.13.1*	*2.13.1: .1a, .1b, .1c, .1d, 1e*	*Mobile crises outreach team expansion*
Mental Health and Mental Retardation Authority of Harris County			*113180703*
Related Category 3 Measure(s):	*IT-6.1*		*Percent improvement over baseline of patient satisfaction scores*

Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Milestone 1: P-2. Re-design MCOT treatment program to provide empirically based services **Metric 1:** P-2.1. Project plans will be based on empirically supported treatment approaches such as those proffered by SAMHSA **Data Source:** Written plan	**Milestone 2:** P-3. Enroll and serve individuals with targeted complex needs (e.g., a diagnosis of severe mental illness who are unable or unwilling to access emergency and routine psychiatric care.) **Metric 2:** P-3.1. Number of intakes/initial services completed by MCOT **Data Source:** Project documentation **Goal:** Provide 200 more initial interventions from baseline	**Milestone 6:** P-3. Enroll and serve individuals with targeted complex needs (e.g., a diagnosis of severe mental illness who are unable or unwilling to access emergency and routine psychiatric care.) **Milestone 6: P-3.1.** Number of intakes/initial services completed by MCOT **Data Source:** Project documentation **Goal:** Provide 450 more initial interventions from baseline (250 increase from YR3)	**Milestone 9:** P-3. Enroll and serve individuals with targeted complex needs (e.g., a diagnosis of severe mental illness who are unable or unwilling to access emergency and routine psychiatric care.) **Metric 9:** P-3.1. Number of intakes/initial services completed by MCOT **Data Source:** Project documentation **Goal:** Provide 720 more initial interventions from baseline (270 increase from YR 4)
Incentive Payment:$2,707,923.66	**Incentive Payment $744,216.04**	**Incentive Payment: $1,060,365.89**	**Incentive Payment: $1,024,508.11**

113180703.2.5	***2.13.1***	***2.13.1: .1a, .1b, .1c, .1d, 1e***	***Mobile crises outreach team expansion***
Mental Health and Mental Retardation Authority of Harris County			*113180703*
Related Category 3 Measure(s):	*IT-6.1*		*Percent improvement over baseline of patient satisfaction scores*

Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
N/A	**Milestone 3**: I-X. Psychiatric Emergency Service (PES) Admissions and Inpatient Psych. Admissions **Metric 3**: I-X.1. Establish a baseline of MCOT consumers' inpatient admissions. **Data Source**: Psychiatric Emergency Services (PES) records are part of the MHMRA electronic record. Harris County Psychiatric Center (HCPC) is the local public psychiatric inpatient unit which maintains separate records	**Milestone 7:** I-X. Psychiatric Emergency Service (PES) Admissions and Inpatient Psych. Admissions **Metric 7:** I-X.1. A 5% decrease from baseline in PES/HCPC admissionsa. Numerator: Percent of patients receiving MCOT services admitted to PES/HCPC during measurement period. b. Denominator: The number of patients receiving MCOT services **Data Source**: MHMRA and HCPC records	**Milestone 10:** I-X. Psychiatric Emergency Service (PES) Admissions and Inpatient Psych. Admissions **Metric 10:** I-X.1.A 10% decrease from baseline in PES/HCPC admissionsa. Numerator: Percent of patients receiving MCOT services admitted to PES/HCPC during measurement period. b. Denominator: The number of patients receiving MCOT services **Data Source:** MHMRA and HCPC records
N/A	**Incentive Payment $744,216.04**	**Incentive Payment: $1,060,365.90**	**Incentive Payment: $1,024,508.11**

113180703.2.5	*2.13.1*	*2.13.1: .1a, .1b, .1c, .1d, 1e*	*Mobile crises outreach team expansion*
Mental Health and Mental Retardation Authority of Harris County			*113180703*
Related Category 3 Measure(s):	*IT-6.1*		*Percent improvement over baseline of patient satisfaction scores*

Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
N/A	**Milestone 4**: I-X. Follow Up with mental health treatment **Metric 4**: I-X.1. Establish a baseline of MCOT consumers' follow/up with outpatient mental health treatment within 30 days of discharge from MCOT **Data Source**: MHMRA electronic record and MCOT program data	**Milestone 8:** I-X. Follow Up with mental health treatment **Metric 8:** I-X.1. 5% increase from baseline a. Numerator: Percent of MCOT patients who follow up at MHMRA outpatient clinic within 30 days of discharge from MCOTb. Denominator: The number of patients receiving MCOT services **Data Source**: MHMRA/MCOT data	**Milestone 11:** I-X. Follow Up with mental health treatment **Metric 11:** I-X.1. A 10% increase from baseline a. Numerator: Percent of MCOT patients who follow up at MHMRA outpatient clinic within 30 days of discharge from MCOTb. Denominator: The number of patients receiving MCOT services **Data Source**: MHMRA/MCOT data
N/A	**Incentive Payment $744,216.04**	**Incentive Payment: $1,060,365.90**	**Incentive Payment: $1,024,508.11**
N/A	**Milestone 5: P-4.** Hire and train staff to implement MCOT expansion. **Metric 5: P-4.1.** 100% staff hired and trained by end of YR3 **Data Source:** Human Resource records	**N/A**	**N/A**
N/A	**Incentive Payment $744,216.04**	**N/A**	**N/A**
Year 2 Estimated Milestone Bundle Amount: $2,707,923.66	**Year 3 Estimated Milestone Bundle Amount: $2,976,864.16**	**Year 4 Estimated Milestone Bundle Amount: $3,181,097.69**	**Year 5 Estimated Milestone Bundle Amount:$3,073,524.33**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $11,939,409.84			

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Hugo, M., Smout, M. & Bannister, J. (2002). A comparison in hospitalization rates between a community-based mobile emergency service and a hospital-based emergency service. *Australian & New Zealand Journal of Psychiatry, 36*, 504-508.

Hickey, S., Strang, S., & Cantu, A. (2012). *Psychiatric emergency service use among MHMRA of Harris County consumers.* Presentation to the Board of Directors at MHMRA, Houston, Texas.

Project Option 2.13 PROVIDE AN INTERVENTION FOR A TARGETED BEHAVIORAL HEALTH POPULATION TO PREVENT UNNECESSARY USE OF SERVICES IN A SPECIFIED SETTING: Transitional Residential Treatment Post-Incarceration

Unique RHP Project ID: 113180703.2.6/Pass 3

Performing Provider Name/TPI: MHMRA of Harris County / 113180703

Project Summary:

Provider**:** The Mental Health and Mental Retardation Authority (MHMRA) of Harris County is a public agency serving as the safety net provider for adults with serious mental illnesses, for children and adolescents with serious emotional disorders, for the developmentally delayed and for individuals experiencing acute psychiatric distress. MHMRA provides inpatient, residential and outpatient treatments, including psycho-therapy, case management and medication management for individuals. MHMRA serves more than 49,000 Harris County residents out of a culturally and ethnically diverse population of over 4.1 million. Of those individuals who received any agency service in FY12, 36.5% were medically indigent and 51.9% had Medicaid. Of those who received psychiatric emergency services in FY12, such as those being proposed in this project, 59.3% were medically indigent and 28.7% had Medicaid.

Intervention(s): MHMRA proposes a 25-bed residential facility to provide supportive housing to individuals who are at risk for mental health crisis due to recent release from Harris County Jail. This program would provide transitional services for up to 60 days with the goal of linking clients with outpatient psychiatric treatment, medical services, and social security benefits or employment through the Department of Assistive and Rehabilitative Services (DARS). Peer supporters will offer counseling, peer led groups, assistance in resource identification, coping skills enhancement, substance abuse and mental health treatment and models of behavioral change.

Need for the project: Currently there are no programs that provide temporary housing for recent inmates while they are attempting to re-enter society. Such a program is needed due to the significant overlap between crime and mental health issues. Even individuals without a history of mental health issues may enter a crisis upon their release when there are no supports.

Target population: Individuals who are at risk for mental health crisis due to recent release from Harris County Jail. It is anticipated the program will provide service for about 200 patients.

Category 1 or 2 expected patient benefits: MHMRA will

- Enroll and serve 200 patients by DY5
- Reduce readmission rate to criminal justice system by 10% by DY 5 and
- Reduce readmission rate to psychiatric emergency services by 10% by DY 5

Category 3 outcomes: MHMRA expects to increase one domain of patient satisfaction (TBD) by 10% from baseline by DY5.

Project Option 2.13 Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specific setting: transitional residential treatment post-Incarceration

Unique RHP Project Identification Number: 113180703.2.6
Performing Provider Name/TPI: Mental Health and Mental Retardation Authority of Harris County/113180703

Project Description:
The Mental Health and Mental Retardation Authority (MHMRA) of Harris County proposes to provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specific setting: transitional residential treatment post-Incarceration.

The Mental Health and Mental Retardation Authority (MHMRA) of Harris County is a public agency serving as the safety net provider for adults with serious mental illnesses, for children and adolescents with serious emotional disorders, for the developmentally delayed and for individuals experiencing acute psychiatric distress. MHMRA serves more than 49,000 Harris County residents out of a culturally and ethnically diverse population of over 4.1 million. Of those who received mental health services in FY12, such as those being proposed in this project, 55% were medically indigent and 34.9% had Medicaid.

MHMRA proposes a 25-bed residential facility to provide supportive housing to individuals who are at risk for mental health crisis due to recent release from Harris County Jail. These individuals are at heightened risk for destabilization subsequent to poor supports in the community. They often have difficulty accessing mental health treatment, medical interventions, and secure housing. This program would provide transitional services for up to 60 days with the goal of linking clients with outpatient psychiatric treatment, medical services, and social security benefits or employment through the Department of Assistive and Rehabilitative Services (DARS). Peer support is an essential element of the program; peers will co-lead 2 – 3 groups per day to enhance coping skills, identify resources and model behavioral changes that will improve efficacy in community interactions. Integrated interventions aimed at reducing substance abuse and symptoms of mental disorder will be offered for residents with these co-morbid conditions (estimated at 30-50% of the population).

Goals and Relationship to Regional Goals:
The five year goal is to establish a transitional housing program tailored to meet the needs formerly incarcerated individuals. The program seeks to serve 150 clients per year by providing cognitive behavioral therapy and psycho-education (e.g., symptom management, problem solving and coping skills, and after-care). The milestones we selected are to reduce unnecessary inpatient hospitalizations, reduce criminal recidivism, and provide transitional housing and community mental health treatment.

Challenges:
One of the biggest challenges is the stigma related to offering high quality services to former inmates. Although offenders have technically paid their debt to society (e.g., via incarceration), there are many barriers to obtaining adequate employment, support services and

education in order to regain a viable status within society. Because of frequent recidivism and public safety concerns, this population is an unpopular one to provide advocacy. We plan to address this challenge by meeting regularly with stakeholders and other performing partners and by providing education about the needs of this population and the societal benefits of addressing these needs.

Starting Point/Baseline:

Currently there are no supportive psychiatric housing programs for post-incarceration in the Houston area.

Rationale: Research indicates half of all prison and jail inmates have a mental health problem (James & Glaze, 2006). The percent of mental illness varies depending on the setting. For example, 56% of state prisoners, 45% of federal prisoners, and 64% of jail inmates are reported to have a diagnosed mental illness. The findings in this report were based on data from personal interviews with state and federal prisoners in 2004 and jail inmates in 2002. Whether an individual has a pre-existing mental illness or not, the psychosocial stress related to incarceration and re-entry without support are sufficient to lead to mental health crises.

In addition to mental health issues, this population commonly experiences other barriers to re-entry such as substance abuse, physical health problems, homelessness and employability. Between 20% and 38% of those with infectious diseases, such as HIV and tuberculosis, have been in the prison system and will need ongoing medical treatment upon release (Travis, Solomon & Waul, 2001).

According to Travis et al., (2001) prison health systems are significant providers of health and behavioral health services to a largely indigent population. Travis and colleagues also noted that individuals who are gainfully employed, and are paid adequately are less likely to commit future crimes and be incarcerated than those who are not employed. By providing supportive housing, mental health and substance abuse treatment, employment training and linkage to other needed services, those being released from jails and prisons may be able to reduce their recidivism and become more stable, productive members of society.

Project Components:

In order to develop the program described above, the following option and core components were chosen: 2.13.1, Design, implement, and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population. These components have also been imbedded in the program process and improvement milestones (See milestone and metric chart for further details).

A. MHMRA will assess size, characteristics and needs of the post-incarcerated population through collaborations with local agencies.
B. MHMRA will 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, forensic encounters, or incarceration, while improving 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.

Unique community need identification number the project addresses:

This project directly meets broad goals identified by the regional needs assessment. First, it improves on existing programs and infrastructure by filling a void that is unmet by existing psychiatric outpatient clinics and psychiatric emergency services. Second, it increases access to specialty care services by providing these services to a disenfranchised population. The program also offers a preventative, patient-centered approach that provides short-term mental health treatment to those without other resources. By providing such services the community problem of increased demand on criminal justice system will be addressed. The proposed program will also complement the regional need to develop a culture of "best practices" whereby the patient plays a more active role as a stakeholder by completing patient satisfaction surveys.
The proposed program will address the following community needs:

- CN2-Insuffcient Access to Behavioral HealthCN3-Inadequate access to Behavioral Health
- CN6- Inadequate access to treatment and services designed for special needs populations, including disabled, homeless, children and elderly
- CN9- High rates of preventable hospital readmissions
- CN18- Insufficient access to integrated care programs for behavioral health and physical health conditions

Relationship to other Projects: The proposed project complements several MHMRA DSRIP proposals, including the expansion of the Crisis Residential Unit and expansion of the Chronic Consumer Stabilization Initiative. All three proposals seek to expand psychiatric stabilization while reducing inpatient admissions.

The behavioral health crisis in Region 3 is considerable and the proposed initiatives in our RHP plan will only imply a small impression into the overall community need for treatment, but is a good start. The outpatient focus of many RHP Plan initiatives will help numerous facilities focus to treating the patients in an ambulatory setting as well as continued navigation of services with a focus to keeping patients from the inpatient unit. This initiative is similar to many others in the sense of the category of behavioral health. The Region 3 Initiative Grid attached in the addendum will show the relationship to other programs.

Plan for Learning Collaborative: We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other performing providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our region's healthcare system.

Project Valuation:

In the effort to value the proposed project accurately, assistance was sought from H. Shelton Brown, Ph.D. of the UT Houston School of Public Health and Thomas Bohman, Ph.D.

of the UT Austin Center for Social Work Research. Their consultation was limited to only the valuation section of this document. 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: Although no direct studies of this type were found, a study related to housing for persons living with HIV seemed relevant. A cost-utility analysis by Holtgrave and colleagues (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-per-QALY gained. They estimated that the cost-per-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.

For this valuation we focus on housing assistance. Assuming our 100 participants who each participate in crisis residential program, the total value gained from this component would be:

100	(persons served)
0.0324	(QALY gained)
× $50,000	(life year value)
= $162,000	**QALY Value**

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. We identified several related cost-benefit studies.

Crisis Residential Treatment: Research indicates crisis residential units are more cost effective than inpatient hospitals; in 2002, Fenton and team found the mean cost of an acute

treatment episode was 44% lower per treatment in a residential crisis program as compared to treatment at a general hospital. They found an average savings of $17,504 (2012 US dollars) per acute care episode per year (treated in residential crisis program rather than a general hospital). Sledge and colleagues (1996) found similar results; they reported that when patients were randomly assigned to crisis respite care rather than hospitalization, respite care costs were $13,585 (2012 US dollars) lower per year. **The average cost savings between these two studies was $15,544.**

A study conducted by Adams and El-Mallakh (2009) investigated crisis stabilization services in Kentucky. The authors determined the cost for one day of care of crisis stabilization was $195 (in 2012 US dollars), while the cost for a day at the state hospital was $488 (in 2012 US dollars) – a savings of $293 per day. Although the Adams and El-Mallakh (2009) study is relevant, the study design did not randomize the patients; therefore it was not used to value this project.

Based on average savings of $15,544 per acute care episode per year (treated in residential crisis program rather than a general hospital):

100	(persons served)
× $15,544	(savings per acute care episode)
= $1,554,400	**Cost Savings**

Dual Disorder (Substance Abuse and Residential) Treatment: French, Salomé & Carney, et al. (2002b) estimated the costs and benefits of residential addiction treatment at five programs in the State of Washington that serve publicly funded clients. They reported an average (per client) total economic benefit was $58,868 (2012 US Dollars) over one year, leading to estimates of $45,314 for average net benefit and 4.34 for the benefit–cost ratio.

The benefits and costs associated with mutual-help community-based recovery homes were reported by Lo Sasso, Byro, Jason, Ferrari and Olson (2012). They noted that the intervention compared quite favorably to usual care: the net benefit was estimated to be between $9,450 and $15,370 (2012 US Dollars) per person per year on average, depending on the method employed.

In a study with a more comparable target sample, French and colleagues examined the effectiveness of a therapeutic community for homeless mentally ill chemically dependent consumers (French, McCollister, Sacks, McKendrick & De Leon, 2002a). Among this homeless, mentally ill sample the incremental economic benefit estimate was $163,708 (2012 US Dollars), net benefit was $132,148, and the benefit–cost ratio was 5.2.

Community residential treatment for those with dual (mental health and substance abuse) disorders has been observed to reduce subsequent heath care costs by half, a value or $13,288 per treated individual when compared to hospital care (Timko, Shuo, Sempel & Barnett, 2006).

An average across the four relevant studies yields an estimated annual savings per treated person of $33,341. Since the residential substance abuse treatment cannot clearly be identified as a unique contributor to positive outcome above and beyond the crisis residential treatment component, its value is offered as indication of probable additional benefit but this value will not be added to the overall valuation.

Additional Cost Savings: Buck, Brown & Hickey (2011) reported on a less intensive intervention with just-released mentally ill jail offenders in Harris County. Results indicate that those who were linked to services after their release had arrest rates that were 36% lower one year after contact with the program compared with the number of arrests one year before contact with the program. Also, the average number of days spent in jail decreased by 23, from 65 to 42 days during the year after contact with the program. Total annual criminal charges (misdemeanors and felonies) for each participant had also been reduced by 56% during the year after contact with the program.

Using the Buck et al., (2011) data and an estimated 23 day reduction in incarceration, we can calculate an estimated savings of $2,990 per treated individual, since the cost of a jail day for an individual with mental disorders is locally estimated at $130 (Harris County Office of Budget Management, personal communication). Summed across 100 patients the savings is $299,000.

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 expected value of benefits, based on the average of the Fenton article and the Sledge et al. article, is $1,554,400. The Fenton et al., (2002) study's QALY-based estimate was $162,000. Jail avoidance would contribute an additional $299,000. The total valuation is $2,015,400. In addition, other studies have shown this program will likely result in additional cost-savings. Since the program is projected to serve 200 patients, **the total value will be ($2,015,400 x 2 x 100) $4,030,800 per year.**

113180703.2.6	***2.13.1***	***2.13.1: .1a, .1b, .1c, .1d, .1e***	***Transitional residential treatment post-carceration***
Mental Health and Mental Retardation Authority of Harris County			*113180703*
Related Category 3 Measure(s):	*IT-6.1*		*Percent improvement over baseline of patient satisfaction scores*
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1: P-1. Conduct needs assessment **Metric 1:** P-1.1. Numbers of individuals, demographics, location, diagnoses, housing status, natural supports, functional issues, criminal justice and psychiatric needs **Data Source:** Project documentation; criminal justice records; public psychiatric facility records; survey of stakeholders (inpatient providers, mental health providers, social services and forensics)	**Milestone 2:** P-2. Design community-based specialized interventions for post-incarceration **Metric 2:** P-2.1. Project plans will be based on empirically based treatment approaches such as those proffered by SAMHSA **Data source:** Written plan **Goal:** complete project plan	**Milestone 5**: P-3. Enroll and Serve individuals **Metric 2**: P-3.1. Number of targeted individuals enrolled **Data source**: Project reports **Goal**: Enroll and serve 100 patients	**Milestone 8**: P-3. Enroll and Serve individuals **Metric 8**: P-3.1. Number of targeted individuals enrolled **Data source**: Project reports **Goal**: Enroll and serve 100 patients (100 new patients from YR4)
Estimated Incentive Payment $3,225,852.01	**Estimated Incentive Payment: $1,182,077.05**	**Estimated Incentive Payment: $1,263,175.73**	**Estimated Incentive Payment: $1,220,459.64**

113180703.2.6	***2.13.1***	***2.13.1: .1a, .1b, .1c, .1d, .1e***	***Transitional residential treatment post-carceration***
Mental Health and Mental Retardation Authority of Harris County			*113180703*
Related Category 3 Measure(s):	*IT-6.1*	*Percent improvement over baseline of patient satisfaction scores*	
Year 2 (10/1/2012 – 9/30/2013)	**Year 3** (10/1/2013 – 9/30/2014)	**Year 4** (10/1/2014 – 9/30/2015)	**Year 5** (10/1/2015 – 9/30/2016)
N/A	**Milestone 3**: I-1. Criminal Justice Admissions/Readmissions**Metric 3**: I-1.1. X% decrease in preventable admissions and readmissions into CriminalJustice Systema. Numerator: The percentage of individuals receiving specializedinterventions that had a potentially preventable admission/readmissionto a criminal justice setting b. Denominator: The number of individuals receiving specializedinterventions. **Data Source**: County jail records **Goal**: Establish baseline	**Milestone 6**: I-1: Criminal Justice Admissions/Readmissions**Metric 6**: I-1.1. : X% decrease in preventable admissions and readmissions into CriminalJustice System; **Data Source**: County jail records **Goal**: Reduce readmission rate by 5%	**Milestone 9**: I-1: Criminal Justice Admissions/Readmissions**Metric 9**: I-1.1. : X% decrease in preventable admissions and readmissions into CriminalJustice System; **Data Source**: County jail records **Goal**: Reduce readmission rate by 10%
N/A	**Estimated Incentive Payment: $1,182,077.05**	**Estimated Incentive Payment: $1,263,175.74**	**Estimated Incentive Payment: $1,220,459.65**

113180703.2.6	***2.13.1***	***2.13.1: .1a, .1b, .1c, .1d, .1e***	***Transitional residential treatment post-carceration***
Mental Health and Mental Retardation Authority of Harris County			*113180703*
Related Category 3 Measure(s):	*IT-6.1*		*Percent improvement over baseline of patient satisfaction scores*
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
N/A	**Milestone 4**: I-X. Psychiatric Emergency Service (PES) Readmissions and Inpatient Public Hospital Admissions **Metric 4:** I-X.1. % decrease from baseline in PES/HCPC a. Numerator: Percent of patients receiving services admitted to PES/HCPC during measurement period. b. Denominator: The number of patients receiving services **Data Source**: MHMRA and HCPC records **Goal:** Establish baseline	**Milestone 7:** I-X. Psychiatric Emergency Service (PES) Readmissions and Inpatient Public Hospital Admissions **Metric 7:** I-X.1. % decrease from baseline in PES/HCPC **Data Source**: MHMRA and HCPC records **Goal**: Reduce readmission rate by 5% from baseline	**Milestone 10:** I-X. Psychiatric Emergency Service (PES) Readmissions and Inpatient Public Hospital Admissions **Metric 10:** I-X.1. % decrease from baseline in PES/HCPC **Data Source:** MHMRA and HCPC records **Goal**: Reduce readmission by 10% from baseline
N/A	**Estimated Incentive Payment: $1,182,077.05**	**Estimated Incentive Payment: $1,263,175.74**	**Estimated Incentive Payment: $1,220,459.65**
Year 2 Estimated Milestone Bundle Amount: $3,225,852.01	**Year 3 Estimated Milestone Bundle Amount: $3,546,231.15**	**Year 4 Estimated Milestone Bundle Amount: $3,789,527.21**	**Year 5 Estimated Milestone Bundle Amount: $3,661,378.94**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $14,222,989.31			

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Project Option 2.13 PROVIDE AN INTERVENTION FOR A TARGETED BEHAVIORAL HEALTH POPULATION TO PREVENT UNNECESSARY USE OF SERVICES IN A SPECIFIED SETTING: CRISIS INTERVENTION RESPONSE TEAM (CIRT)

Unique RHP Project ID: 113180703.2.7/Pass 3

Performing Provider Name/TPI: MHMRA of Harris County / 113180703

Project Summary:

Provider: The Mental Health and Mental Retardation Authority (MHMRA) of Harris County is a public agency serving as the safety net provider for adults with serious mental illnesses, for children and adolescents with serious emotional disorders, for the developmentally delayed and for individuals experiencing acute psychiatric distress. MHMRA provides inpatient, residential and outpatient treatments, including psycho-therapy, case management and medication management for individuals. MHMRA serves more than 49,000 Harris County residents out of a culturally and ethnically diverse population of over 4.1 million. Of those individuals who received any agency service in FY12, 36.5% were medically indigent and 51.9% had Medicaid. Of those who received psychiatric emergency services in FY12, such as those being proposed in this project, 59.3% were medically indigent and 28.7% had Medicaid.

Intervention(s): We propose an expansion of three additional teams of the Crisis Intervention Response Team (CIRT), which is a program that partners law enforcement officers who are certified in crisis intervention training with licensed master-level clinicians to respond to law enforcement calls. Together, these teams respond to calls involving with individuals in serious mental health crises. Additionally, the team responds to SWAT team calls and conducts follow-up investigations on individuals when indicated.

Need for the project: it is the only program that partners directly with law enforcement agencies. CIRT also plays a critical role in addressing unmet needs in a population with a high base rate of mental illness—those who interface with criminal justice agencies. It is also important to note that many of these individuals do not require detention and may be treated effectively in the community. Furthermore, detention may be traumatizing for the patient, making him/her less likely to interface with treatment professionals in the future. Thus, CIRT plays a vital role in de-escalating conflict, providing mental health assessment, and decreasing unnecessary arrests.

Target population: Individuals in crisis and require law enforcement intervention. It is anticipated the program will provide service for about 1005 patients.

Category 1 or 2 expected patient benefits: MHMRA will:

- Respond to 15% more CIRT calls than baseline by DY5.
- Increase the percent of CIRT cases that result in resolution on-site by % to be determined.

Category 3 outcomes: MHMRA expects to decrease mental health admissions and readmissions to criminal justice settings by 10% from baseline by DY5.

Project Option 2.13 Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specified setting: crises intervention response team (CIRT)

Unique RHP Project Identification Number: 113180703.2.7
Performing Provider name/TPI: Mental Health and Mental Retardation Authority of Harris County/113180703

Project Description:
The Mental Health and Mental Retardation Authority (MHMRA) of Harris County proposes to provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specified setting by expansion of a crises intervention response team.

The Mental Health and Mental Retardation Authority (MHMRA) of Harris County is a public agency serving as the safety net provider for adults with serious mental illnesses, for children and adolescents with serious emotional disorders, for the developmentally delayed and for individuals experiencing acute psychiatric distress. MHMRA serves more than 49,000 Harris County residents out of a culturally and ethnically diverse population of over 4.1 million. Of those who received mental health services in FY12, such as those being proposed in this project, 55% were medically indigent and 34.9% had Medicaid. In an effort to provide needed services to the most critically ill population, MHMRA proposes to increase outpatient capacity by approximately 500 individuals potentially eliminating the current wait list for services in this geographic area. In order to address this issue we will choose to focus on project option 1.12.2: Expand the number of community based settings where behavioral health services may be delivered in underserved areas.

We propose an expansion of the Crisis Intervention Response Team (CIRT), which is a program that partners law enforcement officers who are certified in crisis intervention training with licensed master-level clinicians to respond to law enforcement calls. Together, these teams respond to calls involving with individuals in serious mental health crises. Additionally, the team responds to SWAT team calls and conducts follow-up investigations on individuals when indicated. While the team works collaboratively, the officer's role includes transportation and security, whereas the clinician's role is de-escalation, assessment, and resolution of the problem. The program operates in partnership with Houston Police Department and the Harris County Sheriff's Office. The proposed project seeks to expand this program by adding more CIRT teams to respond to crises.

Goals and Relationship to Regional Goals:
The goal of the program is to assist law enforcement officers in the de-escalation of crises and provide appropriate mental health treatment during a crisis. First, we expect an increase in the number of law enforcement calls that have a CIRT team response. Second, we plan to see a decrease in the number of hospital admissions for recipients of the CIRT intervention. Additionally, we hope the percent of CIRT calls that end with a peaceful resolution increase. Finally, in Category 3, we plan to see a decrease in arrests. It is also important to note process milestones have been selected which pertain to the development of this program, such as adding new CIRT teams and engaging in continuous quality improvement. The overall five year

outcome is to create a total of 3 new CIRT teams that accomplish these goals. Specific milestones and metrics are outlined in the Category 2 and 3 charts, which follow this narrative.

Challenges:

The challenges include identifying appropriate ongoing service providers for linkage. This challenge will be addressed through expansion of outpatient behavioral health services for individuals with severe psychiatric conditions.

Starting Point/Baseline:

MHMRA currently has a small CIRT unit which consists of thirteen teams. Specifically, this proposal seeks to add three more teams.

Rationale:

Law enforcement is often the front-line response to people experiencing mental health crises; however, until recently, law enforcement officers have had little to no mental health training (Hails & Borum, 2003). Recent studies that examined the impact of CIRT teams have found that partnerships between law enforcement and mental health system improve collaboration, efficiency, and the treatment of people with mental illness. Additionally, mobile services have been found to decrease inpatient hospital admissions. For example, Scott (2000) reported a 27% reduction in hospitalization rates, coupled with a 23% decrease in costs. Similarly, Hugo, Smout, and Bannister (2002) reported a 30% decrease in hospitalization rates when mobile crisis services were utilized.

While MHMRA has several crisis intervention programs, CIRT is unique. Specifically, it is the only program that partners directly with law enforcement agencies. CIRT also plays a critical role in addressing unmet needs in a population with a high base rate of mental illness—those who interface with criminal justice agencies. It is also important to note that many of these individuals do not require detention and may be treated effectively in the community. Furthermore, detention may be traumatizing for the patient, making him/her less likely to interface with treatment professionals in the future. Thus, CIRT plays a vital role in de-escalating conflict, providing mental health assessment, and decreasing unnecessary arrests. Finally, CIRT provides an educative role in policing and may improve the competency of law enforcement officers who respond to psychiatric emergencies.

Project Components:

In order to enhance the transition from inpatient to develop such a program, the following option and core components were chosen: 2.13.1, Design, implement, and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population. These components have also been imbedded in the program process and improvement milestones (See milestone and metric chart for further details). The status of each component is noted, if that activity is currently underway:

a) Assess size, characteristics and needs of target population(s)
    - MHMRA will continue to assess characteristics and needs of individuals involved in crisis calls involving law enforcement agents.

b) Review literature / experience with populations similar to target population.
    - MHMRA will continue to review literature and evaluate ongoing experiences with individuals in crisis 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, forensic encounters, death 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.
    - MHMRA's Outcome Management department will 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.
    - MHMRA will continue to evaluate improvements on 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.
    - MHMRA will continue to assess the impact of interventions based on standardized quantitative measures and qualitative analysis relevant to the target population.

f) Community-based interventions should be comprehensive and multispecialty.
    - As mentioned above, this program is inherently multidisciplinary.

Unique community needs identification number project addresses:

This project directly meets broad goals identified by the regional needs assessment. First, it improves on existing programs and infrastructure by filling a void that is unmet by existing psychiatric outpatient clinics and psychiatric emergency services. Second, it increases access to specialty care services by providing mobile treatment. The program also offers a patient-centered approach that provides short-term mental health treatment to those in urgent need. The proposed program will also complement the regional need to develop a culture of "best practices" whereby the patient receives collaborative treatment that is empirically supported by research.

The CIRT Expansion will address the following community needs:

- CN3-Inadequate access to Behavioral Health
- CN6- Inadequate access to treatment and services designed for special needs populations, including disabled, homeless, children and elderly
- CN9- High rates of preventable hospital readmissions
- CN10 High rates of preventable hospital admissions

<u>Relationship to other Projects:</u>

At this time there is not enough information available from the RHP to describe how this project may or may not be related to other RHP DSRIP proposals. However, the proposed project complements several MHMRA DSRIP proposals, including the expansion of the Crisis Residential Unit, Mobile Crisis Outreach Team, and Chronic Consumer Stabilization Initiative. All four proposals seek to expand psychiatric stabilization in the community while reducing inpatient admissions.

Numerous community needs assessments reflect an extreme need for behavioral health services to include outpatient treatment centers, crisis stabilization units, inpatient beds, and much more. The lack of funding as well as complexity of the regions patient base has limited the amount of behavioral health treatments available to our region and continues to drive cost in emergent and inpatient situations. The Crisis Stabilization Unit has a direct correlation to all behavioral health programs recommended in the RHP plan and will be a focus of two of the largest Local Mental Health Authorities of our region. Both CSU's share the outcome measures of mental health admissions & readmissions, and improvement of patient satisfaction scores. The Region 3 Initiative Grid attached in the addendum reflects the direct relationships of this initiative.

Plan for Learning Collaborative:

We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other performing providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system.

Project Valuation:

In the effort to value the proposed project accurately, assistance was sought from H. Shelton Brown, Ph.D. of the UT Houston School of Public Health and Thomas Bohman, Ph.D. of the UT Austin Center for Social Work Research. Their consultation was limited to only the valuation section of this document. 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: After an exhaustive review of the literature, no studies were located that contained a QALY.

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. We did identify a benefit-cost study that is related.

Outcomes studies have documented the benefits of mobile crisis teams, both with law enforcement involvement, and absent police presence. Scott (2000) assessed a psychiatric mobile outreach service in Alabama and compared the intervention to police intervention *without* the presence of a mental health professional. In this study, the mobile outreach service successfully avoided hospitalization among 55% of patients, compared to routine law enforcement interventions (28%, $p<.01$), for an overall reduction of 27%. Additionally, the average cost of mobile services with a police officer were 23% less per person ($1,520, a value equivalent to $2,034 in 2012 (U.S. Department of Labor, 2012)) compared to those served by the police department ($1,963); these costs include both program costs and hospitalization costs.

In 2010, Kisely and colleagues sought to evaluate the impact of an integrated mobile team that paired a plain-clothed police officer with a mental health professional (Kisely, Campbell, Peddle, Hare, Pyche, Spicer & Moore, 2010). The researchers used a mixed-method which provided a controlled before-and-after comparison of the intervention area with a control area without access to such a service. Services were assessed for one year before and two years after program implementation. The intervention (CIRT) was highly utilized within the community, evidenced by an increase in recipients from 464 to 1666 per year. Although the number of participants increased, the time spent per service was less in the experimental condition, 136 minutes than in the control group (165 minutes; Student t test = 3.4, df = 1649, $P < 0.001$). This reduction in intervention time may translate into cost savings in the future as consumers were diverted into outpatient and preventative services rather than expensive psychiatric emergency services.

Using the combined estimate of cost savings from Scott (2000), one can estimate the value of mobile crisis services as follows:

100	patients served
x $2,034	per person inflation adjusted savings
= $203,400	Savings per 100 served

Summary and Total Valuation: This valuation analysis shows that the intervention will have a positive value for participants who receive the intervention(s). All valuations used 100 individuals that would receive all components of the program. The total valuation is estimated at $203,400 per 100 individuals served per year.

113180703.2.7	***2.13.1***	***2.13.1: .1a, .1b, .1c, .1d, .1e***	***Crises intervention response team expansion***
Mental Health and Mental Retardation Authority of Harris County			*113180703*
Related Category 3 Measure(s):	*IT-9.1*	*Decrease in mental health admissions and readmissions to criminal justice settings*	

Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Milestone 1: P-X. Hire and train staff to implement CIRT expansion. **Metric 1:** P-X.1. 33% staff hired and trained by end of YR 2 **Data Source:** Human Resource records	**Milestone 3:** P-X. Hire and train staff to implement CIRT expansion. **Metric 3:** P-X.1. 100% staff hired and trained by end of YR 3 **Data Source:** Human Resource records	**Milestone 6:** P-3. Enroll and serve individuals with targeted complex needs. **Metric 6:** P-3.1. Number of calls in which CIRT responds **Data Source:** Project documentation **Goal:** CIRT will respond to 10% more calls than baseline	**Milestone 8:** P-3. Enroll and serve individuals with targeted complex needs. **Metric 8:** P-3.1. Number of calls in which CIRT responds **Data Source:** Project documentation **Goal:** CIRT will respond to 15% more calls than baseline
Estimated Incentive Payment: :$817,975.33	**Estimated Incentive Payment: $599,680.93**	**Estimated Incentive Payment: $960,905.75**	**Estimated Incentive Payment: $928,411.36**

113180703.2.7	*2.13.1*	*2.13.1: .1a, .1b, .1c, .1d, .1e*	*Crises intervention response team expansion*
Mental Health and Mental Retardation Authority of Harris County			*113180703*
Related Category 3 Measure(s):	*IT-9.1*	*Decrease in mental health admissions and readmissions to criminal justice settings*	

Year 2 (10/1/2012 – 9/30/2013)	**Year 3** (10/1/2013 – 9/30/2014)	**Year 4** (10/1/2014 – 9/30/2015)	**Year 5** (10/1/2015 – 9/30/2016)
Milestone 2: P-3. Enroll and serve individuals with targeted complex needs **Metric 2: P-**3.1. Number of calls in which CIRT responds **Data Source:** Project documentation **Goal:** Establish baseline	**Milestone 4:** P-3. Enroll and serve individuals with targeted complex needs. **Metric 4:** P-3.1. Number of calls in which CIRT teams respond**Data Source:** Project documentation**Goal:** CIRT will respond to 5% more calls than baseline	**Milestone 7:** I-X. On Site Crisis Resolution **Metric 7:** I-X.1. Percent of CIRT cases that result in resolution on-sitea. Numerator: Percent of CIRT cases resolved on-site b. Denominator: The number of patients receiving CIRT intervention **Data Source:** MHMRA and law enforcement records **Goal:** Base-rate is unknown; Improvement goal to be determined later.	**Milestone 9:** I-X. On Site Crisis Resolution **Metric 9:** I-X.1. Percent of CIRT cases that result in resolution on-sitea. Numerator: Percent of CIRT cases resolved on-site b. Denominator: The number of patients receiving CIRT intervention **Data Source:** MHMRA and law enforcement records **Goal:** Base-rate is unknown; Improvement goal to be determined later.
Estimated Incentive Payment: :$817,975.33	**Estimated Incentive Payment: $599,680.93**	**Estimated Incentive Payment: $960,905.76**	**$928,411.35**

113180703.2.7	***2.13.1***	***2.13.1: .1a, .1b, .1c, .1d, .1e***	***Crises intervention response team expansion***
Mental Health and Mental Retardation Authority of Harris County			*113180703*
Related Category 3 Measure(s):	*IT-9.1*	*Decrease in mental health admissions and readmissions to criminal justice settings*	

Year 2 (10/1/2012 – 9/30/2013)	**Year 3** (10/1/2013 – 9/30/2014)	**Year 4** (10/1/2014 – 9/30/2015)	**Year 5** (10/1/2015 – 9/30/2016)
N/A	**Milestone 5**: I-X. On-Site Crisis Resolution **Metric 5:** I-X.1. Percent of CIRT cases that result in crisis resolution on-site **Data Source:** MHMRA and law enforcement records **Goal:** Establish baseline	**N/A**	**N/A**
N/A	**Estimated Incentive Payment: $599,475.65**	**N/A**	**N/A**
Year 2 Estimated Milestone Bundle:	**Year 3 Estimated Milestone Bundle:**	**Year 4 Estimated Milestone Bundle:**	**Year 5 Estimated Milestone Bundle:**
$1,635,950.66	**$1,798,426.95**	**$1,921,811.51**	**$1,856,822.71**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5): $7,213,011.83			

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Mental Health and Mental Retardation Authority of Harris County

Pass 2

Project Option 2.13.1: Design, implement, and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population- IDD/ASD Wrap-Around and In-Home Services

RHP Project ID: 113180703.2.8 / Pass 2
Performing Provider / TPI: Mental Health and Mental Retardation Authority of Harris County / 113180703

Project Summary:
Provider: The Mental Health and Mental Retardation Authority (MHMRA) of Harris County is a public agency serving as the safety net provider for adults with serious mental illnesses, for children and adolescents with serious emotional disorders, for the developmentally delayed and for individuals experiencing acute psychiatric distress. MHMRA provides inpatient, residential and outpatient treatments, including psycho-therapy, case management and medication management for individuals. MHMRA serves more than 49,000 Harris County residents out of a culturally and ethnically diverse population of over 4.1 million. Of those individuals who received any agency service in FY12, 36.5% were medically indigent and 51.9% had Medicaid. Of those who received IDD services in FY12, such as those being proposed in this project, 34.1% were medically indigent and 57.1% had Medicaid.

Intervention(s): The proposed program seeks to develop wrap-around and in-home services for high risk consumers with Intellectual and Developmental Disabilities and Autism Spectrum Disorders (IDD and ASD) and their families to avoid utilization of intensive, costlier services. More specifically, program staff will provide community based interventions for individuals to prevent them from cycling through multiple systems, by providing community-based, wrap-around services that help stabilize behavioral problems in the natural home, while linking the patient and family to other supports, such as a medical home, transition services to help individuals establish a stable living environment, peer support, employment, specialized therapies, respite, personal assistance, and linkage to short or long term residential options.

Need for the project: Harris County also has approximately 106,494 residents are with an intellectual and developmental disability; 24,000 with autism spectrum disorder; and of people in these groups, 38,700 are dually diagnosed with co-occurring mental illness. By providing timely intervention and linkage to community resources, individuals can be empowered to live independently or with their families, with minimal intrusion and maximum clinical benefit.

Target population: Harris County High risk consumers with Intellectual and Developmental Disabilities and Autism Spectrum Disorders (IDD and ASD) and their families. It is anticipated the program will provide service for about 200 patients.

Category 1 or 2 expected patient benefits:

- improvement in functional assessment (TBD) by 10% over baseline
- 10% decrease in admissions to State Supported Living Centers by DY 5

Category 3 outcomes: MHMRA expects to increase one domain of patient satisfaction (TBD) by 10% from baseline by DY5.

Project Option 2.13.1: Design, implement, and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population- IDD/ASD Wrap-Around and In-Home Services

RHP Project ID: 113180703.2.8 / Pass 2
Performing Provider / TPI: Mental Health and Mental Retardation Authority of Harris County / 113180703

Project Description:
The Mental Health and Mental Retardation Authority (MHMRA) of Harris County is public agency serving as the safety net provider for adults with serious mental illnesses, for children and adolescents with serious emotional disorders, for the developmentally delayed and for individuals experiencing acute psychiatric distress. MHMRA provides inpatient, residential and outpatient treatments, including psycho-therapy, case management and medication management for individuals. MHMRA serves about 49,000 Harris County residents out of a culturally and ethnically diverse population of over 4.1 million. Of those individuals who received agency services in FY12, 60.0% were medically indigent and 32% had Medicaid. Of those who received IDD services, such as those being proposed in this project, 34.1% were medically indigent and 57.1% had Medicaid. With regard to incomes, 88% report family size and annual income placing them at or below 133% of 2012 Federal Poverty Level Guidelines. Only 5.2% of the agency's clientele report incomes above 100% of FPL. Harris County's ethnic diversity is reflected in the population served. Agency consumers self-describe the following ethnic backgrounds: African-Americans (34.5%), Anglos (27.1%), persons of Hispanic heritage (26.6%), Asian-Americans (2.8%) and those reporting other ethnicities (0.4%).

The proposed program seeks to develop wrap-around and in-home services for high risk consumers with Intellectual and Developmental Disabilities and Autism Spectrum Disorders (IDD and ASD) and their families to avoid utilization of intensive, costlier services. More specifically, program staff will provide community based interventions for individuals to prevent them from cycling through multiple systems, by providing community-based, wrap-around services that help stabilize behavioral problems in the natural home, while linking the patient and family to other supports, such as a medical home, transition services to help individuals establish a stable living environment, peer support, employment, specialized therapies, respite, personal assistance, and linkage to short or long term residential options.

Goals:
MHMRA will provide specialized services to children and adults with IDD/ASD and behavioral problems. These individuals often have multiple concomitant issues such as physical health conditions, family stressors resulting from the person's disability, homelessness, cognitive challenges, lack of daily living skills, and lack of natural supports. Texas' mental health system provides rehabilitative services and pharmacotherapy to people with certain severe psychiatric diagnoses and functional limitations, but the complex needs of people with IDD/ASD are beyond the resources of the mental health system and usually span across multiple systems of care.

This complex population often becomes frequent users of local public health systems, most notably emergency rooms and psychiatric inpatient units, ultimately at risk for institutional

placement in state supported living centers. The goal of this project is to avert outcomes such as potentially avoidable inpatient admission and readmissions in restrictive settings including state supported living centers and acute care psychiatric units; to avert disruptive and deleterious events such as criminal justice system involvement and institutionalization; to promote wellness and adherence to medication and other treatments; and to promote recovery in the community.

Regional Goals/Community Needs: This project directly meets broad goals identified by the regional needs assessment. First, it improves on existing programs and infrastructure by filling a void that is unmet by existing psychiatric outpatient clinics and psychiatric emergency services. Second, it increases access to specialty care services by providing treatment in an additional Houston location. The program also offers a preventative, patient-centered approach that provides brief psychiatric care to those in urgent need. The proposed program will also complement the regional need to develop a culture of "best practices" whereby the patient/consumer plays a more active role as a stakeholder by completing consumer satisfaction surveys.

The 5-year expected outcome(s): The hope is that by the end of the 5-year DSRIP project, the proposed program will have established an approach to health care delivery that leverages and improves on existing programs and infrastructure, is responsive to patient and family needs, improves health care outcomes and patient satisfaction, facilitates access to primary and specialty care services for the underserved population of people with IDD/ASD, to ensure that they receive the most appropriate care for their condition, regardless of where they live or their ability to pay. The project is expected to transform health care delivery from a disease-focused model of episodic care to a patient-centered, coordinated delivery model that improves patient satisfaction, empowerment and health outcomes, reduces unnecessary or duplicative services, and builds on the accomplishments of our existing health care system.

These goals are consistent with the regional goals and community needs discussed elsewhere. Furthermore, the improvement metrics chosen for this project (I-2.1: The percent decrease in preventable admissions and readmissions to state supported living centers and I-5.1:
The percentage of individuals receiving specialized interventions who demonstrate improved functional status on standardized instrument TBD) will determine the progress MHMRA is making to meet our stated goals.

Starting Point/Baseline:
Currently, MHMRA does not have a dedicated team as proposed.

Rationale:
Individuals with IDD or ASD exhibit deficits in adaptive behaviors as part of their diagnostic profile; however, when these deficits develop into behavioral excesses resulting from learned contingencies or, in approximately 33% of this population, from the existence of co-occurring mental illness in people with IDD/ASD has been widely recognized, timely intervention is required to avoid costlier levels of care. These behavioral excesses place extreme pressures on families who do not know where to find the few resources available to assist them in a time of need. Families may reach out for help and finding none, decide that out of home placement is the

only option. Such placements are expensive and burden the public system; moreover they are almost always avoidable.

In-home services are beneficial for people with IDD and ASD because behavior change can be effected in the setting where those behaviors are exhibited. This population is known for difficulties in generalizing treatment benefits; i.e., learning a skill in one setting and transferring it without additional training into another setting. In-home services, in contrast with clinic-based services, provide onsite skills training and reduce the need for generalization training. Additionally, individuals and families can experience success within their natural environment, thus reducing the temptation to seek alternative placements. Once behavioral stability is achieved, treatment benefits can be supported by linking the person and family to mainstream services such as specialized therapies, employment services, and other supports that allow increased independence and promote a sense of self-efficacy.

Treating the person with IDD/ASD only addresses part of the presenting problems. Families who have a loved one with a developmental delay and severe behavior problems often report elevated levels of stress, depression and marital discord. These families are further impacted by enforced unemployment when one parent must remain at home to manage the person with IDD/ASD, thus adding financial hardships to the family's stressors. Notably, family therapy is not supported in the array of services for people with IDD/ASD, yet is recognized as an important factor for promoting resilience and creating a strong foundation in which change for the better can occur.

The In-Home Team is designed to provide behavioral interventions, linkage to community options, and family supports to individuals with IDD/ASD who have serious behavior problems and are therefore at high risk of institutional referral, and who are not supported by the network of private Medicaid waiver providers. This intervention targets the decrease of problem behaviors, thus enabling individuals to remain in their homes and avoid more expensive and restrictive placements. Additionally, recognizing that the family must also be stable and healthy for the child to improve, family counseling and linkage and referral to community services is rolled into the service. This service is not included in the array of currently funded IDD services. Harris County also has approximately 106,494 residents are with an intellectual and developmental disability; 24,000 with autism spectrum disorder; and of people in these groups, 38,700 are dually diagnosed with co-occurring mental illness. By providing timely intervention and linkage to community resources, individuals can be empowered to live independently or with their families, with minimal intrusion and maximum clinical benefit.

Project Components:
In order to develop such a program, the following option and core components were chosen:
2.13.1 Expand the number of community based settings where behavioral health services may be delivered in underserved areas:

a. MHMRA will continue to assess the size, characteristics and needs of the target population through ongoing work with patients and families/caregivers.
b. MHMRA will continue to review literature and their experience with IDD/ASD populations 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. MHMRA will utilize a team approach involving clinical and program staff and the newly formed Outcome Management Department and the Quality Management Department, to develop project evaluation plan using qualitative and quantitative metrics to determine outcomes.
d. MHMRA will design models which include an appropriate range of community-based services and residential supports.
e. MHMRA will assess the impact of interventions based on standardized quantitative measures and qualitative analysis relevant to the target population.

Unique Community Need Identification numbers:
Enhancing the Intensity of Outpatient Behavioral Health Services will address the following community needs: CN3-Insuffcient Access to Behavioral Health; CN18- Integrated Care for Behavioral Health; CN20- Improved Access to Patient Education.

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative: Currently, there is not a team dedicated to this service although one is needed due to the insufficient capacity to provide needed services. The proposed project is intended to close these gaps in the service continuum.

Related Category 3 Outcome Measure(s):
IT-6.1 Percent improvement over baseline of patient satisfaction scores
Reasons/rationale for selecting the outcome measure: Measurement of patient satisfaction is a key indicator of patient-centered care and has been targeted as a quality indicator by national organizations dedicated to improvement in patient outcomes, e.g. the National Council for Quality Assurance. Furthermore, if patients and their family are satisfied with services then we can assume they are being provided for adequately. On the other hand, if patients are dissatisfied having an avenue to express their concerns is important to empowering our clients.

Relationship to Other Projects: The proposed project has activities related to the following MHMRA proposals: 1.9 Expand Specialty Care Capacity: IDD Specialized Treatment and Rehabilitative Services (STARS) and 2.12 Implement/Expand Care Transitions Programs: IDD/ASD Inpatient Consultation and Liaison Service

Relationship to Other Projects in the RHP: The behavioral health crisis in Region 3 is considerable and the proposed initiatives in our RHP plan will only imply a small impression into the overall community need for treatment, but is a good start. The outpatient focus of many RHP Plan initiatives will help numerous facilities focus to treating the patients in an ambulatory setting as well as continued navigation of services with a focus to keeping patients from the inpatient unit. This initiative is similar to many others in the sense of the category of behavioral health. The Region 3 Initiative Grid attached in the addendum will show the relationship to other programs.

Plan for Learning Collaborative: We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our

participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system.

Project Valuation:

In the effort to value the proposed project accurately, assistance was sought from H. Shelton Brown, Ph.D. of the UT Houston School of Public Health and Thomas Bohman, Ph.D. of the UT Austin Center for Social Work Research. Their consultation was limited to only the valuation section of this document. 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.

Research has shown that care-givers of individuals with IDD/ASD are at risk for mental health problems of their own due to stress (Cummins, 2001). Past research has also linked aggression to parent distress (Chadwick, Beecham, Piroth, Bernard & Taylor, 2002; Douma, Dekker & Koot, 2006; Plant & Sanders, 2007; Weiss, Lunsky, Gracey, Canrinus & Morris, 2009). Parent training has been an effective tool to reduce stress related to caring for IDD/ASD individual, better ability to manage behaviors in the home and improved use of resources such as reduced ER visits (Hassiotis, Robotham, Canagasabey, Marston, Thomas & King, 2012). Through parent intervention, additional value can be gained. Using Ganz estimated indirect costs to family members caring for an individual with IDD/ASD at the average age of the patient (13 years old), the yearly costs were $9613.25.

100	(patients served)
x $9613.25	(annual indirect family costs)
= $961,325	**Cost Savings: Indirect Family**

Summary and Total Valuation: This valuation analysis shows that the intervention will have a positive value for participants. The combined value is $**961,325** per 100 people served.

Unique Identifier: 113180703.2.8	*RHP PP Reference Number: 2.13.1*	*Project Components: A-E*	*IDD/ASD WRAP AROUND*
Mental Health and Mental Retardation Authority of Harris County			113180703
Related Category 3 Outcome Measure(s):	113180703.3.16	*IT-6.1*	*Percent improvement over baseline of patient satisfaction scores*

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1 [P-1]: Conduct needs assessment of complex behavioral health populations who are frequent users of community public health resources. Metric 1 [P-1.1]: Numbers of individuals, demographics, location, diagnoses, housing status, natural supports, functional and cognitive issues, medical utilization, ED utilization Goal: Complete literature review Data Source: MHMRA Records and public inpatient psychiatric records, possibly jail records Milestone 1 Estimated Incentive Payment: $370,559.48 **Milestone 2** [P-4]: Evaluate and continuously improve interventions Metric 1 [P-4.1]: Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles Goal: incorporate the proposed project into the current biweekly review processes	**Milestone 5** [P-2]: Design community-based specialized interventions for target populations. Metric 1 [P-2.1]: Project plans which are based on evidence / experience and which address the project goals Data Source: Written Plans Goal: Complete a resource library of services for linking participating patients and will maintain this list as services develop. Milestone 5 Estimated Incentive Payment: $332,706.35 **Milestone 6** [P-3]: Enroll and serve individuals with IDD/ASD and targeted behavioral needs Metric 1 [P-3.1]: Number of targeted individuals enrolled / served in the project. Data: Project documentation Goals: Enroll and serve 80 individuals/families by the end of Yr 3. Milestone 6 Estimated Incentive	**Milestone 10** [I-5]: Functional Status Metric 1 [I-5.1]: The percentage of individuals receiving specialized interventions who demonstrate improved functional status on standardized instrument TBD Goal: 5% improvement over baseline Data Source: Standardized functional assessment TBD Numerator: The percent of individuals receiving wrap around who demonstrate improvement Denominator: The number of individuals receiving wrap around Milestone 10 Estimated Incentive Payment: $900,087.41 **Milestone 11** [I-2]: State Supported Living Center (SSLC) Admissions Metric 1[I-2.1]: X% decrease in preventable admissions and readmissions to state supported living centers; Data Source: MHMRA and DADS reports	**Milestone 12** [I-5]: Functional Status Metric 1 [I-5.1]: The percentage of individuals receiving specialized interventions who demonstrate improved functional status on standardized instrument TBD Goal: 10% improvement over baseline Data Source: Standardized functional assessment TBD Milestone 12 Estimated Incentive Payment: $866,571.08 **Milestone 13** [I-2]: State Supported Living Center Admissions Metric 1 [I-2.1]: X% decrease in preventable admissions and readmissions to state supported living centers Goal: 10% decrease in admissions Data Source: MHMRA and DADS reports Milestone 13 Estimated Incentive Payment: $866,571.07

Unique Identifier: 113180703.2.8	*RHP PP Reference Number: 2.13.1*	*Project Components: A-E*	*IDD/ASD WRAP AROUND*	
Mental Health and Mental Retardation Authority of Harris County				113180703
Related Category 3 Outcome Measure(s):	113180703.3.16	*IT-6.1*	*Percent improvement over baseline of patient satisfaction scores*	

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Data Source: Written Quarterly Reports Milestone 2 Estimated Incentive Payment: $370,559.48 **Milestone 3** [P-5]: Participate in at least bi-weekly interactions with other providers and the RHP to promote collaborative learning around shared or similar projects. Metric 1 [P-5.1]: Number of bi-weekly meetings, conference calls, or webinars organized by the RHP that the provider participated in. Data Source: written bi-weekly documentation Metric 2 [P-5.2]: Share challenges and solutions successfully during this bi-weekly interaction. Goal: Attend and participate in meetings Data Source: Written Documentation Milestone 3 Estimated Incentive Payment: $370,559.48 **Milestone 4** [P-7]: Participate in face-to-face learning (i.e. meetings or	Payment:$332,706.35 **Milestone 7** [P-5]: Participate in at least bi-weekly interactions with other providers and the RHP to promote collaborative learning around shared or similar projects. Metric 1 [P-5.1]: Number of bi-weekly meetings, conference calls, or webinars organized by the RHP that the provider participated in. Data Source: written bi-weekly documentation Metric 1 [P-5.2]: Share challenges and solutions successfully during this bi-weekly interaction. Goal: Attend and participate in meetings Data Source: Written Documentation Milestone 7 Estimated Incentive Payment: $332,706.35 **Milestone 8** [P-4]: Evaluate and continuously improve interventions Metric 1 [P-4.1]: Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles	Goal: 5% decrease in admissions Numerator: The percentage of individuals receiving Wrap Around within the measurement period who are admitted Denominator: The number of individuals receiving Wrap Around Milestone 11 Estimated Incentive Payment: $900,087.41	

Unique Identifier: 113180703.2.8	*RHP PP Reference Number: 2.13.1*	*Project Components: A-E*	*IDD/ASD WRAP AROUND*
Mental Health and Mental Retardation Authority of Harris County			113180703
Related Category 3 Outcome Measure(s):	113180703.3.16	*IT-6.1*	*Percent improvement over baseline of patient satisfaction scores*

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. Metric 1 [P-7.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Metric 2 [P-7.2]: Metric: Implement the raise the floor improvement initiatives established at the semiannual meeting. Data Source: Documentation of raise the floor activities Milestone 4 Estimated Incentive Payment: $370,559.48	Goal: The goal is to incorporate the proposed project into the current biweekly review processes Data Source: Written Quarterly Reports Milestone 8 Estimated Incentive Payment: $332,706.35 **Milestone 9** [P-7]: Participate in face-to-face learning at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. Metric 1 [P-7.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Metric 2 [P-7.2]: Implement the raise the floor improvement initiatives Data Source: Written documentation Milestone 9 Estimated Incentive Payment: $332,706.36		
Year 2 Estimated Milestone Bundle Amount: $1,482,237.93	Year 3 Estimated Milestone Bundle Amount: $1,663,531.76	Year 4 Estimated Milestone Bundle Amount: $1,800,174.82	Year 5 Estimated Milestone Bundle Amount: $1,733,142.15
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5): $6,679,086.66*			

Project Option 2.13.2: Implement one or more pilot intervention(s) in care transitions targeting one or more patient care units or a defined patient population- IDD/ASD Inpatient Consultation and Liaison Service

RHP Project ID: 113180703.2.9
Performing Provider / TPI: Mental Health and Mental Retardation Authority of Harris County / 113180703

Project Summary:
Provider**:** The Mental Health and Mental Retardation Authority (MHMRA) of Harris County is a public agency serving as the safety net provider for adults with serious mental illnesses, for children and adolescents with serious emotional disorders, for the developmentally delayed and for individuals experiencing acute psychiatric distress. MHMRA provides inpatient, residential and outpatient treatments, including psycho-therapy, case management and medication management for individuals. MHMRA serves more than 49,000 Harris County residents out of a culturally and ethnically diverse population of over 4.1 million. Of those individuals who received any agency service in FY12, 36.5% were medically indigent and 51.9% had Medicaid. Of those who received IDD services in FY12, such as those being proposed in this project, 34.1% were medically indigent and 57.1% had Medicaid.

Intervention(s): MHMRA proposes to expand and further develop the Inpatient Consultation and Liaison (C&L) team that provides consultation and services to patients suspected of Intellectual and Developmental Disabilities and Autism Spectrum Disorders (IDD and ASD) referred by attending physicians at the Harris County Psychiatric Center (HCPC); with subsequent expansion to provide similar services to other inpatient settings in Harris County.

Need for the project: Approximately 106,494 Harris county residents are diagnosed with an intellectual and developmental disability; 24,000 with autism spectrum disorder; and of people in these groups, 38,700 are dually diagnosed with co-occurring mental illness. When a person with a co-occurring condition requires hospitalization to stabilize symptoms of mental illness, they often encounter well-meaning clinicians who have limited exposure and experience in treating this population. This situation can be alleviated with specialized consultation by clinicians who are experts in ID/ASD and co-occurring mental illness. Not only would effective consultation include recommendations for inpatient treatment, but recommendations for effective discharge planning and care transition would be necessary to reduce preventable rehospitalizations.

Target population: Harris county residents with comorbid mental health and IDD/ASD issues presenting in psychiatric emergency services. It is anticipated that 225 individuals will be served by the program expansion.

Category 1 or 2 expected patient benefits: MHMRA will implement a protocol for inpatient consultation and care transition to be used on least 65% of identified patients by DY 5.

Category 3 outcomes: MHMRA expects to increase one domain of patient satisfaction (TBD) by 10% from baseline by DY5.

Project Option 2.13.2: Implement one or more pilot intervention(s) in care transitions targeting one or more patient care units or a defined patient population- IDD/ASD Inpatient Consultation and Liaison Service

RHP Project ID: 113180703.2.9 / Pass 2
Performing Provider / TPI: Mental Health and Mental Retardation Authority of Harris County / 113180703

Project Description:
The Mental Health and Mental Retardation Authority (MHMRA) of Harris County is public agency serving as the safety net provider for adults with serious mental illnesses, for children and adolescents with serious emotional disorders, for the developmentally delayed and for individuals experiencing acute psychiatric distress. MHMRA provides inpatient, residential and outpatient treatments, including psycho-therapy, case management and medication management for individuals. MHMRA serves about 49,000 Harris County residents out of a culturally and ethnically diverse population of over 4.1 million. Of those individuals who received agency services in FY12, 60.0% were medically indigent and 32% had Medicaid. Of those who received IDD services, such as those being proposed in this project, 34.1% were medically indigent and 57.1% had Medicaid.

MHMRA proposes to expand and further develop the Inpatient Consultation and Liaison (C&L) team that provides consultation and services to patients suspected of Intellectual and Developmental Disabilities and Autism Spectrum Disorders (IDD and ASD) referred by attending physicians at the Harris County Psychiatric Center (HCPC); with subsequent expansion to provide similar services to other inpatient settings in Harris County. This model is intended to divert people with IDD/ASD from higher cost, inpatient placement and into local resources. Accordingly, this project meets the Delivery System Incentive Reform Payment (DSRIP) Pool 1115(a) waiver component 2.12, Implement and expands care transitions programs.

Goals:
The goal of this project is to implement improvements in care transitions and coordination of care from inpatient to outpatient, post-acute care, and home care settings in order to prevent increased health care costs and hospital readmissions. By the end of year five, established protocols should result in a transformation of care that results in diversion of cases that do not need inpatient treatment, improved patient-specific inpatient protocols, and effective discharge and aftercare that promote continuity of treatment benefits.

Regional Goals: By the end of the 5-year DSRIP project, the proposed program will have established an approach to health care delivery that leverages and improves on existing programs and infrastructure, is responsive to patient and family needs, improves health care outcomes and patient satisfaction, facilitates access to inpatient and outpatient specialty care services for the underserved population of people with IDD/ASD, to ensure that they receive the most appropriate care for their condition, regardless of where they live or their ability to pay. The project is expected to transform health care delivery from a disease-focused model of episodic

care to a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary re-hospitalizations, and builds on the accomplishments of our existing health care system.

Starting Point/Baseline:

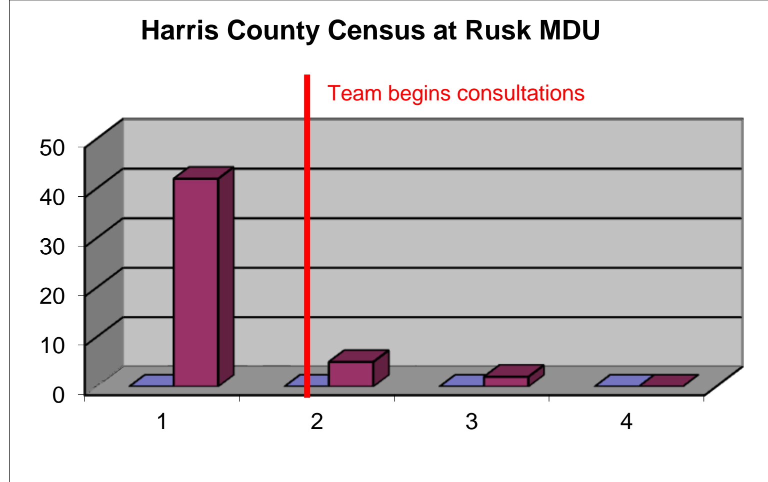
Annually, the current, reduced HCPC Consultation and Liaison (C&L) team consults and assists an average of 110 unduplicated patients each year; however, an increase was noted in the past year, when the team was called to consult on 150 cases. With increased pressure upon state supported living centers to discharge residents into communities, combined with reduced state hospital and state supported living center beds, more cases may be anticipated. Fifty percent of the cases seen by the team are new to MHMRA and can be linked to community resources to minimize the likelihood of recurrent crises. The present team capacity, however, can only address a limited number of patients within HCPC and cannot extend beyond that facility, where additional needs exist. Furthermore, discharge planning is a difficult task without an established protocol that contains a decision tree for linking to appropriate community options. The proposed project is intended to close these gaps.

Rationale:

The existence of co-occurring mental illness in people with IDD/ASD has been widely recognized; however, treatment of psychiatric conditions in this population is still in its infancy, with unremarkable treatment outcomes. Poor treatment outcomes include more frequent psychiatric hospitalizations; longer admissions and later identification in the psychiatric event, resulting in higher levels of care. Furthermore, studies examining the treatment of co-occurring disorders report that mental health clinicians, including psychiatrists, psychologists, social workers, nurses and other disciplines, are rarely formally trained to treat people with IDD/ASD and MI. Lack of exposure to people with developmental disabilities causes clinicians to shy away from these patients; and when they do become involved, they intervene later in the course of the disease process and tend to use medication for sedating purposes and not in accordance with the person's mental illness.

Texas has documented similar concerns. In May 2011, the directors of IDD programs in mental health authorities across Texas were queried about the resources in their areas for responding to behavioral crises. Across the state they reported a lack of skilled clinicians and also noted psychiatric hospitals often refused inpatient services to individuals with co-morbid IDD and psychiatric illness in crisis because they lacked expertise in the population. Conversely, when admitted, they had extended inpatient stays with little improvement in behavioral functioning. With no other alternative in Texas, communities turn to institutional care in State Supported Living Centers (formerly called State Schools) to manage and treat these individuals. This is an expensive choice. The current annual cost for a person with IDD in a state supported living center is $177,624.

Additionally, Harris County has documented a similar need among this population. Approximately 106,494 Harris county residents are diagnosed with an intellectual and developmental disability; 24,000 with autism spectrum disorder; and of people in these groups, 38,700 are dually diagnosed with co-occurring mental illness. When a person with a co-occurring condition requires hospitalization to stabilize symptoms of mental illness, they often encounter well-meaning clinicians who have limited exposure and experience in treating this



population. This situation can be alleviated with specialized consultation by clinicians who are experts in ID/ASD and co-occurring mental illness. Not only would effective consultation include recommendations for inpatient treatment, but recommendations for effective discharge planning and care transition would be necessary to reduce preventable rehospitalizations.

Care transitions refer to the movement of patients from one health care provider or setting to another. When a patient's transition is less than optimal, the repercussions can be far reaching (e.g., hospital readmission, an adverse medical event, and even mortality). Additionally, poorly designed discharge processes create unnecessary stress for medical staff causing failed communications, rework, and frustrations. A comprehensive and reliable discharge plan, along with post-discharge support, can reduce readmission rates, improve health outcomes, and ensure quality transitions. Safe, effective, and efficient care transitions and reduced risk of potentially preventable readmissions require cooperation among providers of medical services, social services, and support services in the community and in long-term care facilities. People with IDD/ASD and co-occurring mental illness are high-risk patients who often have multiple chronic diseases. The implementation of effective care transitions requires practitioners to learn and develop effective ways to successfully manage one disease in order to effectively manage the complexity of multiple diseases (Rittenhouse et al., 2010). The discontinuity of care during transitions typically results in patients with serious conditions falling through the cracks, which may lead to otherwise preventable hospital readmission (Parry et al., 2003).

The model MHMRA is proposing to implement has been tested previously with excellent results. In 1996, MHMRA assigned a team consisting of a psychiatrist, a psychologist, a social worker and a case worker to work within (HCPC) to identify people with IDD/ASD who were hospitalized with co-occurring mental illness and to consult as needed with the hospital's attending physician. When the team was first developed, the Multiple Disabilities Unit (MDU) at Rusk State Hospital housed, on average, 48 Harris County residents per day. With successful diversion by the team, within two years, the average daily census in the MDU from Harris County was reduced to five. It fell further to approximately two, until the MDU was closed for lack of use. This process is illustrated below.

The team was successful at reducing institutional placement, as indicated in the graph below, but over time, with successive funding reductions, the team, was equally reduced and lost state funding. By developing the team fully and expanding its scope, it is anticipated that the diversion of hospital patients into community options will represent substantial savings.

Project Components:

In order to develop such a program, option 2.12.2 was selected. The status of each component is noted, if that activity is currently underway:

a) MHMRA will review best practices from a range of models (e.g. RED, BOOST, STAAR,

INTERACT, Coleman, Naylor, GRACE, BRIDGE, etc.), with specific attention to models that include patients with IDD/ASD.

b) MHMRA will conduct an analysis of the key drivers of 30-day hospital readmissions using a chart review tool (e.g. the Institute for Healthcare Improvement's (IHI) State Action on Avoidable Re-hospitalizations (STAAR) tool) and patient interviews. A literature review has been started to help identify evidence-based factors, but patient and other stakeholder input will be the critical for this component.
c) MHMRA will integrate information systems so that continuity of care for patients is enabled. An electronic medical record is being developed that will interface with other systems seamlessly.
d) MHMRA will develop a system to identify patients being discharged potentially at risk of needing acute care services within 30-60 days
e) MHMRA will implement discharge planning program and post discharge support program. Pilot processes are being sampled and will contribute to lessons learned as this important component evolves
f) MHMRA will develop a cross-continuum team comprised of clinical and administrative representatives from acute care; skilled nursing; ambulatory care; health centers; HCS, ICF-ID and other Medicaid waiver providers; and home care providers of care to people with IDD/ASD.
g) MHMRA will 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 the targeted safety-net populations.

Community Needs: The Consultation and Liaison program will address the following community needs:

- CN2-Insuffcient Access to Behavioral Health
- CN5- Integrated Care for Behavioral Health
- CN12- Improved Access to Patient Education
- CN14-Reduction of ER Services

The improvement metrics chosen for this project was a measure of those receiving the service (I-11: Number over time of those patients in target population receiving standardized, evidence-based interventions). Determining the number of patients served will help determine the progress MHMRA is making toward our stated goals.

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative: Currently, the team capacity is insufficient for the population in need of consultation and liaison services. Furthermore, discharge planning is a difficult task without an established protocol that contains a decision tree for linking to appropriate community options. The proposed project is intended to close these gaps in the service continuum.

Related Category 3 Outcome Measure(s):

IT-6.1 Percent improvement over baseline of patient satisfaction scores

Reasons/rationale for selecting the outcome measure:

Measurement of patient satisfaction is a key indicator of patient-centered care and has been targeted as a quality indicator by national organizations dedicated to improvement in patient outcomes, e.g. the National Council for Quality Assurance. Furthermore, if patients and their family are satisfied with services then we can assume they are being provided for adequately. On the other hand, if patients are dissatisfied having an avenue to express their concerns is important to empowering our clients.

Relationship to Other Projects: At this time there is not enough information available from the RHP to describe how this project may or may not be related to other RHP DSRIP proposals; however, the proposed project has activities related to the following MHMRA proposals: IDD Specialized Treatment and Rehabilitative Services (STARS) and IDD/ASD Wrap-around and In-home Services.

Relationship to Other Projects in the RHP: The behavioral health inpatient crisis in Region 3 is considerable and the increased capacity proposed in the RHP plan will only contribute a small impression into the overall community need for inpatient treatment. The outpatient focus of many RHP Plan initiatives will help numerous facilities focus to treating the patients in an ambulatory setting as well as continued navigation of services with a focus to keeping patients from the inpatient unit. This initiative is only similar to others in the sense of the category of behavioral health but is different in the sense that it focuses to inpatient bed capacity versus outpatient comprehensive treatments. The Region 3 Initiative Grid attached in the addendum will show the relationship to other programs.

Plan for Learning Collaborative: We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system.

Project Valuation:
In the effort to value the proposed project accurately, assistance was sought from H. Shelton Brown, Ph.D. of the UT Houston School of Public Health and Thomas Bohman, Ph.D. of the UT Austin Center for Social Work Research. Their consultation was limited to only the valuation section of this document. 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: After an extensive review of the literature, no studies were located that contained an estimate of QALYs gained due to this intervention.

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. We did identify a benefit-cost study that is related.

After MHMRA of Harris County implemented this service in 1999, the state hospitalization rate was reduced by 97% for the following fiscal year. In the four years prior to the implementation of the consultation and liaison services in 1999, about 255 or 55.69% of those admitted to HCPC had an IDD diagnosis. Of the 255 people admitted to HCPC who had an IDD diagnosis between 1995 and 1998, 44.31% were subsequently sent to a state hospital, an average of 28.25 individuals per year.

The average cost of the state hospital was about $400 per day with an average length of stay of 197.49 days. These figures indicate that a savings of at least $41,622.99 could be expected if the program served 100 individuals. However, because these figures were from 1999 and the state hospital unit has since closed, we will not include this cost savings estimate in the final valuation amount.

Research has shown that care-givers of individuals with IDD/ASD are at risk for mental health problems of their own due to stress (Cummins, 2001). Past research has also linked aggression to parent distress (Chadwick, Beecham, Piroth, Bernard & Taylor, 2002; Douma, Dekker & Koot, 2006; Plant & Sanders, 2007; Weiss, Lunsky, Gracey, Canrinus & Morris, 2009). Parent training has been an effective tool to reduce stress related to caring for IDD/ASD individual, better ability to manage behaviors in the home and improved use of resources such as reduced ER visits (Hassiotis, Robotham, Canagasabey, Marston, Thomas & King, 2012). Through parent intervention, additional value can be gained. Using Ganz estimated indirect costs to family members caring for an individual with IDD/ASD at the average age of admission to HCPC (31 years) the yearly costs were estimated to be $8939.25.

100	(patients served)
x $8939.25	(annual indirect family costs)
= $893,925	**Cost Savings: Indirect Family**

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 for this program is **$893,925 per year.**

Unique Identifier: 113180703.2.9	*RHP PP Reference Number: 2.12.2*	*Project Components: A-G*	*IDD/ASD INPATIENT CONSULTATION AND LIAISON SERVICE*
Mental Health and Mental Retardation Authority of Harris County			113180703
Related Category 3 Outcome Measure(s):	*113180703.3.17*	*IT-6.1*	*Percent improvement over baseline of patient satisfaction scores*

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1 [P-4]: Conduct an assessment and establish linkages with community-based organizations to create a support network for targeted patients post-discharge Metric 1 [P-4.1]: Care transitions assessment Goal: By the end of Yr. 2, the network of allied inpatient stakeholders will expand to include, at minimum, Ben Taub Hospital, three non-psychiatric private hospitals, and two FQHCs Data source: Submission of written care transitions assessment and resource planning documents Milestone 1 Estimated Incentive Payment: $393,554.67 **Milestone 2** [P-7]: Develop a staffing and implementation plan Metric 1 [P-7.1]: Documentation of the staffing plan. Goal: Expansion requires hiring a psychiatrist, licensed psychologist, LCSW and case worker Data Source: Staffing and implementation plan.	**Milestone 5** [P-1]: Develop or implement best practices or evidence-based protocols for effectively communicating with hospital personnel, patients and families during and post-discharge to improve adherence to discharge and follow-up care instructions Metric 1 [P-1.1]: Care transitions protocols Goal: draft protocol for inpatient consultation and care transition will be developed Data Source: Submission of protocols, Care transitions program materials Milestone 5 Estimated Incentive Payment: $441,690.69 **Milestone 6** [P-2]: Implement standardized care transition processes Metric 1 [P-2.1]: Care transitions policies and procedures. Baseline/Goal: With stakeholder input, a draft protocol for inpatient consultation and care transition will be tested by the end of Yr. 3Data Source: Policies and procedures of care transitions program materials	Milestone 9 [I-14]: Implement standard care transition processes Metric 1 [I-14.1]: Measure adherence to processes. Goal: A protocol for inpatient consultation and care transition will be implemented in Yr. 4 on at least 50% of identified patients. Data Source: Hospital and MHMRA data/records Numerator: Number of patients receiving care according to standard protocol. Denominator: Number of population patients discharged. Milestone 9 Estimated Incentive Payment: $1,911,885.24	Milestone 10 [I-14]: Implement standard care transition processes Metric 1 [I-14.1]: Measure adherence to processes. Goal: A protocol for inpatient consultation and care transition will be implemented in Yr. 4 on at least 65% of identified patients. Data Source: Hospital and MHMRA data/records Numerator: Number of patients receiving care according to standard protocol. Denominator: Number of population patients discharged. Milestone 10 Estimated Incentive Payment: $1,840,692.84

Unique Identifier: 113180703.2.9	*RHP PP Reference Number: 2.12.2*	*Project Components: A-G*	*IDD/ASD INPATIENT CONSULTATION AND LIAISON SERVICE*	
Mental Health and Mental Retardation Authority of Harris County				113180703
Related Category 3 Outcome Measure(s):	*113180703.3.17*	*IT-6.1*	*Percent improvement over baseline of patient satisfaction scores*	

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 2 Estimated Incentive Payment: $393,554.67 **Milestone 3** [P-10]: Participate in at least bi-weekly interactions with other providers and the RHP to promote collaborative learning around shared or similar projects Metric 1 [P-10.1]: Number of bi-weekly RHP meetings MHMRA participated in Data Source: Written Documentation Metric 2 [P-10.2]: Share challenges and solutions successfully during this bi-weekly interaction Data Source: Written Documentation Milestone 3 Estimated Incentive Payment: $393,554.67 **Milestone 4** [P-12]: Participate in face-to-face learning at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects Metric 1 [P-12.1]: Participate in semi-annual face-to-face meetings or	Milestone 6 Estimated Incentive Payment: $441,690.69 **Milestone 7** [P-10]: Participate in at least bi-weekly interactions with other providers and the RHP to promote collaborative learning around shared or similar projects Metric 1 [P-10.1]: Number of bi-weekly RHP meetings MHMRA participated in Metric 2 [P-10.2]: Share challenges and solutions successfully during this bi-weekly interaction Data Source: Written Documentation Milestone 7 Estimated Incentive Payment: $441,690.69 **Milestone 8** [P-12]: Participate in face-to-face learning at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects Metric 1 [P-12.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP		

<table>
<tr><td>Unique Identifier: 113180703.2.9</td><td>RHP PP Reference Number: 2.12.2</td><td>Project Components: A-G</td><td colspan="2">IDD/ASD INPATIENT CONSULTATION AND LIAISON SERVICE</td></tr>
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<tr><th>Year 2
(10/1/2012 – 9/30/2013)</th><th colspan="2">Year 3
(10/1/2013 – 9/30/2014)</th><th>Year 4
(10/1/2014 – 9/30/2015)</th><th>Year 5
(10/1/2015 – 9/30/2016)</th></tr>
<tr><td>seminars organized by the RHP
<u>Metric 2</u> [P-12.2]: Implement the “raise the floor” improvement initiatives established at the semiannual meeting
Data Source: Written documentation of meetings

Milestone 4 Estimated Incentive Payment: $393,554.67</td><td colspan="2"><u>Metric 2</u> [P-12.2]:
Implement the “raise the floor” improvement initiatives established at the semiannual meeting.
Data Source: Written documentation of meetings

Milestone 8 Estimated Incentive Payment: $441,690.69</td><td></td><td></td></tr>
<tr><td>Year 2 Estimated Milestone Bundle Amount: $1,574,218.68</td><td colspan="2">Year 3 Estimated Milestone Bundle Amount: $1,766,762.76</td><td>Year 4 Estimated Milestone Bundle Amount: $1,911,885.24</td><td>Year 5 Estimated Milestone Bundle Amount: $1,840,692.84</td></tr>
<tr><td colspan="5">TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5): $7,093,559.52</td></tr>
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Methodist Willowbrook Hospital

Pass 1

Project Option 2.17.1 - Design, implement, and evaluate interventions to improve care transitions from the inpatient setting for individuals with mental health and/or substance abuse disorders: Implement Care Transition Coordination

Unique Project ID#: 140713201.2.1

Performing Provider Name / TPI: *Methodist Willowbrook Hospital* / 140713201

Project Summary:

Provider:

Methodist is a delivery system comprised of 4 community hospitals, 1 academic medical center in the Texas Medical Center, research institute, physician organization which employs 350 physicians and operates multiple ancillary care sites throughout the Houston metropolitan area. Methodist has 13,867 employees and has 4,185 associated physicians. Methodist has been recognized as the top hospital system in Houston & Texas by US News & World Report and honored as the top ranked healthcare provider to work for by Fortune Magazine. Methodist Willowbrook Hospital's payor mix for Medicaid is 9.44% and 8.73% self pay.

Intervention(s):

By facilitating effective transitions of care to behavioral health and primary care through locations within Harris County including HARRIS HEALTH SYSTEM, MHMRA, private physicians, and SJMH Family Medicine Residency physicians we seek to help patients navigate a complicated health-care landscape, participate in mental health choices, increase their self-efficacy, provide better quality of life and prevent readmissions and prevent adverse outcomes of incarceration, chemical dependency or suicide. Outpatient Service Availability is limited, and so we hope to leverage the community mental health workers to connect and encourage care within existing primary care and mental health resources. The program will advocate primary care expansion for mental health, through the use of treatment algorithms and perhaps by embedding counselors within a primary practice who could bill "incident to" for supervised service.

Target Population:

About 140,000 adults in Harris County suffer from severe mental illness, while almost half of these adults had no access to treatment from the public or private health system. Our target population is defined as those individuals who suffer from any behavioral health related condition and who are seeking care in our facilities, more specifically those who are covered by Medicaid or without insurance coverage. At Methodist Willowbrook Hospital we serve those with behavioral health as detailed below:

Total ED Visits - Self Pay & Medicaid	22,059
Total ED Visits - Behavioral Health - Self Pay & Medicaid	760
Total ED Admissions - Self Pay & Medicaid	4,154
Total ED Admissions - Bahavioral Health - Self Pay & Medicaid	88
Total IP Admissions - Self Pay & Medicaid	3,326
Total IP Admissions - Behavioral Health - Self Pay & Medicaid	18

Category 1 or 2 expected patient benefits:

Our project will include a number program innovation and redesign efforts. These include ensuring we have recruiting qualified people to intervene and guide care, educate staff, identify community partners, re-engineering our discharge planning process to ensure patients transition into the ambulatory care setting successfully, setting up care coordination protocols to make sure we identify patient accurately who need our assistance and following our system's CQI efforts of plan, do, check and act to ensure we're achieving our expected outcomes for this target population.

Category 3 outcomes:

Our goal is that in the first year we will coordinate care follow-up post discharge to 20% and increase this to 80% by year 5.

Project Option 2.17.1 - Design, implement, and evaluate interventions to improve care transitions from the inpatient setting for individuals with mental health and/or substance abuse disorders: Implement Care Transition Coordination

Unique Project ID#: 140713201.2.1

Performing Provider Name / TPI: *Methodist Willowbrook Hospital* / 140713201

Project Description:

Preventing Behavioral Health Readmissions by Implementing Care Transition Coordination
According to Healthy Peoples 2010 Mental Illness is on par with heart disease and cancer as a cause for disability. 140,000 residents of Harris County suffer from Mental Illness.[i] Many have no access to treatment from the public or private health system. Almost 20,000 youths in Harris County are in need of treatment while only 24% of cases were addressed.[ii]

Currently in Harris County there are limited locations for follow-up mental health care services. The MHMRA services are provided through an office in Pasadena or League City, which is more than 30-45 minutes away and many patients have limited transportation and other barriers to follow up mental health care. Care can be received at the Harris Health System clinic in Baytown where existing patients have access to a visiting Psychiatrist on site 1 half-day per week. This same scenario of limited facilities and physicians to provide ongoing chronic behavioral health care services plays itself out in Central and Northwest Harris County.

There are many barriers to effective mental health care provision. These can be grouped as patient factors, physician factors and system factors. Primary care and primary care psychiatry working together are necessary to address the care of affective and other mental illnesses.[iii]
The intervention proposed will involve the use of community mental health workers with Behavioral Health Education who can coordinate the care of adult patients through the transition from inpatient care to outpatient levels of care including both mental health and primary care follow up. It will also include promoting and monitoring attendance at community settings such as chemical dependency programs. The community mental health workers will be located at The Methodist Hospital, San Jacinto Methodist Hospital and Methodist Willowbrook Hospital and will receive their case load from hospital discharges, referred discharges from Harris Health System who reside in these communities, and referrals from the Emergency Department.
The community mental health workers will have access to hospital medical records including discharge planning. Ideally the information from SJMH and Harris Health System may be available through shared information systems between EPIC software and Methodist IT platforms. This will involve a software program called Medicity, which is contained in Methodist Connect and Harris County Health Connect. It will also involve securing patient consent for this level of information exchange.

The community mental health worker will then follow recognized treatment protocols to query patient compliance with treatment and contact the primary care physician or mental health specialist. The care transition manager may refer to specialized disease management programs, such as those for alcohol or chemical dependency. To assist primary care physicians providing

mental health follow up, treatment algorithms can guide treatment selection and increased quality and consistency of treatment, provide better clinical outcomes, and more efficient use of health care resources. The care will be directed toward the use guidelines including the Texas Medication Algorithm Project, (TMAP).[iv] It will also include recommending sequenced care such as the Sequenced Treatment Alternatives to Relieve Depression, (STAR-D), which assist patients and clinicians implementing "next step" treatment options.[v] It involves patient-choice and buy-in as well as use of patient-completed rating scales such as the "Quick Inventory for Depressive Symptoms" to monitor response to treatment and alert when urgent outpatient mental health care or crisis intervention is necessary.[vi] Objective measurements such as this can assist the transitions nurse in evaluating severity or priority.

By facilitating effective transitions of care to behavioral health and primary care through locations within Harris County including Harris Health System, MHMRA, private physicians, and SJMH Family Medicine Residency physicians we seek to help patients navigate a complicated health-care landscape, participate in mental health choices, increase their self-efficacy, provide better quality of life and prevent readmissions and prevent adverse outcomes of incarceration, chemical dependency or suicide.

The costs associated with this program will include IT costs, Space Costs and Salary Costs.

Goals and Relationship to Regional Goals:

This project meets the following regional goals:

This program would meet the following three regional health goals #1 by leveraging and improving on existing programs and infrastructure. #2 by increasing access to primary and specialty care services, with a focus on underserved and the Medicaid populations. It will ensure patients receive the most appropriate and accessible care for their condition, regardless of where they live or their ability to pay. #3 It will transform from disease-centered emergency room care to patient-centered preventive approach to behavioral health care. It also reduced duplication of uncoordinated services currently received from county and private health care.

Challenges:

- Recruitment of qualified community mental health workers
- Recruitment of psychiatrists & acute care nurse practitioners
- Patient compliance

5-Year expected outcome for Performing Provider and Patient:

Focused effort to transition patients from the acute and ED setting with behavioral health conditions will improve outcomes and reduce costs. We aim to reduce repeat admissions to our inpatient psychiatric units and reduce repeat emergency room visits from our targeted population. Patients will benefit from a more hands-on, compassionate and integrated care coordination system for behavioral healthcare. This should translate to a reduction of demand for incarcerated patients with mental illness and an improvement in the daily productivity from those who benefit from our program.

Starting Point/ Baseline:

We can get a partial measure of the problem based on recent ED and inpatient admissions. To this we may add utilization at nearby facilities, but the data is not available at present.
At San Jacinto Methodist Hospital in 2011 there were 443 ED admissions with a primary diagnosis of a Mental Health condition, (187 were self-pay and Medicaid) resulting in a financial loss of $119k. At The Methodist Hospital there were 612 ED admissions with a primary diagnosis of a Mental Health condition resulting in a loss of $1.154M. At Methodist Willowbrook Hospital there were 160 ED admissions with a primary diagnosis of a Mental Health condition resulting in a loss of $6k. This may be an underestimate since it only captures primary diagnoses. There were 709 behavioral health admissions, 296 of which were self-pay and Medicaid, for a net financial loss of $324k.

It is estimated that 30-50% are readmitted within a one-year period based on national literature. Outpatient Service Availability is limited, and so we hope to leverage the community mental health workers to connect and encourage care within existing primary care and mental health resources. The program could advocate primary care expansion for mental health, through the use of treatment algorithms and perhaps by embedding counselors within a primary practice who could bill "incident to" for supervised service.

Rationale:

As referenced above, residents of Harris County have difficulty accessing mental health services.

The stated principles of the Harris County behavioral health system include quick, easy and convenient entry into services, full range of services and minimal financial barriers to necessary services. The principles promote recovery, continuity of care, family integration in care, evidence based care, and where possible co-location of behavioral health and general health care. HC Behavioral Health promotes stability of behavioral health conditions by decreasing relapse of mental illness and substance abuse.

A designated mental health professional provides oversight to the care-management team to provide this collaborative care.[vii] There are many examples of collaborative care management.[viii],[ix],[x]

Project Components:

a. Develop a cross-continuum team comprised of clinical and administrative representatives from acute care, ambulatory care, behavioral health and community-based non-medical supports
    a. *We will develop a team of clinical leaders from various care settings to ensure care delivery is integrated and coordinated.*
b. Conduct an analysis of the key drivers of 30-day hospital readmissions for behavioral health conditions using a chart review tool
    a. *We will review each chart and develop a trending report of complications from each patient who is readmitted. Our teams will use this information to ensure we are incorporating the appropriate care pathways while the patients are in the*

hospital and we will also make any changes to our discharge planning process as needed to reduce readmissions.

c. Identify baseline mental health and substance abuse conditions at high risk for readmissions
   a. *We will begin with a retrospective review of all behavioral health related readmissions to identify trends. On a go-forward basis, we will review each chart and develop a trending report of complications from each patient who is readmitted. These reports will be updated to ensure we are identifying those patients who are at high risk for readmissions.*

d. Review best practices for improving care transitions from a range of evidence-based or evidence-informed models
   a. *Our teams will work collaboratively with other groups focused on reducing readmissions and incorporate their best practices to our patient population.*

e. Identify and prioritize evidence-based strategies and clinical protocols that support seamless care transitions and reduce preventable 30-day readmissions.
   a. *Our teams will utilize the plan, do, check, act approach of continuous quality improvement for this project. Using this approach will ensure that we are identifying and prioritizing care transactions and reduce readmissions.*

f. Implement two or more pilot intervention(s) in care transitions targeting one or more patient care units or a defined patient population.

g. *Conduct quality improvement for project using methods such as rapid cycle improvement.*

The project will focus primarily on items b, c, d and e of the above listed components.

Unique community need identification number the project addresses:
CN.3 - Inadequate access to behavioral health care

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

This project represents the first time a focused, coordinated care navigation effort has been targeted at patients who suffer from behavioral health conditions. We feel that this project will significantly reduce unnecessary emergency department utilization & repeat admissions into inpatient psychiatric units.

Related Category 3 Outcome Measures:
OD-1: Primary Care and Chronic Disease Management
IT-1.18 Follow-Up After Hospitalization for Mental Illness- NQF 0576236 (Standalone measure)
Reasons/rationale for selecting the outcome measures:
Rationale for choice of using one standalone measure is that is most specific for the intervention. It has been well established that unnecessary readmissions can be prevented by implementing various measures to ensure outpatient follow-up.[xi]

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.
Our goal is that by year four we will have 60% with follow up within 30 days, and by year 5 we will have 80%.

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.
As it is difficult to arrange appointments so close to discharge because of patient and physician factors, our goal is that by the fourth year we will have 40% follow up within seven days and by the fifth year, 50%.

Relationship to other Projects: This project may share space with an OB care coordinator program run by SJMH, and may have overlapping patients.

Relationship to other Performing Providers Projects within the RHP:
The behavioral health crisis in Region 3 is considerable and the proposed initiatives in our RHP plan will only imply a small impression into the overall community need for treatment, but is a good start. The outpatient focus of many RHP Plan initiatives will help numerous facilities focus to treating the patients in an ambulatory setting as well as continued navigation of services with a focus to keeping patients from the inpatient unit. This initiative is similar to many others in the sense of the category of behavioral health. The Region 3 Initiative Grid attached in the addendum will show the relationship to other programs.

Multiple other Behavioral Health Innovations include care navigators, transition coaches, or case managers. We seek to participate in lessons-learned with all of these programs. We also plan to collaborate with entities receiving Federal SAMSHA funding such as Community Mental Health services block grant, Substance Abuse Prevention and Treatment Block Grant or other mental health and substance abuse grants, (Harris County Adult Treatment STAR Drug Courts, TI021529). The transition nurse would be reaching out to connect the patient with right source of care.

Plan for Learning Collaborative:
We plan to participate in a region-wide learning collaborative as offered by the anchor for Region 3, Harris Health System. Our participation in this collaborative with other performing providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our region's health care system.

Project Valuation:
All milestones and metrics were given equal weight and valuation for this project.

140713201.2.1	***2.17.1***	***A-G***	***PREVENTING BEHAVIORAL HEALTH READMISSIONS BY IMPLEMENTING CARE TRANSITION COORDINATION (Mental Health Program Innovation and Redesign through use of Psychiatric Care Managers)***
Methodist Willowbrook Hospital			140713201
Related Category 3 Outcome Measure(s):	***140713201.3.1***	***IT 1.18***	***Follow up after Hospitalization for Mental Illness***

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-1] Establish Team to support or lead project Metric 1[P-1.1]: Establishment of Team Baseline/Goal: 100% complete Data Source: program documents. List of team members Milestone 1 Estimated Incentive Payment: $201,949 **Milestone 2** [P-2]: Collect information and /or analyze data on factors contributing to preventable readmissions within 30 days. Metric 1 [P-2.4]: Develop an electronic report on readmission data Baseline: Report developed and criteria established. Data Source: program documents. Metric 2 [P-2.5]: Chart review Reports Baseline: List of reports used on a daily basis to improve transition coordination. Data Source: program documents.	**Milestone 8** [P-11]: Evaluate and continuously improve care transitions programs Metric 1 [P-11.1]: Project planning and implementation documentation demonstrates plan, do, study act (PDSA) quality improvement cycles Project reports include examples of how real-time data is used for rapid cycle improvement to guide continuous quality improvement Baseline/Goal: A monthly assessment of PDSA efforts in meeting minutes or other documentation. Data Source: Project reports Milestone 8 Estimated Incentive Payment: $332,620 **Milestone 9** [P-15]: Educate appropriate clinical staff on key contributing factors to preventable readmissions. Metric 1: [P-15.1] X % of key clinical staff completing educational sessions Baseline/Goal: 50% of emergency medicine, internal medicine &	**Milestone 13:** [P-23] Train care transition nurses on standard use of evidence-based care transition tool and framework. Metric 1 [P-23.1]: X% of post-acute partners trained Baseline/Goal: 100 % of 4 transition nurses trained Data Source: Internal Hospital Records. Milestone 13 Estimated Incentive Payment: $311,832.50 **Milestone 14** [P-28]: Gap analysis regarding patient communication with doctors, nurses, and/or discharge information. Metric 1 [P-28.1]: Analysis complete Baseline/Goal: 100% complete Data Source: Internal hospital records/documentation Milestone 14 Estimated Incentive Payment: $311,832.50 **Milestone 15** [P-30]: Participate in bi-weekly interactions (conference calls, or webinars) with other	**Milestone 17** (P-32) Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements. Metric 1: (P-32.1) Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Baseline/Goal: Participate in learning collaborative Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Milestone 17: Estimated Incentive Payment (***maximum amount***): $473,986

140713201.2.1	2.17.1	A-G	PREVENTING BEHAVIORAL HEALTH READMISSIONS BY IMPLEMENTING CARE TRANSITION COORDINATION (Mental Health Program Innovation and Redesign through use of Psychiatric Care Managers)	
Methodist Willowbrook Hospital				140713201
Related Category 3 Outcome Measure(s):	140713201.3.1	IT 1.18	Follow up after Hospitalization for Mental Illness	

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Metric 3 [P-2.6]: Determine baseline metric for all cause 30 day readmissions Data Source: program documents. Metric 4 [P-2.7]: Identification of key factors that increase the likelihood of preventable 30 day readmissions for individuals with mental health and substance use disorders Baseline: Development of factors that increase likelihood of readmission by working committee. Data Source: program documents. Milestone 2 Estimated Incentive Payment: $201,949 **Milestone 3:** [P-4]: Hire clinician(s) with care transition/disease management expertise. Metric 1 [P-4.1]: Position offer letters. Baseline/Goal: 100% completion of budgeted hiring (15 FTEs) or	behavioral health clinicians complete education.. Data Sources: Internal hospital records/documentation; Training curricula Milestone 9 Estimated Incentive Payment : $332,620 **Milestone 10** [P-17]: Re-engineer hospital discharge process for all admitted patients. Metric 1 [P-17.1]: Development of high-risk tool and discharge checklist Baseline/Goal: 100% complete Data Source: EMR Documentation of high risk tool and discharge check list including medication reconciliation Milestone 10 Estimated Incentive Payment: $332,620 **Milestone 11:** [P-20] Identify community-based care transition partners. Metric 1: [P-20.1] Number of care transition partners Baseline/Goal: Identify at least 1 external partner.	providers and the RHP to promote collaborative learning around shared or similar projects. Including: 1) sharing challenges & solutions 2) sharing results and quantitative progress on new improvements that the provider is testing; and 3) identifying a new improvement and publicly commit to testing it in the week to come. Metric 1 [P-30.1]: Number of bi-weekly meetings, conference calls, or webinars organized by the RHP that the provider participated in. Baseline / Goal: 100% complete Data Source: Attendance record logs and conference call meeting minutes Metric 2 [P-30.2]: Share challenges and solutions successfully during this bi-weekly interaction. Baseline / Goal: 100% complete Data Source: Catalogue of challenges, solutions, tests, and progress shared by the participating provider, summarized at quarterly intervals Milestone 15 Estimated Incentive Payment: $311,832.50	**Milestone 18**[I-42]: Follow up after Hospitalization Metric 1 [I-42.1]: 20% increase in number of patients receiving Follow-up After Hospitalization for Mental Illness within 7 and 30 days (NQF#-576) Goal: 20% above baseline Data Source: EMR **Milestone 18 Estimated Incentive Payment:** $473,986

140713201.2.1	2.17.1	A-G	PREVENTING BEHAVIORAL HEALTH READMISSIONS BY IMPLEMENTING CARE TRANSITION COORDINATION (Mental Health Program Innovation and Redesign through use of Psychiatric Care Managers)
Methodist Willowbrook Hospital			140713201
Related Category 3 Outcome Measure(s):	140713201.3.1	IT 1.18	Follow up after Hospitalization for Mental Illness

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
appropriate FTEs based on realized patient demand. Data Source: Documentation of position of offer letters/ Human Resources records Milestone 3 Estimated Incentive Payment: $201,949 **Milestone 4:** [P-5] Develop an assessment tool to identify patients who are at high risk for readmission. Metric 1 [P-5.1]: Multidisciplinary committee approves assessment tool Baseline/Goal: 100% complete Data Source: Approved sample tool and meeting minutes Milestone 4 Estimated Incentive Payment : $201,949 **Milestone 5:** [P-6] Identify evidence-based frameworks that support seamless care transitions and impact preventable 30-day readmissions. Metric 1: [P-6.1] Selection of an	Data Source: Documentation of formal or information partnership Metric 2: [P-20.2] Number of partner post-acute facilities Baseline/Goal: Identify at least 1 external partner. Data Source: Documentation of formal or information partnership Milestone 11 Estimated Incentive Payment: $332,620 **Milestone 12:** [P-23] Train care transition nurses on standard use of evidence-based care transition tool and framework. Metric 1 [P-23.1]: X% of post-acute partners trained Baseline/Goal: 50 % of 4 transition nurses trained Data Source: Internal Hospital Records. Milestone 12 Estimated Incentive Payment: $332,620	**Milestone 16** [I-42]: Follow up after Hospitalization Metric 1 [I-42.1]: 10% increase in number of patients receiving Follow-up After Hospitalization for Mental Illness within 7 and 30 days (NQF#-576) Goal: 10% above baseline Data Source: EMR Milestone 16 Estimated Incentive Payment: $311,832.50	

140713201.2.1	***2.17.1***	***A-G***	***PREVENTING BEHAVIORAL HEALTH READMISSIONS BY IMPLEMENTING CARE TRANSITION COORDINATION (Mental Health Program Innovation and Redesign through use of Psychiatric Care Managers)***
Methodist Willowbrook Hospital			140713201
Related Category 3 Outcome Measure(s):	***140713201.3.1***	***IT 1.18***	***Follow up after Hospitalization for Mental Illness***

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
evidence based framework. Baseline/Goal: 100% developed Data source: Meeting minutes selecting an evidence based framework. Milestone 5 Estimated Incentive Payment: $201,949 **Milestone 6** [P-7]: Develop operations manual for care transitions intervention with administrative protocols and clinical guidelines Metric 1 [P-7.1]: Develop a written operations manual. Baseline/Goal: 100% complete Data Source: Written operations manual Milestone 6 Estimated Incentive Payment: $201,949 **Milestone 7** [P-10]: Develop plan for hospital care transition process Metric 1: [P-10.1] Care management tool Baseline / Goal: 100% complete Data Source: Written process & protocol			

140713201.2.1	***2.17.1***	***A-G***	***PREVENTING BEHAVIORAL HEALTH READMISSIONS BY IMPLEMENTING CARE TRANSITION COORDINATION (Mental Health Program Innovation and Redesign through use of Psychiatric Care Managers)***
Methodist Willowbrook Hospital			140713201
Related Category 3 Outcome Measure(s):	***140713201.3.1***	***IT 1.18***	***Follow up after Hospitalization for Mental Illness***
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Metric 2: [P-10.2] Transition Process Improvement Plan Baseline / Goal: 100% complete Data Source: Written process & protocol Milestone 7 Estimated Incentive Payment: $201,949			
Year 2 Estimated Milestone Bundle Amount: $1,413,640	Year 3 Estimated Milestone Bundle Amount: $1,330,480	Year 4 Estimated Milestone Bundle Amount: $1,247,330	Year 5 Estimated Milestone Bundle Amount: $947,972
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over DYs 2-5)*: $4,939,422			

OakBend Medical Center

Pass 1

Project Option: 2.4.1 Redesign to Improve Patient Experience - Implement Consumer Assessment System
Performing Provider: OakBend Medical Center (OBMC) / 127303903
Unique Project ID: 127303903.2.1

- Provider: OakBend Medical Center is a stand-alone hospital authority that was established in October 1947 under the original name of Polly Ryon Memorial Hospital. OakBend Medical Center has grown to a hospital system, still governed by a hospital authority. It has expanded to two hospital locations, two diagnostic imaging centers, an outpatient surgical center, a free-standing Emergency Room and a Medical Group with 7 clinic locations. The Medical Group consists of Family Practice, OB/Gyn, Infectious Disease, Podiatry, Orthopedic, Cardiology and Interventional Cardiology. OakBend was able to provide more than $29,412,325 in charity care through September during FY 2012.

Volume Statistics - FY2012	**Patient Payor Mix–YTD 9/12**	**Patient Demographics**
Hospital admissions- 5,453 Births (babies delivered)- 1,080 Emergency visits- 23, 433	Self-Pay- 13.8% Medicaid and CHIP- 19.5% Medicare- 40.1% Other Funding- N/A Commercial Insurance- 26.6	Hispanic- 39.6% African American- 16.7 Caucasian- 34.6 Asian- 2.0 Other- 6.7 American Indian- 0.4

- Intervention(s): OBMC plans to establish a patient experience program where patients feel safe, have their voices heard and are empowered. This concept would involve staff education on communication skills and will be in line with the other initiatives that are designed to create an environment that promotes excellence, operational efficiency and quality patient-centered care

- Need for the project: This project addresses the RHP's goal to "[d]evelop a culture of ongoing transformation and innovation that maximizes the use of technology and best-practices, facilitates regional collaboration and sharing, and engages patients, providers, and other stakeholders in the planning, implementation, and evaluation processes."

- Target population: All patients that seek their medical care through any of the OakBend Medical Center system entities, who will benefit from this and other projects. We plan to target all inpatients.

- Category 1 or 2 expected patient benefits: The goal of this project is to change the organizational culture to improve the patient experience, where patient's feel safe, have their voices heard and are empowered.

- Category 3 outcomes: IT-6.1- In DY3 we plan to increase improvement over baseline by 1%, in DY4 by 2% and in DY5 by 3%

Title: Redesign to Improve Patient Experience - Implement Consumer Assessment System

Unique RHP Project Identification Number: 127303903.2.1

Performing Provider Name/TPI: OakBend Medical Center (OBMC) / 127303903

Project Description: 2.4 / 2.4.1

OBMC plans to establish a patient experience program where patients feel safe, have their voices heard and are empowered. This concept would involve staff education on communication skills and will be in line with the other initiatives that are designed to create an environment that promotes excellence, operational efficiency and quality patient-centered care. The program will be established to encompass any patient experience in all OBMC facilities.

Patient experience with care will be assessed through focused surveys. The architecture for patient-focused surveys should be modeled after the Consumer Assessment of Healthcare Providers and Systems (CAHPS) tool, which includes the following domains: patients are getting timely care, appointments, and information; how well providers communicate with patients; patients' rating of provider; and assessment office staff.

OBMC will establish a Hospital Consumer Assessment of Healthcare Provider and Systems (HCAHPS) Steering committee, which will be comprised of organizational leaders, employees, and patients via their feedback. OBMC will then develop or improve upon a curriculum that will focus on staff education, communication skills and cultural diversity, as well as develop a formal policy and procedure that incorporates the communication model to include training staff on program goals and objectives. This will include competency training for all healthcare providers. We will incorporate the communication training model into the annual employee competencies. The training module will include coaching, shadowing and a feedback process. This process is designed to ensure that the knowledge acquired will be retained and performed on an ongoing basis.

Goal(s) and relationship to Regional goal(s):

Project goals:

The goal of this project is to change the organizational culture to improve the patient experience.

This project meets the following Region 3 goals:

This project addresses the RHP's goal to "[d]evelop a culture of ongoing transformation and innovation that maximizes the use of technology and best-practices, facilitates regional collaboration and sharing, and engages patients, providers, and other stakeholders in the planning, implementation, and evaluation processes."

Challenges and how addressed:

Challenges include: population diversity, language barriers, implementation and ongoing monitoring, training for healthcare providers, overcoming past negative experiences; tools to identify service issues during stay; to improve performance on at least one of the three composite

measures on the HCAHPS. OBMC will address these challenges by taking the steps outlined in this project narrative; in particular, OBMC will ensure that the program created under this project will effectively serve the diverse populations receiving care at OBMC. One step is to hire more bilingual staff to assist with the language barriers.

5-year expected outcome for provider and patients:

Improved patient satisfaction and provider performance which is better tailored to the needs of patients as expressed through the assessment system. We plan to do this by improving communication with patients and their families, which will lead to increased quality. Both of these positive metrics will lead to improved HCHAPS scores.

Starting Point/Baseline:

Baseline data:

OBMC currently uses patient satisfaction surveys in a limited number of clinical units and will use this data as a baseline for future project progress.

Time period for baseline:

1/1/12 to 6/30/12

Rationale:

Reasons for selecting the project option:

The feedback gained from this project will help OBMC develop tools to identify service issues during the patient's stay so that corrective action may be implemented at that time. It will also allow OBMC to critique and revise the training process as indicated by the results achieved. These metrics will be shared with all employees on a monthly basis, highlighting for the staff possible ways to enhance the patient experience and as evidenced by our HCAHPS scores.

Project components:

We will meet the following core components:

f) Organizational integration and prioritization of patient experience.
g) Data and performance measurement will be collected by utilizing patient experience of care measures from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) in addition to CAHPS and/or other systems and methodologies to measure patient experience.
h) Implementing processes to improve patient experience in getting through to the clinical practice.
i) Develop a process to certify independent survey vendors that will be capable of administering the patient experience of care survey in accordance with the standardized sampling and survey administration procedures.

Milestones and Metrics:

The following milestones and metrics were chosen for the Implement Consumer Assessment System project based on the core components and the needs of the target population:
Process Milestones and Metrics: P-1 (P-1.1); P-3 (P-3.1); P-18 P-18.1

Improvement Milestones and Metrics: I-16 (I-16.1)

Unique community need identification number the project addresses:

CN.9: High rates of preventable hospital readmissions

CN-11: High rates of chronic disease and inadequate access to treatment programs and services for illnesses associated with chronic disease

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

OBMC currently uses patient satisfaction surveys in a limited number of clinical units. However, this project will allow OBMC to expand the use of patient satisfaction surveys and, more importantly, establish an infrastructure of accountability where the results of these surveys are examined by a steering committee, supported by active feedback from physicians and other practitioners, and eventually incorporated into the hospital's infrastructure.

Related Category 3 Outcome Measure(s):

IT-6.1 Percent Improvement Over Baseline of Patient Satisfaction Scores (Standalone Measure)

Reasons/rationale for selecting the outcome measure(s):

This outcome measure is explicitly related to the improvement of patient satisfaction, which is also the express purpose of this project.

Relationship to Other Projects:

How project supports, reinforces, and enables other projects:

This project will lay a foundation for, and reinforce the clinical effectiveness of OBMC's other DSRIP projects, including:

127303903.2.2: Establish Patient Care Navigation Program

127303903.1.3: Implement and Utilize Disease Management Registry

Relationship to Other Performing Providers' Projects in the RHP:

Healthcare treatment cannot focus to only the acute or chronic encounter and properly treat the patient. It is critical that our region focuses to patient education and community education to ensure a proactive and responsive approach to healthcare needs. The education models represented in the Region 3 RHP plan can be identified in the Initiative Grid (addendum)

and all focus to outcome measures such as appropriate utilization, patient satisfaction scores, and stand alone chronic condition scores such as diabetes and asthma.

Plan for Learning Collaborative:

We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system.

Project Valuation:

Approach for valuing project:

OBMC values each project based on the specific needs of the community, the projected impact on the health outcomes of the community, the level of advancement to the healthcare delivery system, and the time, effort, and clinical resources necessary to implement each project.

In valuing this project, OBMC took into account the extent to which the implementation of a consumer assessment system would potentially meet the goals of the Waiver (support the development of a coordinated care delivery system, improve outcomes while containing costs, improve the healthcare infrastructure), the extent to which it will address the community needs, the population served, and the resources and cost necessary to implement the project.

Rationale/justification for valuation:

The implementation of a consumer assessment system will promote and encourage patients to access care, and foster a relationship of trust and communication between patients and providers—ultimately leading to better clinical outcomes for the community. OBMC took these potential effects into account when considering the appropriate incentive payment value for this project.

<table>
<tr><td>127303903.2.1</td><td>2.4.1</td><td>2.4.1A-D</td><td colspan="2">REDESIGN TO IMPROVE PATIENT EXPERIENCE - IMPLEMENT CONSUMER ASSESSMENT SYSTEM</td></tr>
<tr><td colspan="4">OAKBEND MEDICAL CENTER</td><td>127303903</td></tr>
<tr><td>Related Category 3 Outcome Measure(s):</td><td>127303903.3.4</td><td>IT-6.1</td><td colspan="2">Percent Improvement Over Baseline of Patient Satisfaction Scores</td></tr>
<tr><th>Year 2

(10/1/2012 – 9/30/2013)</th><th>Year 3

(10/1/2013 – 9/30/2014)</th><th colspan="2">Year 4

(10/1/2014 – 9/30/2015)</th><th>Year 5

(10/1/2015 – 9/30/2016)</th></tr>
<tr>
<td>Milestone 1 [P-1]: Appoint an executive accountable for experience performance or create a percentage of time in existing executive position for experience performance.

<u>Metric 1</u> P-1.1 Documentation of an executive assigned responsibility experience performance.

Data Source: Organizational chart or job description (if percentage of time).

Milestone 1 Estimated Incentive Payment (maximum amount): $673,829</td>
<td>Milestone 2 [P-3]: Establish a steering committee comprised of organizational leaders, employees and patients/families to implement and coordinate improvements in patient and/or employee experience. Steering committee will meet at least twice a month.

<u>Metric 1</u> P-3.1: Documentation of committee proceedings and list of committee members.

Data Source: Meeting minutes, agendas, participant lists, and/or list of steering committee members.

Milestone 2 Estimated Incentive Payment: $735,111</td>
<td colspan="2">Milestone 3 [I-16]: Improve patient satisfaction/experience scores.

Baseline/Goal:

<u>Metric 1</u> <u>I-16.1</u> Percentage improvement of patient satisfaction scores for a specific tool over baseline.

<u>Goal: 1% improvement over baseline.</u>

Data Source: Patient satisfaction/experience surveys such as Clinician and Group Consumer Assessment of Health Care Providers and Systems (CG CAHPS) and/or Hospital Quality Initiative Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) scores. Raw scores provided by Jackson Group (third-party vendor).

Milestone 3 Estimated Incentive Payment: $368,624

Milestone 4 [P-18 Participate in face-</td>
<td>Milestone 5 [I-16]: Improve patient satisfaction/experience scores.

Baseline/Goal:

<u>Metric 1</u> <u>i-16.1</u> Percentage improvement of patient satisfaction scores for a specific tool over baseline.

Goal: 2% improvement over baseline.

Data Source: Patient satisfaction/experience surveys such as Clinician and Group Consumer Assessment of Health Care Providers and Systems (CG CAHPS) and/or Hospital Quality Initiative Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) scores. Raw scores provided by Jackson Group (third-party vendor).

Milestone 5 Estimated Incentive Payment: $304,515

Milestone 6 [P-18 Participate in face-</td>
</tr>
</table>

127303903.2.1	2.4.1	2.4.1A-D	REDESIGN TO IMPROVE PATIENT EXPERIENCE - IMPLEMENT CONSUMER ASSESSMENT SYSTEM
OAKBEND MEDICAL CENTER			127303903
Related Category 3 Outcome Measure(s):	127303903.3.4	IT-6.1	Percent Improvement Over Baseline of Patient Satisfaction Scores

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
		to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance. Each participating provider should publicly commit to implementing these improvements. **Metric 1** P-18.1 Participate in semi-annual face-to-face meetings or seminars organized by the RHP. **Data Source:** Documentation of semi-annual meetings including meeting agendas, slides from presentations, and/or meeting notes. Milestone 4 Estimated Incentive Payment: **$368,624**	to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance. Each participating provider should publicly commit to implementing these improvements. **Metric 1** P-18.1 Participate in semi-annual face-to-face meetings or seminars organized by the RHP. **Data Source:** Documentation of semi-annual meetings including meeting agendas, slides from presentations, and/or meeting notes. Milestone 6 Estimated Incentive Payment: **$304,515**
Year 2 Estimated Milestone Bundle Amount *(add incentive payments*	Year 3 Estimated Milestone Bundle	Year 4 Estimated Milestone Bundle	Year 5 Estimated Milestone Bundle

127303903.2.1	***2.4.1***	***2.4.1A-D***	***REDESIGN TO IMPROVE PATIENT EXPERIENCE - IMPLEMENT CONSUMER ASSESSMENT SYSTEM***
OAKBEND MEDICAL CENTER			*127303903*
Related Category 3 Outcome Measure(s):	*127303903.3.4*	*IT-6.1*	*Percent Improvement Over Baseline of Patient Satisfaction Scores*
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
amounts from each milestone): **$673,829**	Amount: **$735,111**	Amount: **$737,248**	Amount: **$609,031**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over DYs 2-5)***: $2,755,219**			

Project Option: 2.9.1 Establish Patient Care Navigation Program
Performing Provider: OakBend Medical Center (OBMC) / 127303903
Unique Project ID: 127303903.2.2

- Provider: OakBend Medical Center is a stand alone hospital authority that was established in October 1947 under the original name of Polly Ryon Memorial Hospital. OakBend Medical Center has grown to a hospital system, still governed by a hospital authority. It has expanded to two hospital locations, two diagnostic imaging centers, an outpatient surgical center, a free-standing Emergency Room and a Medical Group with 7 clinic locations. The Medical Group consists of Family Practice, OB/Gyn, Infectious Disease, Podiatry, Orthopedic, Cardiology and Interventional Cardiology. OakBend was able to provide more than $29,412,325 in charity care through September during FY 2012.

Volume Statistics - FY2012	**Patient Payor Mix–YTD 9/12**	**Patient Demographics**
Hospital admissions- 5,453 Births (babies delivered)- 1,080 Emergency visits- 23, 433	Self-Pay- 13.8% Medicaid and CHIP- 19.5% Medicare- 40.1% Other Funding- N/A Commercial Insurance- 26.6	Hispanic- 39.6% African American- 16.7 Caucasian- 34.6 Asian- 2.0 Other- 6.7 American Indian- 0.4

- Intervention(s): Patient Navigators will help and support these patients to navigate through the continuum of health care services. Patient Navigators will ensure that patients receive coordinated, timely, and site-appropriate health care services. Navigators may assist in connecting patients to primary care physicians and/or medical home sites, as well as diverting non-urgent care from the Emergency Department to site-appropriate locations.

- Need for the project: Traditionally, a hospital's care of patients ends the instant the patient is discharged. This project will offer targeted patient populations assistance in coordinating their care. In addition to helping individual patients, this project will allow all providers across the spectrum of care to utilize their resources more efficiently, delivering care to patients in the most appropriate setting. This will result in lower costs for the delivery system and higher patient satisfaction.

- Target population: All patients that seek their medical care through any of the OakBend Medical Center system entities, who will benefit from this and other projects. We plan to target patients with Medicaid, CHIP and Self-Pay, especially those with chronic disease(s).

- Category 1 or 2 expected patient benefits: In DY3 we plan to increase the number of PCP referrals for patients without a medical home who use the ED, urgent care and/or hospital services as their primary means for access to healthcare.

- Category 3 outcomes: IT 3.2 – Our goal is to increase scheduled appointments over baseline to PCP's and SCP's, by 2% in DY3, by 5% in DY4 and by 8% in DY5.

Title: Establish Patient Care Navigation Program

Unique RHP Project Identification Number: 127303903.2.2

Performing Provider Name/TPI: OakBend Medical Center (OBMC) / 127303903

Project Description: 2.9 / 2.9.1

Patient Navigators will help and support these patients to navigate through the continuum of health care services. Patient Navigators will ensure that patients receive coordinated, timely, and site-appropriate health care services. Navigators may assist in connecting patients to primary care physicians and/or medical home sites, as well as diverting non-urgent care from the Emergency Department to site-appropriate locations. OBMC will implement and coordinate post-discharge support for patients with congestive heart failure (CHF), Diabetes, and Chronic Obstructive Pulmonary Disease (COPD). Education would begin upon admission for these specific diagnoses and follow throughout the acute inpatient stay and into the post-discharge phase.

Those patients without a Primary Care Physician (PCP) would be set up with one from OakBend Medical Group (OMG) or the Fort Bend Family Health Center (FBFHC), and the initial appointment would be coordinated and scheduled in conjunction with the patient's availability, prior to the patient being discharged home. A follow-up call by a Community Health Worker (CHW) to remind the patient of the appointment 48-72 and again 24 hours prior to the appointment will be made. During the 48-72 hour prior appointment call, confirmation that the patient has transportation to get to the appointment would be confirmed. This coordination for transportation would be scheduled at least 24 hours in advance.

If no transportation is available, the CHW will, in collaboration with United Way, Red Cross and the County Transportation Service, coordinate to ensure that the patient has transportation to the physician office appointment.

Patient Navigators will help and support patients to navigate through the continuum of health care services. Patient Navigators will ensure that patients receive coordinated, timely, and site-appropriate health care services. Navigators may assist in connecting patients to primary care physicians and/or medical home sites, as well as diverting non-urgent care from the Emergency Department to site-appropriate locations.

Goal(s) and relationship to Regional goal(s):

Project goals:

The goal of this project is to utilize community health workers, case managers, or other types of health care professionals as Patient Navigators to provide enhanced social support and culturally competent care to vulnerable and/or high-risk patients.

This project meets the following Region 3 goals:

This project addresses the RHP's goal to "[d]evelop a culture of ongoing transformation and innovation that maximizes the use of technology and best-practices, facilitates regional

collaboration and sharing, and engages patients, providers, and other stakeholders in the planning, implementation, and evaluation processes."

Challenges and how addressed:

Developing a well-planned-out support system which includes education for the patient/family/caregivers; promoting and incentivizing the patient population to utilize available services in lieu of the Emergency Department (ED); hiring and training of CHWs; managing non-compliant patients; space allocation for CHWs; establishing a more focused coordination between the hospital and affiliated medical group physicians, FBCHC, the CHW and other entities to achieve the shared goal of decreased avoidable readmissions; coordination of medical information from the specific HH companies with feedback to the patient's PCP and hospital CM staff if necessary. OBMC will structure this project in order to overcome these challenges, in part through careful planning of the project, and in part through conducting ongoing quality improvement activities for the project upon its implementation.

5-year expected outcome for provider and patients:

Improved health outcomes for patients who require post-discharge care.

<u>Starting Point/Baseline</u>:

<u>Baseline data</u>:

OBMC currently does limited post-discharge support for a small subset of its patient population (Medicare patients with certain conditions).

<u>Time period for baseline</u>:

1/1/12 to 6/30/12

<u>Rationale</u>:

Reasons for selecting the project option:

Traditionally, a hospital's care of patients ends the instant the patient is discharged. This has resulted in fragmented or overlapping care that is complicated for patients to access and navigate. This project will offer targeted patient populations assistance in coordinating their care. In addition to helping individual patients, this project will allow all providers across the spectrum of care to utilize their resources more efficiently, delivering care to patients in the most appropriate setting. This will result in lower costs for the delivery system and higher patient satisfaction.

Project components:

The core components of this project will be:

j) Identify frequent ED users and use Patient Navigators as part of a preventable ED reduction program. Train Patient Navigators in cultural competency.
k) Deploy innovative health care personnel, such as case managers/workers, community health workers and other types of health professionals as Patient Navigators.
l) Connect patients to primary and preventive care.
m) Increase access to care management and/or chronic care management, including education in chronic disease self-management.
n) Conduct quality improvement for the project, using methods such as rapid cycle improvement. Activities may include, but are not limited to, identifying project impacts, identifying "lessons learned," opportunities to scale all or part of the project to a broader patient population, and identifying key challenges associated with expansion of the project, including special considerations for safety-net populations.

Unique community need identification number the project addresses:

CN.8: High rates of inappropriate emergency department utilization

CN.9: High rates of preventable hospital readmissions

CN.10: High rates of preventable hospital admissions

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

OBMC currently does limited post-discharge support for a small subset of its patient population (Medicare patients with certain conditions). This program would allow OBMC to expand the level of post-discharge support by dedicating personnel and resources, offering enhanced support such as transportation, and offering the navigation services to all patients with certain targeted conditions.

Related Category 3 Outcome Measure(s):

IT-9.2 ED Appropriate Utilization (Standalone Measure)

Reasons/rationale for selecting the outcome measure(s):

If the project is successful, then it will result in improved access to care for patients with targeted conditions. By improving access to care and ensuring that patients receive the right care in the right setting, this project will reduce the inappropriate use of the Emergency Department to deliver the same care.

Relationship to Other Projects:

How project supports, reinforces, and enables other projects:

This project will lay a foundation for, and reinforce the clinical effectiveness of, OBMC's other DSRIP projects, including:

127303903.1.1: Implement and Utilize Disease Management Registry Functionality
127303903.1.2: Increase the number of primary care providers (PCP's)
127303903.1.3: Expand Specialty Care Capacity

Relationship to Other Performing Providers' Projects in the RHP:

The ability to properly identify and monitor specific patients with chronic conditions or frequent emergency department utilization trends will allow the region to accurately mange the very large patient base. Patient navigation includes a comprehensive list of tasks as well as unique provider types based on the focus of the initiative and will help the focus of cost containment, emergency department utilization, and chronic disease management. The Region 3 Initiative Grid in the addendum allows for a cross reference of all initiatives proposed within this concept.

Plan for Learning Collaborative:

We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system.

Project Valuation:

Approach for valuing project:

OBMC values each project based on the specific needs of the community, the projected impact on the health outcomes of the community, the level of advancement to the healthcare delivery system, and the time, effort, and clinical resources necessary to implement each project.

In valuing this project, OBMC took into account the extent to which the implementation of a patient care navigation program would potentially meet the goals of the Waiver (support the development of a coordinated care delivery system, improve outcomes while containing costs, improve the healthcare infrastructure), the extent to which it will address the community needs, the population served, and the resources and cost necessary to implement the project.

Rationale/justification for valuation:

The implementation of a patient care navigation program will significantly improve access to both primary and specialty care for targeted patient populations, foster the more efficient use of the community's healthcare resources, and ultimately result in the reduction of healthcare costs; therefore, OMBC took these factors into account when considering the appropriate incentive payment value for this project.

127303903.2.2	2.9.1	2.9.1 A-E	ESTABLISH PATIENT CARE NAVIGATION PROGRAM
OAKBEND MEDICAL CENTER			127303903
Related Category 3 Outcome Measure(s):	127303903.3.5	IT-9.2	ED Appropriate Utilization (Standalone Measure)
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Milestone 1 P-1 Conduct a needs assessment to identify the patient population(s) to be targeted with the Patient Navigator program. **Metric 1** P-1.1 Provide report identifying the following: - Targeted patient population characteristics (e.g. patients with no PCP or medical home, frequent ED utilization, homelessness, insurance status, low health literacy). - Gaps in services and service needs. - How program will identify, triage and manage target population (i.e. policies and procedures, referral and navigation protocols/algorithms, service maps or flowcharts). - Ideal number of patients targeted for enrollment in the patient navigation program. - Number of Patient Navigators	**Milestone 2** P-3 Provide care management/navigation services to targeted patients. **Metric 1**P-3.1 Increase in the number or percentage of targeted patients enrolled in the program. **Baseline/Goal:** No patient care navigation program currently in place **Data Source:** Enrollment reports. Milestone 2 Estimated Incentive Payment: **$395,829** **Milestone 3** I-6 Increase number of PCP referrals for patients without a medical home who use the ED, urgent care and/or hospital services . **Metric 1** I-6.4 Percentage of patients without a primary care provider who are given a scheduled primary care provider appointment **Goal**: 2% increase over baseline.	**Milestone 4**I-6 Increase number of PCP referrals for patients without a medical home who use the ED, urgent care and/or hospital services . **Metric 1** I-6.4 Percentage of patients without a primary care provider who are given a scheduled primary care provider appointment **Goal**: 5% increase over baseline. **Data Source:** Performing Provider administrative data on patient encounters and scheduling records from Patient Navigator program. Milestone 4 Estimated Incentive Payment: **$396,979** **Milestone 5** P-8 Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify	**Milestone 6** I-6 Increase number of PCP referrals for patients without a medical home who use the ED, urgent care and/or hospital services [. Metric 1: I-6.4 Percentage of patients without a primary care provider who are given a scheduled primary care provider appointment **Goal**: 10% increase over baseline. **Data Source:** Performing Provider administrative data on patient encounters and scheduling records from Patient Navigator program. Milestone 6 Estimated Incentive Payment: **$327,939** **Milestone 7** P-8: Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and

127303903.2.2	2.9.1	2.9.1 A-E	ESTABLISH PATIENT CARE NAVIGATION PROGRAM
OAKBEND MEDICAL CENTER			127303903
Related Category 3 Outcome Measure(s):	127303903.3.5	IT-9.2	ED Appropriate Utilization (Standalone Measure)
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
needed to be hired. - Available site, state, county and clinical data including flow patients, cases in a given year by race and ethnicity, number of cases lost to follow-up that required medical treatment, and percentage of monolingual patients. **Data Source:** Program documentation, EHR, claims, needs assessment survey. Milestone 1 Estimated Incentive Payment *(maximum amount):* **$725,662**	**Data Source:** Performing Provider administrative data on patient encounters and scheduling records from Patient Navigator program. Milestone 3 Estimated Incentive Payment: **$395,829**	and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance. Each participating provider should publicly commit to implementing these improvements. **Metric 1** P-8.1: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. **Data Source**: Documentation of semiannual meetings including meeting agendas, slides from presentations and/or meeting Milestone 5 Estimated Incentive Payment: **$396,979**	agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance. Each participating provider should publicly commit to implementing these improvements. Metric 1 P-8.1 Participate in semi-annual face-to-face meetings or seminars organized by the RHP. **Data Source:** Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Milestone 7 Estimated Incentive Payment: **$327,939**
Year 2 Estimated Milestone Bundle Amount *(add incentive payments amounts from each milestone):* **$725,662**	Year 3 Estimated Milestone Bundle Amount: **$791,658**	Year 4 Estimated Milestone Bundle Amount**: $793,959**	Year 5 Estimated Milestone Bundle Amount: **$655,880**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over DYs 2-5)***: $2,967,159**			

OakBend Medical Center

Pass 2

Project Option: 2.6.1 Implement Evidence-Based Health Promotion Programs – Breastfeeding
Performing Provider: OakBend Medical Center (OBMC)/127303903
Unique Project ID: 127303903.2.3

- Provider: OakBend Medical Center is a stand-alone hospital authority that was established in October 1947 under the original name of Polly Ryon Memorial Hospital. OakBend Medical Center has grown to a hospital system, still governed by a hospital authority. It has expanded to two hospital locations, two diagnostic imaging centers, an outpatient surgical center, a free-standing Emergency Room and a Medical Group with 7 clinic locations. The Medical Group consists of Family Practice, OB/Gyn, Infectious Disease, Podiatry, Orthopedic, Cardiology and Interventional Cardiology. OakBend was able to provide more than $29,412,325 in charity care through September during FY 2012.

Volume Statistics - FY2012	Patient Payor Mix–YTD 9/12	Patient Demographics
Hospital admissions- 5,453 Births (babies delivered)- 1,080 Emergency visits- 23, 433	Self-Pay- 13.8% Medicaid and CHIP- 19.5% Medicare- 40.1% Other Funding- N/A Commercial Insurance- 26.6	Hispanic- 39.6% African American- 16.7 Caucasian- 34.6 Asian- 2.0 Other- 6.7 American Indian- 0.4

- Intervention(s): OBMC will educate and train patients and staff on the health benefits of breastfeeding, as well as evidence-based strategies to enhance breastfeeding. In furtherance of this goal, OBMC will partner with Fort Bend Family Health Center (FBFHC) to educate their staff and the community on the importance of initiating early breastfeeding. The training will incorporate the development of educational materials in both Spanish and English.

- Need for the project: One of the Region's goals is to "[t]ransform health care delivery from a disease-focused to a wellness model. Breastfeeding has been shown to have a positive impact on infant health. By implementing an evidence-based program aimed at promoting breastfeeding, OBMC can make an effort to increase the incidence of breastfeeding in the community.

- Target population: This project is explicitly tied to postnatal care and we plan to target patients with Medicaid, CHIP and Self-Pay.

- Category 1 or 2 expected patient benefits: The implementation of an evidence-based breastfeeding promotion program will directly contribute to the health outcomes of the community and has been linked to a reduction in chronic diseases later in life.

- Category 3 outcomes: IT-8.1 In DY3 we plan to increase improvement over baseline by 2%, in DY4 by 4% and in DY5 by 6%.

Project Option 2.6.1: Engage in population-based campaigns or programs to promote healthy lifestyles using evidence-based methodologies including social media and text messaging in an identified population- Implement Evidence-Based Health Promotion Programs – Breastfeeding Promotion Program

Unique RHP Project Identification Number: 127303903.2.3 / Pass 2

Performing Provider Name/TPI: OakBend Medical Center (OBMC) / 127303903

Project Description:

OBMC will educate and train patients and staff on the health benefits of breastfeeding, as well as evidence-based strategies to enhance breastfeeding. In furtherance of this goal, OBMC will partner with Fort Bend Family Health Center (FBFHC) to educate their staff and the community on the importance of initiating early breastfeeding. This program will utilize a structured approach that incorporates training, motivation and specific practices for implementation.

This program will involve training staff on the evidence-based strategies to promote exclusive breastfeeding during the initial hospitalization of the mother. Because evidence has shown that the health benefits of breastfeeding, and the mechanisms by which human milk confers protection against disease is essential. The training will incorporate the development of educational materials in both Spanish and English to be used at the educational sessions. The educational sessions will begin in the prenatal phase and continue through postpartum. The infant will be placed skin to skin and breast feeding initiated within the first 30 minutes of life. This will improve both clinical outcomes as well as quality of life.

During the educational process, staff and parents will be instructed on procedures and techniques, including hands-on modules that demonstrate correct positioning, skin to skin techniques, and proper latch, as well as the nutritional benefits of breastfeeding for baby and mother.

Goal(s) and relationship to Regional goal(s):

Project goals:

The goal of this project is to implement evidence-based strategies to promote infant wellness by developing an exclusive breastfeeding program at OBMC that will be initiated immediately following the birth of the newborn. An estimated 8.3% of babies are born with a low birth weight and nearly 40% of pregnant mothers receive no prenatal care in the first trimester. Early education of this population will improve the overall health of the community. There are, of course, financial benefits including, no need for bottles, bottle supplies and formula, which, can cost between $800 and $1200 per year. Breastfeeding also slows the fertility process, helping to space out children and create less strain on the family's budget.

This project meets the following Region 3 goals:

One of the Region's goals is to "[t]ransform health care delivery from a disease-focused model of episodic care to a patient-centered, coordinated delivery model that improves patient

satisfaction and health outcomes, reduces unnecessary or duplicative services, and builds on the accomplishments of our existing health care system[.]" This project puts emphasis on establishing wellness and patient-centered interaction, rather than only reacting to and focusing on disease. This is a proactive approach to patient care.

Challenges:

The top challenge in developing this initiative is the language diversity of the population served at OBMC, as well as the cultural diversity and the level of education of the patients. An additional challenge will be recruiting and hiring an International Board Certified Lactation Consultant (IBCLC) who will coordinate the training sessions for physicians, nurses and parents. OBMC plans to hire the lactation consultant during milestone year two (2) of this project. The lactation consultant will be responsible for coordinating the educational sessions, performing competency assessment on staff, providing hands on and ongoing evidence based education as well as compiling and maintaining statistical data and implementing quality improvement strategies to achieve the desired outcomes.

5-year expected outcome for provider and patients:

All mothers who deliver at OBMC will be educated on the benefits of breastfeeding and the nutritional value human milk provides for their infants. OBMC will be a community resource for all breastfeeding mothers. The resource center will provide training sessions, educational information as well as equipment to assist mothers in achieving successful breastfeeding.

Starting Point/Baseline:

Baseline data:

OBMC does not currently have a certified lactation consultant on staff or a comprehensive program to promote breastfeeding. OBMC is in the process of searching for a certified breastfeeding consultant and will have this person in place by Milestone year two (2).

Time period for baseline:

1/1/12 to 6/30/12

Rationale:

Reasons for selecting the project option:

Breastfeeding has been shown to have a positive impact on infant health. By implementing an evidence-based program aimed at promoting breastfeeding, OBMC can make an effort to increase the incidence of breastfeeding in the community. This is a proven method of improving health outcomes and increasing patient satisfaction. This will improve both clinical outcomes as well as quality of life.

Project components:

The project will include opportunities to expand to a broader patient population, and identify key challenges associated with expansion of the project, including special considerations for safety-net populations.

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

- One of OakBend's milestones in Year 4 is to implement a continuous quality improvement plan by establishing meetings with other RHP providers.

Unique community need identification number the project addresses:

- CN.20- Lack of access to programs providing health promotion education, training and support, including screenings, nutrition counseling, patient education programs
- CN.14- High rates of poor birth outcomes and low birth-weight babies

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

Although OBMC currently provides some information and guidance regarding breastfeeding, this would be a significant expansion of the program by increasing the amount of education available to both patients and staff. We plan to implement a dedicated breastfeeding resource department that is equipped with information in English and Spanish, as well as the availability of equipment and interactive training modules to better facilitate learning. The hiring of a full-time certified lactation consultant would also dedicate significantly more resources to this goal. Efforts will also be made to follow up with the patients to determine whether they are still breastfeeding post discharge This Project allows OBMC to participate in a learning collaborative and inter-agency coordination effort with other entities who's focus is to improve quality of life for the mother and infant.

Related Category 3 Outcome Measure(s):

IT-8.1 Timeliness of Prenatal/Postnatal Care

Reasons/rationale for selecting the outcome measure(s):

This project is explicitly tied to postnatal care. Therefore, it is reasonable to measure other areas of prenatal/postnatal care.

Relationship to Other Projects:

How project supports, reinforces, and enables other projects:

This project will lay a foundation for, and reinforce the clinical effectiveness of, other DSRIP projects such as:

1.1 Expand Primary Care Capacity

2.4 Redesign to Improve Patient Experience

2.7 Implement Evidence-Based Disease Prevention Programs

Relationship to Other Performing Providers' Projects in the RHP:

Healthcare treatment cannot focus to only the acute or chronic encounter and properly treat the patient. It is critical that our region focuses to patient education and community education to ensure a proactive and responsive approach to healthcare needs. The education models represented in the Region 3 RHP plan can be identified in the Initiative Grid (addendum) and all focus to outcome measures such as appropriate utilization, patient satisfaction scores, and standalone chronic condition scores such as diabetes and asthma.

Plan for Learning Collaborative:

We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system.

Project Valuation:

Approach for valuing project:

OBMC values each project based on the specific needs of the community, the projected impact on the health outcomes of the community, the level of advancement to the healthcare delivery system, and the time, effort, and clinical resources necessary to implement each project.

In valuing this project, OBMC took into account the extent to which the implementation of an evidence-based breastfeeding promotion program would potentially meet the goals of the Waiver (support the development of a coordinated care delivery system, improve outcomes while containing costs, improve the healthcare infrastructure), the extent to which it will address the community needs, the population served, and the resources and cost necessary to implement the project.

Rationale/justification for valuation:

The implementation of an evidence-based breastfeeding promotion program will directly contribute to the health outcomes of the community and has been linked to a reduction in chronic diseases later in life. OBMC took these potential effects into account when considering the

appropriate incentive payment value for this project. OBMC has identified the space and is currently advertising for a certified lactation consultant to begin the process

127303903.2.3	2.6.1	N/A	IMPLEMENT EVIDENCE-BASED HEALTH PROMOTION PROGRAMS – BREASTFEEDING PROMOTION PROGRAM
OAKBEND MEDICAL CENTER			127303903
Related Category 3 Outcome Measure(s):	127303903.3.6	IT-8.1	Timeliness of Prenatal/Postnatal Care

Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Milestone 1 [P-3]: Implement, document and test an evidence-based innovative project for targeted population; Metric 1 [P-3.1]: Document implementation strategy and testing outcomes. Data Source: Performing Provider contract or other documentation of implementation TBD by Performing Provider. Milestone 1 Estimated Incentive Payment: $260,969.50 **Milestone 2** [P-2]: Development of evidence-based projects for targeted population based on distilling the needs assessment and determining priority of interventions for the community. Metric 1 [P-2.1]: Document innovational strategy and plan. Data Source: Performing Provider	**Milestone 3** [I-8]: Increase access to health promotion programs and activities using innovative project option. Metric 1 [I-8.1]: Increase percentage of target population reached. Baseline/Goal: Data Source: Documentation of target population reached, as designated in the project plan. Milestone 3 Estimated Incentive Payment: $290,974 **Milestone 4** [P-7]: Review project data and respond to it every week with tests of new ideas, practices, tools, or solutions. Metric 1 [P-7.1]: Number of new ideas, practices, tools, or solutions tested. Data Source: Brief description of the idea, practice, tool, or solution tested each week, to be summarized at	**Milestone 5** [I-8]: Increase access to health promotion programs and activities using innovative project option. Metric 1 [I-8.1]: Increase percentage of target population reached. Baseline/Goal: Increase percentage of target population reached by 10% Data Source: Documentation of target population reached, as designated in the project plan. Milestone 5 Estimated Incentive Payment: $295,195 **Milestone 6** **CQI**: P-8 Participate in interactions with other providers and RHP to promote collaborative learning around shared or similar projects Metric	**Milestone 7**[I-8]: Increase access to health promotion programs and activities using innovative project option. Metric 1 [I-8.1]: Increase percentage of target population reached. Baseline/Goal: Increase percentage of target population reached by 15% Data Source: Documentation of target population reached, as designated in the project plan. Milestone 7 Estimated Incentive Payment: $242,993.50 **Milestone 8** [P-7]: Review project data and respond to it every week with tests of new ideas, practices, tools, or solutions. Metric 1 [P-7.1]: Number of new ideas, practices, tools, or solutions tested. Data Source: Brief description of the

127303903.2.3	*2.6.1*	*N/A*	*IMPLEMENT EVIDENCE-BASED HEALTH PROMOTION PROGRAMS – BREASTFEEDING PROMOTION PROGRAM*
OAKBEND MEDICAL CENTER			*127303903*
Related Category 3 Outcome Measure(s):	*127303903.3.6*	*IT-8.1*	*Timeliness of Prenatal/Postnatal Care*
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
evidence of innovational plan. Milestone 2 Estimated Incentive Payment: $260,969.50	quarterly intervals. Milestone 4 Estimated Incentive Payment: $290,974	**CQI: P-8.1** Number meetings, conference calls or webinars organized by the RHP that the provider participated in. <u>Data Source</u> Meeting Agendas, sign-n sheets, conference calls, presentations, email Milestone 6 Estimated Incentive Payment: $295,195	idea, practice, tool, or solution tested each week, to be summarized at quarterly intervals. Milestone 8 Estimated Incentive Payment: $242,993.50
Year 2 Estimated Milestone Bundle Amount: $521,939	Year 3 Estimated Milestone Bundle Amount: $581,948	Year 4 Estimated Milestone Bundle Amount: $590,390	Year 5 Estimated Milestone Bundle Amount: $485,987
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over DYs 2-5)**:** $2,180,264*			

Oakbend Medical Center

Pass 3

Project Option: 2.14.3 Other Patient-Centered Wellness Management Program
Performing Provider: OakBend Medical Center (OBMC)/127303903
Unique Project ID: 127303903.2.4

- Provider: OakBend Medical Center is a stand-alone hospital authority that was established in October 1947 under the original name of Polly Ryon Memorial Hospital. OakBend Medical Center has grown to a hospital system, still governed by a hospital authority. It has expanded to two hospital locations, two diagnostic imaging centers, an outpatient surgical center, a free-standing Emergency Room and a Medical Group with 7 clinic locations. The Medical Group consists of Family Practice, OB/Gyn, Infectious Disease, Podiatry, Orthopedic, Cardiology and Intervential Cardiology. OakBend was able to provide more than $29,412,325 in charity care through September during FY 2012.

Volume Statistics - FY2012	Patient Payor Mix–YTD 9/12	Patient Demographics
Hospital admissions- 5,453 Births (babies delivered)- 1,080 Emergency visits- 23,433	Self-Pay- 13.8% Medicaid and CHIP- 19.5% Medicare- 40.1% Other Funding- N/A Commercial Insurance- 26.6	Hispanic- 39.6% African American- 16.7 Caucasian- 34.6 Asian- 2.0 Other- 6.7 American Indian- 0.4

- Intervention(s): OBMC will formalize partnerships with local community agencies to work on projects specifically dedicated to health and wellness promotion such as Fort Bend Family Health Center (FBFHC), United Way, Weight Watchers, OBMC (OakBend Medical Group) and other agencies. We will form a task force of community members from each of the different agencies to do a needs assessment to determine targeted areas where a wellness management program in English and Spanish would be beneficial.

- Need for the project: This project directly relates to the Regional goal to "[t]ransform health care delivery from a disease-focused model of episodic care to a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary or duplicative services including hospital admissions, and builds on the accomplishments of our existing health care system[.]"

- Target population: All patients that seek their medical care through any of the OakBend Medical Center system entities, who will benefit from this and other projects. We plan to target patients with Medicaid, CHIP and Self-Pay, especially those with chronic disease(s).

- Category 1 or 2 expected patient benefits: OBMC does not currently operate a wellness program. However, OBMC has identified a minimum of five patient populations that would benefit from this wellness program. Most of these patients overlap to more than one population, which only increases the likelihood of non-compliance and poor quality of life.

- Category 3 outcomes: IT□3.4 In DY3 we plan to train staff and decrease inappropriate use of emergency department care by 2% over baseline, in DY4 by 5% and in DY5 by 8%.

Project Option 2.14.3: "Other" project option: Implement other evidence-based project to implement person-centered wellness self-management strategies and self-directed financing models that empower consumers to take charge of their own health care– Patient-Centered Wellness Management Program

Unique RHP Project Identification Number: 127303903.2.4 / Pass 3

Performing Provider Name/TPI: OakBend Medical Center (OBMC) / 127303903

Project Description:

OBMC will formalize partnerships with local community agencies to work on projects specifically dedicated to health and wellness promotion such as Fort Bend Family Health Center (FBFHC), United Way, OakBend Medical Group (OBMG), Weight Watchers and other agencies. We will form a task force of community members from each of the different agencies to do a needs assessment to determine targeted areas where a wellness management program would be beneficial.

This project will involve hiring and training of wellness staff, care coordination, development of educational materials, outreach to community of services offered in bilingual availability, access to or expanded transportation services as well as coordination for transportation, reminder calls to recipients regarding appointment times, eventually a help line for access of services offered, and printed educational materials in multiple languages. Depending on the needs assessment, outreach nurses, physical therapists or physical therapy assistants, dieticians and chaplaincy services, along with transportation coordination with Fort Bend County and other agencies providing such services, would be required. The project will also involve meetings led by nephrologists, cardiologists, pulmonologists and dieticians, etc to conduct awareness and education seminars for patients with end-stage renal diseases, congestive heart failure, COPD, diabetes and obesity.

Goal(s) and relationship to Regional goal(s):

Project goals:

The goal of this project is to create a wellness, self-management program that employs research-supported interventions, singly or in combination, to help individuals manage their chronic physical and behavioral health conditions.

This project meets the following Region 3 goals:

This project directly relates to the Regional goal to "[t]ransform health care delivery from a disease-focused model of episodic care to a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary or duplicative services including hospital admissions, and builds on the accomplishments of our existing health care system[.]"

Challenges:

Formalizing partnerships.

5-year expected outcome for provider and patients:

Improved management and compliance with treatment regimens of chronic conditions for patients, particularly patients with renal disease, COPD, congestive heart failure, diabetes and obesity.

Starting Point/Baseline:

Baseline data:

OBMC does not currently operate a wellness program. However, OBMC has identified a minimum of five patient populations, listed above, that would benefit from this wellness program. Most of these patients overlap to more than one population, which only increases the likelihood of non-compliance and poor quality of life.

Time period for baseline:

1/1/12 to 6/30/12

Rationale:

Reasons for selecting the project option:

This project will help OBMC to successfully engage the individual consumer in disease self-management and wellness activities related to chronic physical and behavioral health conditions, and empower person-centered recovery and improved health outcomes. This will improve both clinical outcomes as well as quality of life. Giving the individual consumer control over health resources is another complementary promising practice. Evidence has shown that navigation and support from community health workers and case managers trained in Motivational Interviewing resulted in increased access to and use of appropriate health services, including: more use of preventative care; more outpatient visits; more mental health and dental visits; greater adherence and persistence in taking prescribed medications for chronic conditions such as hypertension, respiratory conditions, diabetes, and high cholesterol; more medical stability for chronic conditions; and greater satisfaction with healthcare.

Project components:

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

- One of OakBend's milestones in Year 4 is to implement a continuous quality improvement plan by establishing meetings with other RHP providers.

Unique community need identification number the project addresses:

- CN.20- Lack of access to programs providing health promotion education, training and support, including screenings, nutrition counseling, patient education programs
- CN.23- Lack of patient navigation, patient and family education and information programs

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

This project will allow OBMC to deliver care in a much more coordinated and collaborative manner than it currently does. It will allow OBMC to participate in a learning collaborative and inter-agency coordination effort with other entities who's focus is to improve both access to and understanding of healthcare. This type of disease specific, patient-centered comprehensive wellness program would be a totally new initiative for OBMC.

Related Category 3 Outcome Measure(s):

IT-3.4 Renal Disease 30-Day Readmission Rate

Reasons/rationale for selecting the outcome measure(s):

OBMC has a relatively large population with all of the above listed chronic disease conditions. Part of the wellness program will be specifically targeted to these patient populations, Therefore, measuring the readmission rate for these chronic diseases will be a reasonable measure of this project's success because better disease management should result in fewer readmissions for manageable diseases. Currently over 45% of our patient population either has Medicaid or are Indigent. We foresee a significant improvement in access to healthcare in this payer population. That percentage equates to approximately 3,215 inpatient admissions in 2011.

Relationship to Other Projects:

How project supports, reinforces, and enables other projects:

This project will lay a foundation for, and reinforce the clinical effectiveness of, other DSRIP projects such as:

- 1.10 Enhance Performance Improvement and Reporting Capacity
- 2.2 Expand Disease Specific Chronic Care Management Models
- 2.4 Redesign to Improve Patient Experience
- 2.5 Redesign for Cost Containment

Relationship to Other Performing Providers' Projects in the RHP:

Healthcare costs are significantly increased within a patient base with such aggressive chronic conditions that have gone untreated. The initiatives focused to chronic disease management focus to conditions such as asthma, hypertension, and diabetes and are similar in the approach of managing & proactively treating chronic conditions in order to reduce 30-day readmission rates, inappropriate emergency department utilization, and healthcare costs. The Region 3 Initiative grid allows a cross reference of initiatives associated with chronic disease management. (addendum)

Plan for Learning Collaborative:

We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and successes as well as testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system.

Project Valuation:

Approach for valuing project:

OBMC values each project based on the specific needs of the community, the projected impact on the health outcomes of the community, the level of advancement to the healthcare delivery system, and the time, effort, and clinical resources necessary to implement each project. We recently hired a Community Health Coordinator to begin the process of compiling the patient information related to the aforementioned patient populations. She be working in partnership with the other community agencies and entities to ensure a successful collaborative effort.

In valuing this project, OBMC took into account the extent to which the implementation of a patient-centered wellness program would potentially meet the goals of the Waiver (support the development of a coordinated care delivery system, improve outcomes while containing costs, improve the healthcare infrastructure), the extent to which it will address the community needs, the population served, and the resources and cost necessary to implement the project.

Rationale/justification for valuation:

The implementation of a patient centered wellness program will promote and encourage patients to access care, and will allow them to more closely follow their treatment plans, which will lead to better clinical outcomes and higher patient satisfaction in the community. OBMC took these potential effects into account when considering the appropriate incentive payment value for this project.

127303903.2.4	2.14.3		Other Patient-Centered Wellness Management Program
OakBend Medical Center			127303903
Related Category 3 Outcome Measure(s):	127303903.3.7	IT-3.4	Renal Disease 30-Day Readmission Rate

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1 [P-1]: Develop screening criteria and a process for selecting eligible participants. Metric 1 [P-1.1]: Screening criteria and process are documented. Baseline/Goal: Screening criteria have not yet been developed Data Source: Project documentation. Milestone 1 Estimated Incentive Payment: $762,968.50 **Milestone 2** [P-2]: Identify population for intervention. Metric 1 [P-2.1]: Number of individuals meeting program entry criteria. Baseline/Goal: Zero patients have been identified Data Source: Project records Milestone 2 Estimated Incentive Payment: $762,968.50	**Milestone 3** [P-4]: Train staff in required knowledge, skills and abilities. Metric 1 [P-4.1]: Number of staff trained. Baseline/Goal: Screening criteria will be developed with input from the other RHP entities that we will be collaborating with on this project. Data Source: Project training records; training curricula. Milestone 3 Estimated Incentive Payment: $860,493.00 **Milestone 4** [I-13]: Emergency Department use. Metric 1 [I-13.1]: 2% reduction in inappropriate use of Emergency Department (ED) Care by individuals in the person-centered self-management project. Baseline: We will compile data from DY 2 for utilization review and evaluation, and increase contact with	**Milestone 5** [I-13]: Emergency Department use. Metric 1 [I-13.1]: 5% reduction in inappropriate use of Emergency Department Care by individuals in the person-centered self-management project. Baseline/Goal: 5% reduction Data Source: Project data; claims and encounter data; medical records. Milestone 5 Estimated Incentive Payment: $587,704.67 **Milestone 6** [P-12]: Review project data and respond to it every week with tests of new ideas, practices, tools, or solutions. Metric 1 [P-12.1]: Number of new ideas, practices, tools, or solutions tested. Data Source: Brief description of the idea, practice, tool, or solution tested each week, and summarized at	**Milestone 7** [I-13]: Emergency Department use. Metric 1 [I-13.1]: 8% reduction in inappropriate use of Emergency Department Care by individuals in the person-centered self-management project. Baseline/Goal: 8% reduction Data Source: Project data; claims and encounter data; medical records. Milestone 7 Estimated Incentive Payment: $724,969.50 **Milestone 8** [P-12, p. 428]: Review project data and respond to it every week with tests of new ideas, practices, tools, or solutions. Metric 1 [P-12.1]: Number of new ideas, practices, tools, or solutions tested. Data Source: Brief description of the idea, practice, tool, or solution tested each week, and summarized at

127303903.2.4	*2.14.3*		***OTHER PATIENT-CENTERED WELLNESS MANAGEMENT PROGRAM***
OAKBEND MEDICAL CENTER			*127303903*
Related Category 3 Outcome Measure(s):	*127303903.3.7*	*IT-3.4*	*Renal Disease 30-Day Readmission Rate*

Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
	these patients by the Community Health Coordinator (CHC or CHW) or worker to collaborate on steps to reduce inappropriate ED use as well as educate the patients and their families regarding other options for non-emergent health care needs. Goal: 2% reduction Data Source: Project data; claims and encounter data; medical records. Milestone 4 Estimated Incentive Payment: $860,493.00	quarterly intervals. Milestone 6 Estimated Incentive Payment: $587,704.67 **Milestone 7** **CQI**: P-8 Participate in interactions with other providers and RHP to promote collaborative learning around shared or similar projects Metric **CQI: P-8.1** Number meetings, conference calls or webinars organized by the RHP that the provider participated in. Data Source Meeting Agendas, sign-n sheets, conference calls, presentations, email Milestone 7 Estimated Incentive Payment: $587,704.67	quarterly intervals. Milestone 8 Estimated Incentive Payment: $724,969.50
Year 2 Estimated Milestone Bundle	Year 3 Estimated Milestone Bundle	Year 4 Estimated Milestone Bundle	Year 5 Estimated Milestone Bundle

127303903.2.4	***2.14.3***		***OTHER PATIENT-CENTERED WELLNESS MANAGEMENT PROGRAM***
OAKBEND MEDICAL CENTER			*127303903*
Related Category 3 Outcome Measure(s):	*127303903.3.7*	*IT-3.4*	*Renal Disease 30-Day Readmission Rate*
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Amount: $1,525,937	Amount: $1,720,986	Amount: $1,763,114	Amount: $1,449,939
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over DYs 2-5)*: *$6,459,976*			

Rice Medical Center

Pass 1

Project Option 2.7.1- Implement innovative evidence-based strategy to increase appropriate use of technology and testing: Expand Use of Immunization Tracking

Unique RHP Project Identification Number: 212060201.2.1
Performing Provider/TPI: Rice/212060201

Project Summary:

Provider: Rice Medical Center is a 25-bed critical access hospital with Trauma IV designation in Eagle Lake, Texas serving an 1100 square mile area and a population of approximately 20,000.

Intervention(s): Rice will implement across-the-board tracking of patients' immunization schedules and completed immunizations in order to avoid duplication and tardiness, and to promote preventative health care.

Need for the project: Rice Medical Center currently reports only on pediatric immunizations. The hospital needs to expand reporting through additional age groups, and can do so through its critical access hospital and rural health clinics in Southern Colorado County and Northern Wharton County. Keeping track of immunizations (including yearly flu and bacterial pneumonia shots) is an especially important endeavor to promote the health of the elderly citizens in Colorado County, who are more susceptible to disease and more likely to have difficulty tracking their immunization history. The RHP 3 Workgroups have identified that the Region as a whole suffers from a lack of immunization compliance, resulting in rising incidence of preventable illnesses such as mumps, measles, pertussis, and tuberculosis.

Target population: Rice Medical Center provides approximately 125,000-130,000 individual patient encounters per year, treating approximately 8,000-10,000 patients, through its hospital and clinic sites. All of these patients will be targeted by this project, and approximately 28-32% are Medicaid-eligible or uninsured.

Category 1 or 2 expected patient benefits: The project seeks to track immunizations for 30% of its patients by the end of DY3, 50% by the end of DY4, and 70% by the end of DY5. This tracking will benefit patients who will enjoy additional protection from duplicative immunizations and assistance in maintaining an appropriate immunization schedule.

Category 3 outcomes: IT-6.1 – Rice seeks to improve patients' satisfaction with their timely access to appointments, care, and information regarding immunizations through providing the ImmTrack service. In DY3, Rice will establish its patients' baseline of satisfaction with their timely access to care, appointments and information. Rice seeks to improve the satisfaction scores by 5% in DY4 and by 10% in DY5.

Project Option 2.7.1- Implement innovative evidence-based strategy to increase appropriate use of technology and testing: Expand Use of Immunization Tracking

Unique RHP Project Identification Number: 212060201.2.1
Performing Provider/TPI: Rice/212060201

Project Description:
Rice will implement across the board tracking of patients' immunization schedules and immunizations received in order to avoid duplication and tardiness, and to promote preventative health care.

Rice Medical Center currently reports only on pediatric immunizations. The hospital needs to expand reporting through additional age groups, and can do so through its critical access hospital and rural health clinics in Southern Colorado County and Northern Wharton County. Keeping track of immunizations (including yearly flu and bacterial pneumonia shots) is an especially important endeavor to promote the health of the elderly citizens in Colorado County, who are more susceptible to disease and more likely to have difficulty tracking their immunization history.

Goals and Relationship to Regional Goals:

While the Region has many specific objectives and improvement targets based on stakeholder input and community needs assessments, the over-arching goals that have guided many of our decisions include the following:
Project Goals:

- Develop a regional approach to health care delivery that leverages and improves on existing programs and infrastructure, is responsive to patient needs throughout the entire region, and improves health care outcomes and patient satisfaction.
- Increase access to primary and specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their condition, regardless of where they live or their ability to pay.
- Transform health care delivery from a disease-focused model of episodic care to a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary or duplicative services, and builds on the accomplishments of our existing health care system, and
- Develop a culture of ongoing transformation and innovation that maximizes the use of technology and best-practices, facilitates regional collaboration and sharing, and engages patients, providers, and other stakeholders in the planning, implementation, and evaluation processes.

Challenges:

Rice expects challenges in the following areas: (1) training providers to use the ImmTrack technology to track the immunization history and schedule for all patients visiting the hospital or its clinics; (2) educating patients about the benefits of maintaining a punctual immunization schedule; and (3) obtaining an accurate baseline history from patients; and the ability of computer systems to dependably collect and report.

Rice will confront these challenges by organizing comprehensive training session for providers before the program is in place. Rice's providers will communicate with clients about the benefits of this program, and the hospital may use social media forums to reach out to community members who may not visit the hospital or clinics. Rice will attempt to gather the most accurate information available, and the program will only become more successful as the years go by and the data is more accurate.

5-year Expected Outcome for Provider and Patients:
Rice expects to have 70% of its patients seen in the ImmTrack system, enabling Rice to avoid duplication and to inform patients when they are due for updated shots. Increased reporting will allow Rice Medical Center to provide better quality treatment to patients because physicians will have access to reliable information about the patients' medical history, and will be able to identify patients who are overdue for immunizations.

Starting Point/Baseline:
Rice Medical Center currently reports only on pediatric immunizations.

Rationale:
Rice Medical Center currently reports only on pediatric immunizations. The expansion of this reporting will allow the hospital to manage patients' immunization needs in a coordinated manner. This is important for several reasons: Colorado County has a high morbidity rate, some of which is likely attributable to flu and pneumonia infections that could be prevented by immunizations (as well as other conditions); and, Colorado County has a high rate of premature death, at least some of which is likely related to infections that can be prevented by maintaining regularly scheduled immunizations. Additionally, the RHP 3 Workgroups have identified that the Region as a whole suffers from a Lack of immunization compliance, resulting in rising incidence of preventable illnesses such as:

- Mumps
- Measles
- Pertussis
- Tuberculosis

Project Components:
With the development of the Disease Management Registry: Expand use of immunization tracking Project we propose to meet the required project component 2.7.1 - Implement innovative evidence-based strategy to increase appropriate use of technology and testing

Milestones & Metrics:
Process milestones and metrics: P-2 (P-2.1)
Improvement milestones and metrics: I-5 (I-5.1)
Unique community needs identification numbers the project addresses:
Ties to unique community needs: CN.1, CN.6, CN.7, CN.10, CN.17, CN.19

Related Category 3 Outcome Measure(s):

OD 6, IT 6.1(1) Rice selected this outcome because expanding the use of the ImmTrack system will allow the hospital to reach out to patients with immunization reminders (e.g. beginning of

flu season) and assure that they are scheduled for timely appointments and shots when due. This service to patients is intended to increase their satisfaction with Rice's healthcare delivery, and the survey given to patients in the registry should support patients' increased satisfaction with the program.

Relationship to other Projects:
This project relates to the following projects: Reduce Inappropriate Use of the ED and Establish the Wallis Clinic. These projects will work in tandem to improve the system's ability to track patients and assist patients in managing their needed immunizations.

Relationship to Other Performing Providers' Projects in the RHP:

The sheer volume of population as well as the complexity of patient conditions dictate the need of numerous disease registries in our region to properly identify and manage chronic conditions. The concept is utilized consistently throughout our region in order to help achieve milestones and outcomes specific to patient conditions. All disease registries presented have a similarity in concept but are unique in the sense of condition or patient population focus. The Region 3 initiative grid in the addendum reflects direct relations between all projects.

Plan for Learning Collaborative*:*

We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system.

Project Valuation:

The valuation of each Rice project takes into account the degree to which the project accomplishes the triple-aim of the Waiver, community needs, the population served by the project (both number of people and complexity of patient needs), and investment required to implement the project. This project's value derives from the fact that it will reach almost all of Rice's patients (and its clinics' patients) and constitutes preventative care aimed at reducing acute episodes of disease-related symptoms. The project is valued lower than Rice's other projects because it will take less time and investment to implement than some other projects, and the cost is expected to be lower. However, Rice believes this project meets patients' needs, and has value for the Region in preventing the spread of disease and related hospital admissions, and improving patient's ongoing quality of life.

212060201.2.1	***2.7.1***	***N/A***	***IMPLEMENT INNOVATIVE EVIDENCE-BASED STRATEGIES TO INCREASE APPROPRIATE USE OF TECHNOLOGY AND TESTING FOR TARGETED POPULATION - DISEASE MANAGEMENT REGISTRY: EXPAND USE OF IMMUNIZATION TRACKING***
Rice			212060201
Related Category 3 Outcome Measure(s):	*212060201.3.2*	*IT-6.1*	*OD-6 Patient Satisfaction, IT 6.1(1) Percent Improvement over baseline of patient satisfaction scores*
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-2]: Implement evidence-based innovational project for targeted population. Metric 1 [P-2.1]: Document implementation strategy and testing outcomes Baseline/Goal**:** No current tracking - Rice will train direct patient care providers in the clinics and hospital to use the ImmTrack software to create an immunization history and schedule for all patients. Data Source: Documentation of implementation Milestone 1 Estimated Incentive Payment: $ 20,246	**Milestone 2** [I-5]: Identify percent of Rice's hospital and clinic patients included in the ImmTrack registry Metric 1 [I-5.1] Number of patients added into ImmTrack Baseline/Goal: Rice will include 30% of patients seen in the ImmTrack registry. Data Source: ImmTrack Registry Milestone 2 Estimated Incentive Payment 2: $22,087	**Milestone 3** [I-5]: Identify percent of Rice's hospital and clinic patients included in the ImmTrack registry Metric 1 [I-5.1]: Numerator: total number of patients added into ImmTrack Denominator: total number of patients seen Baseline/Goal**:** Rice will include 50% of patients seen in the ImmTrack registry. Data Source**:** ImmTrack Registry Milestone 3 Estimated Payment Incentive Payment: $22,151	**Milestone 4** [I-5]: Identify percent of Rice's hospital and clinic patients included in the ImmTrack registry Metric 1 [I-5.1]: Numerator: total number of patients added into ImmTrack Denominator: total number of patients seen Baseline/Goal: Rice will include 70% of patients seen in the ImmTrack registry. Data Source: ImmTrack Registry Milestone 4 Estimated Payment Incentive Payment: $18,299
Year 2 Estimated Milestone Bundle Amount: $20246	Year 3 Estimated Milestone Bundle Amount: $22,087	Year 4 Estimated Milestone Bundle Amount: $22,151	Year 5 Estimated Milestone Bundle Amount: $18,299
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:** $82,783			

Project Option: 2.2.2 - Apply Evidence Based Care Management Model to Patients Identified as Having High Risk Health Needs: Chronic Disease Outreach

Unique RHP Project Identification Number: 212060201.2.2
Performing Provider/TPI: Rice/212060201

Project Summary:

Provider: Rice Medical Center is a 25-bed critical access hospital with Trauma IV designation in Eagle Lake, Texas serving an 1100 square mile area and a population of approximately 20,000.

Intervention(s): Rice will partner with the Colorado County Health Department and other local stakeholders to provide an organized, systematic approach to chronic disease outreach, reduction, and management using the Care Management Model. Specifically, Rice will identify patients with conditions or health statuses that place them at high risk for hospitalization, acute episodes, diminished quality of life, and long-term interventions (i.e. reduction in ADLs, inability to live independently, progression of the disease at a fast pace). Rice is already aware that diabetes is a prevalent condition within Region 3 and Colorado County, so the care management model will be implemented for those patients. Other potential targets will be patients with hypertension, heart disease, COPD, or other conditions identified as prevalent and placing patients at risk for costly and invasive health care interventions.

Need for the project: Colorado County has a high rate of obesity (29%) and physical inactivity (31%), both of which are linked to chronic diseases such as diabetes and hypertension. Colorado County has a higher rate of poor physical and mental health days, as well as a significantly higher rate of premature death and mortality, than both Harris County and the statewide average (again, which are at least partially linked to chronic disease). This project seeks to bridge the gap in care for the members of the population who are included in these statistics and likely suffer from chronic conditions.

Target population: The target population of this project includes the approximately 2,500-3,500 diabetic patients Rice (and its clinics) treats each year. The target will also include frequent flyers in Rice's ED, wherein approximately 40-50% of the patient conditions are deemed non-emergent. Finally, patients with a history of PPAs and PPRs will be targeted. Rice's rate of PPAs linked to diabetes, COPD, and hypertension is approximately 20%, and the leading condition linked to PPRs is COPD.

Category 1 or 2 expected patient benefits: Rice will identify three prevalent chronic diseases to target using the Care Management Model and implement the program for the targeted conditions by the end of DY3. In DY4, Rice will increase the number of targeted patients participating in care management by 25% over DY3, and by 50% over DY3 by the end of DY5.

Category 3 outcomes: IT-10.1 – Through this project, Rice seeks to improve the quality of life scores for Rice patients participating in the Care Management program by 5% in DY4 over the baseline established in DY3, and by 10% in DY5.

Project Option: 2.2.2 - Apply Evidence Based Care Management Model to Patients Identified as Having High Risk Health Needs: Chronic Disease Outreach

Unique RHP Project Identification Number: 212060201.2.2
Performing Provider/TPI: Rice/212060201

Project Description:
Rice proposes to provide a systematic approach to chronic disease outreach, reduction, and management.

Rice will partner with the Colorado County Health Department and other stakeholders to provide an organized, systematic approach to chronic disease outreach, reduction, and management. Patient education, follow-up, and management will result in better overall health outcomes for the targeted population, including increased quality of life, reduced use of acute care, and slower progression of chronic disease. Developing an effective outreach program that educates patients to the benefits of preventative and management practices; providing and training staff.

Specifically, Rice will identify patients with conditions or health statuses that place them at high risk for hospitalization, acute episodes, diminished quality of life, and long-term interventions (i.e. reduction in ADLs, inability to live independently, progression of the disease at a fast pace). Rice is already aware that diabetes is a prevalent issue in the State and within Region 3 and Colorado County, so the care management model will be used for those patients. Other potential targets will be patients with hypertension, heart disease, COPD, or other conditions identified as prevalent and placing patients at risk for costly and invasive health care interventions.

Goals and Relationship to Regional Goals:
The goal of this project is to develop and partner with the Colorado County Health Department and implement chronic disease management interventions that are geared toward improving effective management of chronic conditions and ultimately improving patient clinical indicators, health outcomes and quality, and reducing unnecessary acute and emergency care utilization.

While the Region has many specific objectives and improvement targets based on stakeholder input and community needs assessments, the over-arching goals that have guided many of our decisions include the following:
Project Goals:

- Develop a regional approach to health care delivery that leverages and improves on existing programs and infrastructure, is responsive to patient needs throughout the entire region, and improves health care outcomes and patient satisfaction.
- Increase access to primary and specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their condition, regardless of where they live or their ability to pay.
- Transform health care delivery from a disease-focused model of episodic care to a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary or duplicative services, and builds on the accomplishments of our existing health care system, and

- Develop a culture of ongoing transformation and innovation that maximizes the use of technology and best-practices, facilitates regional collaboration and sharing, and engages patients, providers, and other stakeholders in the planning, implementation, and evaluation processes.

Challenges:
Expected challenges include recruiting staff for the clinic, negotiating space for the clinic, reaching out to traditionally underserved communities, engaging in effective patient education, and doing so with limited resources. To address these challenges, Rice will work closely with the community to develop a plan to address these concerns and seek guidance from local resources including providers, associations, and other stakeholders to ensure we implement and provide the most effective process for positive outcomes for our community. We will create an organized, comprehensive program for reaching out to the target populations in Colorado County and coordinating their care to include medication management, lifestyle education, support, and health status monitoring.

5 Year Expected Outcome for Provider and Patients:
By developing an effective outreach program that educates patients about their chronic conditions and the benefits of preventative and management practices we expect to see a significant number of patients receiving care under our Chronic Care Model and by DY 5 expect to see a 50% increase (over the baseline) of the target population receiving care under this model. Through our comprehensive care coordination and ongoing management of the target population we also expect to see patients with improved symptoms and function which are two essential components of health-related quality of life.

Starting Point/Baseline:
Residents within the Rice Hospital District experience a high rate of diabetes, COPD and hypertension. Rice will establish a baseline in DYs 2 and 3 to determine the most prevalent and/or underserved chronic disease for which the greatest impact can be realized in DYs 4 and 5.

Rationale:
Because Rice does not currently have an organized, systematic approach to chronic disease outreach, reduction, and management, at-risk patients in the community often receive little to no professional support. Colorado County has a high rate of obesity (29%) and physical inactivity (31%), both of which are linked to chronic diseases such as diabetes and hypertension. Colorado County has a higher rate of poor physical and mental health days, as well as a significantly higher rate of premature death and mortality, than both Harris County and the statewide average (again, which are at least partially linked to chronic disease). This project seeks to bridge the gap in care for the members of the population who make up these statistics and likely suffer from common chronic conditions.

Project Components:
This project will address the core requirement of this project option which is to apply evidence-based care management model to patients identified as having high-risk health care needs.

Milestones and Metrics:
The following milestones and metrics were chosen for the chronic disease outreach project based on the requirements and the needs of this target population:
Process Milestones and Metrics: P-X (P-X.1); P-3 (P-3.1)
Improvement Milestones and Metrics: I-17 (I-17.1)

Unique community needs identification numbers:
Ties to unique Region community needs: CN.1, CN.7, CN.9, CN.10, CN.20, CN.23, CN.24

Related Category 3 Outcome Measure(s):
OD-10 Quality of Life/Functional Status, IT 10.1 Quality of Life – demonstrate improvement in quality of life scores, as measured by evidence based and validated assessment tool for the target population. Rice chose this outcome measure (improvement target) because the purpose of the outreach is to assist patients with chronic disease to maintain their health and well-being by managing their condition, which ties directly into their ongoing quality of life.

Relationship to other Projects:
This project is related to the FP/OB project, the Diabetes Center project, and the Reducing Inappropriate Use of the ED project. These initiatives are intended to work in tandem to create better patient outcomes for local residents suffering from chronic disease who do not have adequate access to primary care.

Relationship to Other Performing Providers' Projects in the RHP:

Healthcare costs are significantly increased within a patient base with such aggressive chronic conditions that have gone untreated. The initiatives focused to chronic disease management focus to conditions such as asthma, hypertension, and diabetes and are similar in the approach of managing & proactively treating chronic conditions in order to reduce 30-day readmission rates, inappropriate emergency department utilization, and healthcare costs. The Region 3 Initiative grid allows a cross reference of initiatives associated with chronic disease management. (addendum)

Plan for Learning Collaborative:

We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system.

Project Valuation:

The valuation of each Rice project takes into account the degree to which the project accomplishes the triple-aim of the Waiver, community needs, the population served by the project (both number of people and complexity of patient needs), and investment required to implement the project. Chronic disease management is essential to improving the short- and long-term health outcomes for Colorado County's residents, and for reducing the cost of health

care delivery in the Region. Chronic diseases such as diabetes, hypertension, COPD, and heart disease are fairly prevalent around Texas, and this will likely be the case for Rice's catchment area. Thus, the project will touch a broad base of the surrounding population. The project will take initial investment to create the parameters and identify the target population, and afterward to maintain communication with patients to manage their conditions and medication.

212060201.2.2	***2.2.2***	***N/A***	***CHRONIC DISEASE OUTREACH***
Rice			*212060201*
Related Category 3 Outcome Measure(s):	*212060201.3.3*	*IT 10.1*	*OD 10 Quality of Life/Functional Status*
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-X]: Conduct a needs/gap analysis in order to inform the establishment or expansion of services/programs (Rice will engage in a survey of its Colorado County patient records and community outreach, along with coordinate with the Colorado County Health Department to identify the 3 chronic conditions putting patients most at risk that are currently not managed under a care model.) Metric 1 [P-X.1] Assessment and findings of the inquiry. Baseline/Goal: Produce gap analysis Data source**:** Report of the findings Milestone 1 Estimated Incentive Payment: $40,492	**Milestone 2** [P-3]: Develop a comprehensive care management program for the identified chronic diseases (Rice will create an organized, comprehensive program for reaching out to the target populations in Colorado County and coordinating their care to include medication management, lifestyle education, support, and health status monitoring.) Metric 1 [P-3.1] Documentation of care management program Baseline/Goal: Develop and document program Data source**:** Program materials Milestone 2 Estimated Incentive Payment: $44,174	**Milestone 3** [I-17]: Apply the Chronic Care Model to targeted chronic diseases which are prevalent in Colorado County Metric 1 [I-17.1] Increase % of target population receiving care under the Chronic Care Model Goal: Increase by 25% over the baseline Data source: Registry Milestone 3 Estimated Incentive Payment : $44,303	**Milestone 4** [I-17]: Apply the Chronic Care Model to targeted chronic diseases which are prevalent in Colorado County Metric 1[I-17.1] Increase % of target population receiving care under the Chronic Care Model Goal: Increase by 50% over the baseline Data source**:** Registry Milestone 4 Estimated Incentive Payment: $36,598
Year 2 Estimated Milestone Bundle Amount: $40,492	Year 3 Estimated Milestone Bundle Amount: $44,174	Year 4 Estimated Milestone Bundle Amount: $44,303	Year 5 Estimated Milestone Bundle Amount: $36,598
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:** $165,567			

Project Option 2.6.2 - Establish self-management programs and wellness using evidence-based designs

Unique RHP Project identification number: 212060201.2.3
Performing Provider/TPI: Rice/212060201

Project Summary:

Provider: Rice Medical Center is a 25-bed critical access hospital with Trauma IV designation in Eagle Lake, Texas serving an 1100 square mile area and a population of approximately 20,000.

Intervention(s): Rice will develop a Certified Diabetes Teaching Center to educate and assist patients with managing their chronic disease. Rice will provide guidance to at-risk community members to accomplish the goal of prevention and management of diabetes for at-risk patients. Certified Diabetes Teaching Centers promote self-management for diabetic patients to achieve individualized behavioral and treatment goals that optimize health outcomes, which will benefit individual patients and the healthcare delivery system in Region 3.

Need for the project: Currently, the community does not have a certified diabetes teaching center. Residents within the Rice Hospital District currently must travel long distances to urban providers or rely on primary care physicians for specific education related to diabetes management and prevention. A large portion of the population is both unable to travel and does not maintain an established relationship with a primary care physician. Presently, 15% of Colorado County residents receiving primary care are not even screened for diabetes. Nearly 1/3 of adult residents are obese, and 31% of the population engages in physical inactivity, both of which are linked to the onset and exacerbation of diabetes. Finally, the County has a higher rate of preventable hospital stays than the State wide average and Harris County, some of which are related to diabetes.

Target population: Approximately 20% of the patients Rice currently treats in its hospital and local clinics are diagnosed with Type I or II diabetes, and of those patients 40-50% are Medicaid eligible or uninsured. These patients are the direct target population of this project, while patients in the community who are at risk or pre-diabetic are the secondary target of this project.

Category 1 or 2 expected patient benefits: The project seeks create an operational Certified Diabetes Teaching Center, including staff trained in protocols and community outreach, by the end of DY3. In DY 4, Rice intends to measure the number of patients identified with diabetes who are receiving disease-specific interventions through the diabetes center. In DY5, Rice will increase the number of targeted patients receiving disease-specific interventions through the Center by 10% over DY 4's baseline.

Category 3 outcomes: IT-1.10 – Rice seeks to increase the percentage of patients it treats in its hospital and clinics with controlled blood sugar (HbA1c of 9% or lower) by 10% over baseline in DY5.

Project Option 2.6.2 - Establish self-management programs and wellness using evidence-based designs

Unique RHP Project identification number: 212060201.2.3
Performing Provider/TPI: Rice/212060201

Project Description:
Rice will develop and implement a program for diabetic care management support in its primary care clinics.

Rice will develop a Certified Diabetes Teaching Center to educate and assist patients with managing their chronic disease. Rice will provide guidance to at-risk community members to accomplish the goal of prevention and management of diabetes for at-risk patients. Establishing self-management and wellness programs for our targeted population we provide the best opportunity for positive results and ongoing outcomes.

Goals and Relationship to Regional Goals:
While the Region has many specific objectives and improvement targets based on stakeholder input and community needs assessments, the over-arching goals that have guided many of our decisions include the following:
Project Goals:

- Develop a regional approach to health care delivery that leverages and improves on existing programs and infrastructure, is responsive to patient needs throughout the entire region, and improves health care outcomes and patient satisfaction.
- Increase access to primary and specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their condition, regardless of where they live or their ability to pay.
- Transform health care delivery from a disease-focused model of episodic care to a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary or duplicative services, and builds on the accomplishments of our existing health care system, and
- Develop a culture of ongoing transformation and innovation that maximizes the use of technology and best-practices, facilitates regional collaboration and sharing, and engages patients, providers, and other stakeholders in the planning, implementation, and evaluation processes.

Challenges:
Rice expects challenges as follows: 1) developing a program eligible for certification as a certified teaching center; 2) training and/or acquiring qualified staff to administer the program; and 3) educating patients about the benefits of preventative care. Rice intends to address these challenges by researching best practices and planning effectively to implement a center that will receive certification. As part of developing the plan, Rice will create a timeline and allocate resources for timely training and/or recruiting of staff, so as to coincide with the implementation of the center. Finally, Rice will engage stakeholders in reaching out to the at-risk community by using innovative methods, such as social media, provider outreach, or other community messaging forums.

5-Year Expected Outcome for Provider and Patients:
Rice expects a high rate of prevention of the onset of Type II diabetes for targeted pre-diabetics in the community through provider-furnished education and management about lifestyle choices, medications, and risks. Additionally, Rice expects a higher rate of controlled diabetes among community members with the chronic disease.

Starting Point/Baseline:
The current community does not have a certified diabetes teaching center. Residents within the Rice Hospital District currently must travel long distances or rely on primary care physicians for specific education related to diabetes management and prevention. A large portion of the population is both unable to travel and do not maintain an established relationship with a primary care physician.

Rationale:
Colorado County residents will benefit from primary care providers educating at-risk patients on how to prevent the onset of Type II Diabetes and providing disease management best-practices to those suffering from diabetes already. The prevalence of diabetes increases annually around the State, and this project will further address Colorado County's rate of premature death and poor physical health days, which exceed the statewide rate.

Specifically, 15% of Colorado County residents receiving care are not being screened for diabetes. Nearly 1/3 of adult residents are obese, and 31% of the population engages in physical inactivity, both of which are linked to the onset and exacerbation of diabetes. Finally, the County has a higher rate of preventable hospital stays than the State wide average and Harris County, some of which are related to diabetes.

Project Components:
This project will address the core requirement of this project option which is to establish self-management programs and wellness using evidenced-based designs.

Milestones and Metrics:
The following milestones and metrics were chosen for the Rice Certified Diabetes Teaching Center project based on the core component and the needs of the target population:
Process Milestones: P-1 (P-1.1); P-3 (P-3.1)
Improvement Milestones: I-6 (I-6.1); I-8 (I-8.1)
Unique community needs assessment numbers:
CN.1, CN.4, CN.10, & CN.12.

Related Category 3 Outcome Measure(s):
OD-1 Primary Care and Chronic Disease Management, IT-1.10 Diabetes care: HbA1c poor control (>9.0%)
Reasons/rationale for selection the outcome measures:
Rice chose this Category 3 Outcome because one of the goals of the Certified Diabetes Teaching Center is to assist patients in managing this chronic disease. When a diabetic's blood sugar is properly and regularly managed, the risk of being admitted to the hospital for diabetes related complications is reduced greatly. For example, when patients manage their glucose levels

they are able to reduce micro-vascular and neuropathic complications of type 1 and type 2 diabetes.

Avoiding the hospital stays and other potential consequences of uncontrolled blood sugar (blindness, amputation, etc) is both beneficial for patient short- and long-term health outcomes (less exposure to infection and hospital-based complications, as well as invasive interventions for the related health consequences), and beneficial for the health care delivery system by reducing costs.

Relationship to other Projects:
This project is related to the following Rice projects: Chronic Disease Outreach, establishing the Wallis Clinic and Reducing Inappropriate use of the ED. These projects will work in tandem, creating a comprehensive approach to managing diabetes.

Relationship to Other Performing Providers' Projects in the RHP:
Healthcare treatment cannot focus to only the acute or chronic encounter and properly treat the patient. It is critical that our region focuses to patient education and community education to ensure a proactive and responsive approach to healthcare needs. The education models represented in the Region 3 RHP plan can be identified in the Initiative Grid (addendum) and all focus to outcome measures such as appropriate utilization, patient satisfaction scores, and standalone chronic condition scores such as diabetes and asthma.

Plan for Learning Collaborative:
We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system.

Project Valuation:
The valuation of each Rice project takes into account the degree to which the project accomplishes the triple-aim of the Waiver, community needs, the population served by the project (both number of people and complexity of patient needs), and investment required to implement the project. Rice valued this project based on the following considerations:

1. Managing chronic disease prior to the onset of acute or emergent conditions is a patient-centered and cost-centered goal under the Waiver, which this project will address head-on by providing early intervention, patient education, and provider monitoring of this chronic disease.
2. Due to the County's high rate of obesity and physical activity, there are likely many patients suffering from pre-diabetes or uncontrolled diabetes. Rice needs to first identify these patients (which will mean providing screening to all patients, and engaging new patients to visit the Center for screening). Rice then needs to determine how to have the maximum impact on the lifestyle choices made by the Center's patients by using innovative and evidence-based methods for communicating with and monitoring patient success at preventing and/or controlling the condition.

3. Implementing the Center will require a great deal of investment. Specifically, staff time will need to be dedicated to planning and implementing the development of the Center, seeking Certification, and operating the Center. Rice will need to identify space and start-up costs, as well as ways to engage stakeholders in the community (providers, patients, social groups).

212060201.2.3	**2.6.2**	*N/A*	***Implement Evidence-based Health Promotion Programs - Certified Diabetes Teaching Center***
Rice			*212060201*
Related Category 3 Outcome Measure(s):	*212060201.3.3*	*IT-1.10*	***Diabetes care: HbA1c poor control (.9.0%)-NQF 0059***

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-1] Conduct an assessment of health promotion programs that involve community health workers at the local and regional level (Rice will research accreditation requirements and steps towards establishing a Certified Diabetes Teaching Center.) Metric 1 [P-1.1]Document regional assessment Baseline: No certified diabetes teaching center for current area Data Source: Rice's assessment and summary of findings. Milestone 1 Estimated Incentive Payment: $37,117	**Milestone 2** [P-3] Implement, document and test an evidence-based innovative project for targeted population (Rice will establish the Certified Diabetes Teaching Center and begin identifying and working with those at-risk in the Colorado County community.) Metric 1 [P-3.1] Document implementation strategy and testing outcomes Baseline: TBD Data Source: Evidence of implementation and certification received Milestone 2 Estimated Incentive Payment: $40,493	**Milestone 3** [I-6] Identify percent of patients in defined population receiving intervention consistent with evidence-based model (Rice will determine the impact of the Certified Diabetes Teaching Center for at-risk community members in Colorado County.) Metric 1 [I-6.1]: Defined population with increased patients receiving intervention Baseline: TBD Data Source: Patient records Milestone 3 Estimated Incentive Payment: $ 40,611	**Milestone 4** [I-8] Increase access to health promotion programs and activities using innovative project option. (Rice will increase the target diabetic and pre-diabetic population of Colorado County reached by the center by 10% over the baseline.) Metric 1 [I-8.1]: Increase percentage of target population reached by the project in Colorado County. Baseline: TBD Data Source: Patient records, other documentation showing targeted population versus those seen at the Center Milestone 4 Estimated Incentive Payment: $33,548
Year 2 Estimated Milestone Bundle Amount: $37,117	Year 3 Estimated Milestone Bundle Amount: $40,493	Year 4 Estimated Milestone Bundle Amount: $40,611	Year 5 Estimated Milestone Bundle Amount: $33,548
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $151,769			

Spindletop Center

Pass 1

Project Option 2.15.2 - Integrate primary and behavioral healthcare services: design, implement and evaluate projects that provide integrated primary and behavioral health care services
Unique RHP Project Identification Number: 096166602.2.1
Performing Provider Name/TPI: Spindletop Center / 096166602

Project Summary:

Provider: Spindletop Center is a public entity community that provides services for approximately 2900 adult, child, and adolescent behavioral health clients, With locations in Beaumont, Orange, Port Arthur, Lumberton, and Silsbee, Spindletop serves a population of more than 400,000 in Jefferson, Orange, Hardin, and Chambers counties.

Intervention: Spindletop will co-locate primary care clinics in its buildings to facilitate coordination of primary and behavioral healthcare. A mobile clinic will be acquired to provide physical and behavioral health services for our clients in locations other than existing Spindletop clinics. Spindletop will also implement Individualized Self Health Action Plan for Empowerment ("In SHAPE"), a wellness program for individuals with mental illness.

Need for project: The Region Community Needs Assessment has identified the need for expanded physical health care. Many behavioral health clients cannot access physical health care because they are uninsured or indigent. Health clinics that serve indigent populations often cannot accept more patients and charge a fee higher than many clients can pay. Some of our behavioral health clients have difficulty arranging transportation for multiple healthcare visits.

Target Population: This project is targeted to the 2200 adult mental health clients Spindletop serves. Since 54% of these are Medicaid clients and most of the others are uninsured indigent, almost all of the individuals who participate in this program will be either indigent or enrolled in Medicaid.

Expected benefits: By integrating primary care with Spindletop's behavioral services, 1500 behavioral health clients per year will have open access to outpatient physical health care and appropriate referrals by the end of DY 5, resulting in improved quality of life and reducing emergency room visits and hospitalizations. For DY 2, the process milestone is to develop the integrated sites as reflected in the number of locations and providers participating in the integration project. In demonstration years 3-5, the improvement milestones will be the number of primary care appointments available.

Category 3 outcomes: Spindletop has selected improvement outcome measure OD-6 Patient Satisfaction, IT-6.1, percent improvement over baseline of patient satisfaction scores, (1) patients are getting timely care, appointments, and information. The client survey will be designed to produce comparable data on the client's perspective on care that will allow objective and meaningful assessment of the program in meeting the needs of the clients.

Project Option 2.15.2 - Integrate primary and behavioral healthcare services: design, implement and evaluate projects that provide integrated primary and behavioral health care services

Unique RHP Project Identification Number: 096166602.2.1
Performing Provider Name/TPI: Spindletop Center / 096166602

Project Description:
This project will integrate primary care with the behavioral health care services Spindletop Center ("Spindletop") provides in order to improve care and access to needed health services for the clients we serve.

Spindletop will co-locate primary care clinics in its existing buildings to facilitate coordination of healthcare visits and communication of information among healthcare providers. In addition, a mobile clinic will be purchased or leased and equipped to provide physical and behavioral health services for our clients in locations other than existing Spindletop clinics. The mobile clinic could also be used to provide physical and behavioral health services during disasters such as hurricanes.

To supplement the benefits of integrating primary care with behavioral health services, Spindletop will implement Individualized Self Health Action Plan for Empowerment ("In SHAPE"), a wellness program for individuals with mental illness. Clients will receive proactive, ongoing care that keeps them healthy and empowers them to self-manage their conditions in order to avoid their health worsening and needing ED or inpatient care.

Goals and Relationship to Regional Goals:
This project relates to the Region 3 goal of improving the health of our region by expanding and coordinating access to patient-centered primary care and behavioral health care services that includes health promotion and disease prevention.

Challenges:
Although Spindletop currently provides basic care such as labs and screenings for drugs, pregnancy, glucose and lipid profiles, we have not expanded other physical health care services due to funding limitations. Hiring or contracting for primary care providers may be challenging as well. Spindletop will initially use one of its current physicians to provide primary care two days a week in addition to the behavioral health services she provides.

5-Year Expected Outcome for Provider and Patients:
By integrating primary care with Spindletop's behavioral services, 1500 behavioral health clients per year will have open access to outpatient physical health care and appropriate referrals by the end of demonstration year 5. We will begin the project by providing primary health care two days a week in DY3 and add another day each year, resulting in primary care services offered four days per week by year 5. Note that these outcomes are for both Regions 2 and 3 since this project spans these two areas.

Addressing the physical health needs of clients will result in improved quality of life for these clients as well as reducing emergency room visits and hospitalizations for more severe illnesses and diseases that occur when physical health is neglected.

Starting Point/Baseline:
Spindletop Center currently provides behavioral health services for primarily indigent or Medicaid-eligible clients who have schizophrenia, bipolar disorder, and major depression. We have space in our existing facilities to co-locate primary care providers. A need has been identified to provide primary care for our clients in the same location that they receive behavioral health services. Scheduling, billing, and electronic health records systems are already in place for our clients and could be adapted for integration with primary care services.
Rationale:
Behavioral health clients have a high incidence of high blood pressure, cholesterol, obesity, diabetes, and other severe illnesses that shorten their life spans by 25 years compared to the general public. They are frequently high utilizers of hospital emergency departments because they do not have access to regular physical health care.

The Region 3 Community Needs Assessment has identified the need for expanded and integrated physical and behavioral health care. Spindletop Center has determined that many of our behavioral health clients do not have access to physical health care because they are uninsured or lack funds to pay for these services. Health clinics that serve indigent populations frequently do not have capacity to accept more patients and charge a fee higher than many clients are able or willing to pay. Some of our behavioral health clients have difficulty arranging transportation for multiple healthcare visits. Co-locating primary care providers in our behavioral health facilities, providing a mobile clinic, and coordinating healthcare appointments will increase the likelihood that our clients will receive the physical health care they need.

The primary care/behavioral health integration proposed in this plan relates to community needs CN.1, CN.2, CN.5, and CN.10.

This project represents a new initiative for Spindletop. No U.S. Department of Health and Human Services funding is received for this program.

Project Components:
Components of the project include the following:
- Facilities will be adapted for co-locating primary care services.
- A mobile clinic will be purchased and equipped to provide primary and behavioral health care.
- Medical professionals and support staff will be hired or contracted to provide the primary care services.
- InSHAPE health mentors will be hired and trained to work one-on-one with behavioral health clients for education, planning, coaching, and measuring progress.
- For the InSHAPE program Spindletop will partner with local wellness and fitness centers to help behavioral health clients navigate the available opportunities to improve their health condition.
- Protocols will be established for joint scheduling, shared information and treatment plans, and referrals.
- Spindletop's existing electronic health record system will either be expanded to accommodate physical health data if primary care providers are hired as employees or will be integrated with outside systems if contracted providers are utilized for primary care.
- Spindletop's current medical staff meetings will be expanded to include primary care providers and discussions of primary care issues at least monthly.

- A system of reporting primary care utilization and outcomes will be developed.
- Ongoing quality assessments will be done to provide feedback for impact and improvements.

Milestones & Metrics:
For demonstration year 2, the process milestone is to develop the integrated sites as reflected in the number of locations and providers participating in the integration project.

In demonstration years 3-5, the improvement milestones will be the number of primary care appointments available. Adding 500 appointments each year will increase the number of available appointments to 1500 by the end of demonstration year 5. The number of additional appointments is for both Regions 2 and 3.

Related Category 3 Outcome Measure(s):
Spindletop has selected improvement outcome measure IT-6.1, percent improvement over baseline of patient satisfaction scores, (1) patients are getting timely care, appointments, and information. Since the goal of this project is to provide expanded primary care for our behavioral health clients, measuring the availability and timeliness of physical health care and appointments that meet clients' needs is important. If clients are satisfied with the service, they will be more likely to access primary care that will lead to improved physical health.

Relationship to Other Projects and Measures:
This project relates to Spindletop's Region 2 project to enhance behavioral health training #096166602.2.4 as techniques implemented in that plan may be applied to this program. The project to provide specialty behavioral health care #096166602.1.1 is also related as more clients could receive primary care as well; although this is a Region 2 project, it will also expand care in Region 3

Relationship to Other Performing Providers' Projects and Measures:
Other providers in the region are expanding behavioral health capacity and integrating behavioral and physical health. Spindletop's project will complement those activities.

The cohabitation of primary care and behavioral health is an important focus of our region in order to treat the patient base with comprehensive physical and behavioral healthcare issues. There are multiple initiatives in our RHP plan that address this need and all can be found on the Region 3 Initiative Grid in the addendums. The outcome measures focused to screening measures and access of the patient base.

Plan for Learning Collaborative: We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our region's healthcare system.

Project Valuation:
Spindletop considered several factors in valuing this project including reductions in costs associated with emergency room visits and hospitalizations for diseases and illnesses. Improving the physical health of behavioral health clients should reduce the number of ED visits and the occurrences of hospitalizations. The average cost of an ED visit in Spindletop's area is $1,265; average cost of a cardiology-related hospital stay is about $16,000.

Another valuation factor used for this project is the monetary value for a collaborative primary/behavioral health intervention as measured by quality adjusted life-years multiplied by a life year value. This valuation methodology uses health economic studies to assign a life year value associated with the health intervention. Since behavioral health clients have a high incidence of severe illnesses that shorten their life spans by 25 years compared to the general public, any programs that improve their mental and physical health should increase both the length and quality of their lives.

<table>
<tr><td>096166602.2.1</td><td>2.15.2</td><td>N/A</td><td colspan="2">Integrate Primary and Behavioral Health Care Services</td></tr>
<tr><td colspan="4">Spindletop Center</td><td>096166602</td></tr>
<tr><td>Related Category 3 Outcome Measure(s):</td><td>096166602.3.1</td><td>OD-6 IT-6.1 (1)</td><td colspan="2">Percent improvement over baseline of patient satisfaction scores-Patients are getting timely care, appointments, and information</td></tr>
<tr><td>Year 2
(10/1/2012 – 9/30/2013)</td><td colspan="2">Year 3
(10/1/2013 – 9/30/2014)</td><td>Year 4
(10/1/2014 – 9/30/2015)</td><td>Year 5
(10/1/2015 – 9/30/2016)</td></tr>
<tr><td>Milestone 1 P-5: Develop integrated sites reflected in number of locations and providers participating in the integration project
Metric 1 P-5.2:
Goal: Number of primary care providers newly located in behavioral health settings
Baseline/Goal: 1 primary care provider
Data Source: Employment records and/or contracts

Milestone 1 Estimated Incentive Payment : $267,378</td><td colspan="2">Milestone 2 I-X: Expand primary care available appointments
Metric 1 [I-X.1]:
Baseline/Goal: Number of primary care appointments available: 500 primary care appointments
Data Source: Scheduling records

Milestone 2 Estimated Incentive Payment: $293,611</td><td>Milestone 3 I-X: Expand primary care available appointments
Metric 1 [I-X.1]:
Baseline/Goal: Number of primary care appointments available: additional 500 primary care appointments over prior year
Data Source: Scheduling records

Milestone 3 Estimated Incentive Payment: $314,096</td><td>Milestone 4 I-X: Expand primary care available appointments
Metric 1 [I-X.1]:
Baseline/Goal: Number of primary care appointments available: additional 500 primary care appointments over prior year
Data Source: Scheduling records

Milestone 4 Estimated Incentive Payment: 303,476</td></tr>
<tr><td>Year 2 Estimated Milestone Bundle Amount: $267,378</td><td colspan="2">Year 2 Estimated Milestone Bundle Amount: $293,611</td><td>Year 4 Estimated Milestone Bundle Amount: $314,096</td><td>Year 5 Estimated Milestone Bundle Amount: $303,476</td></tr>
<tr><td colspan="5">TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5): $1,178,561</td></tr>
</table>

St. Joseph Medical Center

Pass 1

Project Option: 2.17.1 – Design, implement, and evaluate interventions to improve care transitions from the inpatient setting for individuals with mental health and/or substance abuse disorders: Partial Hospitalization Program

Unique RHP Project Identification Number: 181706601.2.1
Performing Provider Name/TPI: St. Joseph Medical Center/181706601

Project Description:
St. Joseph Medical Center proposes to expand services to individuals that have a mental health and/or substance abuse disorder through a Partial Hospitalization Program.
Provider:
St. Joseph Hospital is a 792 licensed facility. Located in the heart of downtown Houston, St. Joseph's Hospital has provided medical and psychiatric care to Houstonians for 125 years.

Volume Statistics - FY2012	Patient Payer Mix: Overall Hospital (%)	Patient Payer Mix: Psychiatry (%)	Patient Demographics (%)
ER visits- 29,155 Emergency visits- 173,263 Behavioral Health Admissions - 3,518 Med-surg admits – 7049	1.18 - Commercial 18.76- Managed Care 19.28- Managed Medicaid 16.34- Managed Medicare 15.09- Medicaid 20.78- Medicare 8.37 - Charity	2.27- Commercial 8.77- Managed Care 18.40- Managed Medicaid 3.05 - Managed Medicare 10.41 - Medicaid 35.61 - Medicare 21.48 - Charity	Caucasion – 33.47 Black – 37.59 Hispanic – 11.51 Asian - .44 American Indian/Native American - .38 Unknown – 13.24 Other – 3.34

Intervention(s):
In this program we will only take voluntary patients and patients must agree to the program rules. All patients are seen by a psychiatrist, psychiatric residents and a RN. They attend four "core" groups per day ran by a licensed therapist. The program runs from the hours of 9:00 to 3:00 and a small breakfast, lunch and snacks are provided.
Need for the project:
Within the Houston community, there are several similar programs servicing the outlying areas. Few programs of this sort assist those clients in or around the Downtown community. Many shelters and low-income type agencies are housed in and around St Joseph's Hospital.
Target Population:
The program will serve both clients discharging from the inpatient unit and also clients coming from outside referral sources.
Category 1 or 2 expected patient benefits:
Our goal is to provide the "best" model for the patients in this program (typically lower functioning individuals with a GAF below 40). To do this, we are investigating the best evidence-based models and implementing a model within the next 6 months.
Related Category 3 Outcome Measure(s):
OD-1 Primary Care and Disease Management
IT-1.18 Follow Up After Hospitalization for Mental Illness

Project Option: 2.17.1 – Design, implement and evaluate interventions to improve care transitions from the mental health and/or substance abuse disorder

Unique RHP Project Identification Number: 181706601.2.1

Performing Provider Name/TPI: St Joseph Medical Center/181706601

Project Description:

St. Joseph Medical Center proposes to expand services to individuals that have a mental health and/or substance abuse disorder through a Partial Hospitalization Program.

The plan and goal for this program is to expand services within the community for the Partial Hospitalization Program at St. Joseph Medical Center. Many times, clients who are functioning at or below a GAF of 40 (CMS recommendation for this level of care) do not follow through with their care recommendations including; medication compliance, living situation stability, therapy and aftercare needs. This in turn results in a high level of recidivism and/or re-admissions that having a partial program helps correct.

Through the ongoing efforts of wrap-around services such as a PHP, clients are able to attend groups, maintain and be monitored with their medication compliance and have support in communication with their current residential setting. To enhance compliance, transportation is provided to/from the patient's residence.

Many patients in the PHP programs are participants in medicare programs and are unable to remain compliant with their care post inpatient care. Many underinsured in the Houston area (Medicaid HMO) are unable to access care and become non-compliant with their medications and over utilize inpatient care. It is believed that with a collaborative effort with MHMRA, these patients could have their needs met better through a Partial program that ensures compliance by monitoring them daily (Monday-Friday) and ensuring they participate in the program by providing transportation to this vulnerable population.

Each patient in the PHP is initially evaluated to determine if they are appropriate and willing to be compliant with the program- therefore, in this program we only take voluntary patients and they must agree to the program rules. All patients are seen by a psychiatrist, psychiatric residents and a RN. They attend four "core" groups per day ran by a licensed therapist. The program runs from the hours of 9:00 to 3:00 and a small breakfast, lunch and snacks are provided.

Goals and Relationship to Regional Goals:

Project Goals:

- Expand PHP services to individuals in the Houston metro area
- Expand Transportation to/from the PHP for those patients requiring care from our PHP

- Collaborate with other area agencies to provide services for their clients and offer better wrap-around services to meet the needs within the community
- Increase the percentage of patients 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. Rate reported will be those patients with follow up visits within 30 days of discharge.
-

This project meets the following Region 3 goals:

Develop a culture of ongoing transformation and innovation that maximizes the use of technology and best-practices, facilitates regional collaboration and sharing, and engages patients, providers, and other stakeholders in the planning, implementation, and evaluation processes.

Challenges:

1. Locating, hiring and training staff appropriate for the PHP (RN's, therapists and Techs)

2. Higher level of scrutiny on all levels of PHP due to multiple concerns with other providers which will require the Director be involved in and attending semi-annual conferences on compliance and regulatory concerns.

3. Physician coverage issue may be an issue for any off site locations

The facility will address these challenges by:

1. Work through Human Resources to advertise, identify and help in the hiring/training portion of these issues.
2. Attendance at the semi-annual conferences on compliance and regulatory concerns held by the state. Additionally, an internal auditor will assist with ensuring compliance through regular chart and programmatic audits.
3. Facility will identify community practitioners willing to provide physician coverage and partner with the facility.

5-Year Expected Outcome for Performing Provider and Patients:

-Patient expansion will reach 50 ADC (Average Daily Census) through a gradual ramp-up
-Patients will participate in evidence-based programming
-Ongoing feedback from both the patients and community partners will help determine best practices and consistent re-evaluation of the program will occur

Starting Point/Baseline:

-We currently have one van which is operational providing transportation to the clients within the program
-Staffing currently includes one full time RN, one full-time therapist, one tech/driver along with a working manager
-Current Average Daily Census is: 5

Rationale:

Many of the clients identified as needing this service are currently being readmitted to the facility for inpatient care on a regular basis. The goal of this program is to decrease recidivism; increase compliance to discharge plans and help ensure the patient is more functional in an outpatient setting. Most clients admitted to a partial program have a GAF (global assessment of functioning – as noted in the DSM4 Manual) of 40 or below. Typically, this means that they have poor psycho-social skills and low compliance to discharge plans and poor follow through with their medication regimen.

Project Components:

Through the Partial Hospitalization Program, we propose to meet all required project components listed below and believe that the selected milestones and metrics relate to project components.

a) Develop a cross-continuum team comprised of clinical and administrative representatives from acute care, ambulatory care, behavioral health and community-based non-medical supports
b) Conduct an analysis of the key drivers of 30-day hospital readmissions for behavioral health conditions using a chart review tool and patient and provider interviews.
c) Identify baseline mental health and substance abuse conditions at high risk for readmissions
d) Review best practices for improving care transitions form a range of evidence-based or evidence-informed models
e) Identify and prioritize evidence-based strategies and clinical protocols that support seamless care transitions and reduce preventable 30-day readmissions
f) Implement two or more pilot interventions in care transitions targeting one or more patient care units or a defined patient population.
g) Conduct quality improvement for project using methods such as rapid cycle improvement.

Milestones & Metrics:

The following milestones and metrics have been chosen for the Partial Hospitalization Program project based on the needs of the target population:

- Process milestones and Metrics: P-6; P-6.1

Unique community need identification number the project addresses:

- CN-3 – Inadequate access to behavioral health care

Related Category 3 Outcome Measure(s):

OD-1 Primary Care and Disease Management

IT-1.18 Follow Up After Hospitalization for Mental Illness – NQF 0576

Project Valuation:

This project has an assigned value of $8,205,536 for the four years starting with DY2 – DY5. Extensive analysis was initiated to derive at this value. Project costs (capital and operational) and community benefits were among the factors used to create the valuation. Modest renovations to an existing space in the Psychiatric building (Cullen Building) must be made to accommodate the expected OP census. Renovation costs are estimated at $250,000 (capital). In addition, a medical director must be paid to care for these patients. Also, clinical staff must be employed to conduct the non-physician care associated with this service line. In addition, a transport van must be purchased to increase our census as this project expects ($40,000 capital estimated).

181706601.2.1	***2.17.1***	***2.17.1 A-G***	***Partial Hospitalization Program***
St. Joseph's Medical Center	***181706601***		
Related Category 3 Outcome Measure(s): *IT-1.18: Follow Up after Hospitalization for Mental Illness NQF 0576*	*[unique Category 3 IT identifier(s)]* *181706601.3.5*	*[Reference number(s) from RHP PP]* *OD-1*	*[Outcome Measure (Improvement Target) Title(s)]*
Year 2 (10/1/2012 – 9/30/2012)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1 [P-6] Identify evidence-based frameworks that support seamless care transitions Metric 1 [PX] Conduct needs assessment, literature review for evidence-based practices and tailor intervention to local context Baseline/Goal: Track recidivism to inpatient or PHP up to 3 months subsequent to discharge. Data Source: Medical records, program documentation, EHR Milestone 1 Estimated Incentive Payment: $ 2,062,779 .	**I-17. Milestone:** Improve patient satisfaction/experience scores **I-17.1. Metric:** Percent improvement of patient satisfaction scores over baseline by domain.106 a. Calculated as (re-measurement score – baseline score)/baseline score b. Data Source: Patient satisfaction/experience survey and/or CMS Medicare Hospital Quality Initiative Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) or CG-CAHPS scores c. Rationale/Evidence: Improvement in experience scores will be the ultimate measure of success of improvement	**Milestone 3** Improvement in percentage of "High Risk" patients with customized care plans before discharge Baseline/Goal: 25% percent improvement in percentage of "High Risk" patients with customized care plans before discharge Data Source: Medical Records, Program Documentation, E.H.R. Milestone 3 Estimated Incentive Payment: $2,256,923	**Milestone 4** Metric: Follow up after hospitalization Baseline/Goal: 25% increase in number of patients receiving follow-up care after hospitalization for Mental Illness within 7 to 30 days Data Source: Medical Records, Program Documentation, E.H.R. Milestone 4 Estimated Incentive Payment: $1,635,452

	efforts. Milestone 2 Estimated Incentive Payment: $2,250,382		

Project Option: 2.15.1 – Design, implement and evaluate interventions to improve care transitions from the mental health and/or substance abuse disorder

Unique RHP Project Identification Number: 181706601.2.2
Performing Provider Name/TPI: St Joseph Medical Center/181706601
Project Description:
This proposed unit will meet the needs of adults (ages 18 and above) who have a primary medical diagnosis with a co-occurring psychiatric diagnosis. These patients will be treated on a unit specifically designed to meet both diagnosis within the hospital. It will be a separate and distinct unit – comprised of 12 beds.
Provider:
St. Joseph Hospital is a 792 licensed facility. Located in the heart of downtown Houston, St. Joseph's Hospital has provided medical and psychiatric care to Houstonians for 125 years.

Volume Statistics - FY2012	**Patient Payer Mix: Overall Hospital (%)**	**Patient Payer Mix: Psychiatry (%)**	**Patient Demographics (%)**
ER visits- 29,155 Emergency visits- 173,263 Behavioral Health Admissions - 3,518 Med-surg admits – 7049	1.18 - Commercial 18.76- Managed Care 19.28- Managed Medicaid 16.34- Managed Medicare 15.09- Medicaid 20.78- Medicare 8.37 - Charity	2.27- Commercial 8.77- Managed Care 18.40- Managed Medicaid 3.05 - Managed Medicare 10.41 - Medicaid 35.61 - Medicare 21.48 - Charity	Caucasion – 33.47 Black – 37.59 Hispanic – 11.51 Asian - .44 American Indian/Native American - .38 Unknown – 13.24 Other – 3.34

Intervention(s):
The concept would be to have a strong emphasis on the medical issues while also focusing on the mental health needs of the clients at the same time. This medical psychiatric nursing and support team will be trained in trauma-informed care models and the interface between medical and psychiatric problems.
Need for the project:
Currently, there are two medical-psychiatric units in Houston. There is a unit at Ben Taub and another unit at Memorial Southwest. According to statements both by their own staff and from referrers within the community, these units stay consistently full.
Target Population:
All eligible patients within the St Joseph Hospital system could benefit from this program.
Category 1 or 2 expected patient benefits:
Our goal is to provide the "best" model for co-occurring diagnosis –which will include investigating the best evidence-based models and implementing the one selected. We will hire and train staff interested in working with individuals with co-occurring diagnosis and also select and pay a psychiatrist to attend to these clients.
Related Category 3 Outcome Measure(s):

OD-9 Right Care, Right Setting, IT-9.4 Other Outcome Improvement Target – our goal is to set up Quality indicators, similar to those used by most managed care companies. They will be established to determine a 3-month outcome post discharge from patients leaving this program.

Project Area: 1.9 Expand Specialty Care Capacity

1.9.3 "Other" project option: Implement other evidence-based project to expand specialty care capacity in an innovative manner not described in the project options above. Providers implementing an innovative, evidence-based project using the "Other" project option may select among the process and improvement milestones specified in this project area or may include one or more customizable process milestone(s) P-X and/or improvement milestone(s) I-X, as appropriate for their project. Milestone I-33 includes suggestions for improvement metrics to use with this innovative project option.

Unique RHP Project Identification Number: 181706601.2.2

Performing Provider Name/TPI: St Joseph Medical Center/181706601

Project Description:

Numerous studies have demonstrated the high prevalence of co-occurring mental health and medical issues in the United States. Due to a severe shortage of inpatient programs which are able to address these co-occurring needs, typically one of two things occurs in the Houston market.

1. The patient is treated for their medical condition and their mental health concerns go largely unaddressed or they are placed in a medical bed with a "sitter" to ensure their safety while also decreasing risk and liability. Once again, this does not address those mental health issues or needs but instead, their treatment is merely delayed.
2. The patient is unable to access care for their mental health issues as their co-occurring medical issues are part of an exclusionary criteria in most free-standing psychiatric hospitals.

Currently, there are two medical-psychiatric units in Houston. There is the unit at Ben Taub and another unit at Memorial Southwest. According to statements both by their own staff and from referrers within the community, these units stay consistently full and it is virtually impossible to get a patient from another facility to either one of these units.

This proposed unit will meet the needs of adults (ages 18 and above) who have a primary medical diagnosis with a co-occurring psychiatric diagnosis. The patients will be screened and admitted by a unit manager, who will either be a Licensed Clinical Social Worker or RN. The unit manager will report to the psychiatric director and manage the daily milieu. The unit will be staffed to include two psychiatric social workers who will conduct the therapeutic interventions and make the discharge plans in collaboration with the attending physician.

The concept would be to have a strong emphasis on the medical issues while also focusing on the mental health needs of the clients at the same time. This medical psychiatric nursing and support team will be trained in trauma-informed care models and the interface between medical and psychiatric problems. They will implement best practices to meet the needs of this particular type of clientele. Training of the staff will be highly important in the first year of opening the unit.

Goals and Relationship to Regional Goals:

Project goals:

- Evaluate and determine the "best" model for co-occurring conditions and open a program to meet those needs
- Determine most effective ways to assist patients in their recovery process from both the medical and psychiatric challenges that they face

Relationship to Regional Goals:

- Develop a culture of ongoing transformation and innovation that maximizes the use of technology and best-practices, facilitates regional collaboration and sharing, and engages patients, providers, and other stakeholders in the planning, implementation, and evaluation processes.

5 year expected outcome for Performing Provider and patients:

- Within 5 years, we will have an operational and clinically sound program for the medical-psychiatric patient at St. Joseph's Behavioral. This program will be managed by a skilled clinician who will ensure that all quality, regulatory and productivity goals are met.
- Determine optimal number of beds with a ramp up to financially cover the % of admissions – as specified in the matrix. Community need has already been determined – clearly, there is a severe lack of services in the city for the medical/psychiatric patient. As of the date of this proposal, there is no known other proposals to cover a medical/psychiatric project.
- Complete renovation, advertise and open a 12 bed unit to address the co-occurring needs of the medical and psychiatric patient

Challenges and how addressed:

- Renovation time frames and opening program to meet the needs of these clients
- Determining exclusionary criteria and processes for accepting transfers from other facilities
- Medical staff integration and operational issues
- Locating nursing and clinical staff appropriate for meeting the needs of this population of patients.
- Understanding licensing standards and initiating licensure, forms and policy and procedures for this program.

Ways to be addressed:

- Renovation plans are easily prepared and upon acceptance of this program can proceed forward
- Exclusionary criteria- will be developed in cooperation with the medical staff and a medical director, who will be selected – other examples exist from the other units and can be utilized as a template
- Medical staff integration will take place immediately and with the assistance of an identified medical director
- Human resources at the hospital will assist with the hiring, training and selection of the appropriate staff for this program
- Licensing standards- the compliance and risk departments within the hospital can be called on to assist with all these issues.

Rationale:

Currently, these clients are being admitted to general floors within the hospital and are "blended" into rooms with patients who may/may not have mental health issues. This project will bring all these patients into one area to better meet both their mental health needs and medical needs in a more appropriate integrated setting.

Listed below are some facts regarding co-occurring diagnosis issues. These were taken from several sources and source information can be found through the Mental Health America website. Based upon the literature review seen below, there are clear indicators that there is a strong correlation between medical illnesses and psychiatric diagnosis. With that in mind, it would appear that treatment of these needs in an appropriate setting whereby both issues are addressed concurrently makes sense. This proposal is to treat both issues concurrently in the most appropriate setting. Most free-standing psychiatric facilities do not feel adequately equipped to address the medical issues and in-fact list the medical issues on their exclusionary admitting criteria. This leaves virtually (with the exception of two units) no options for people in the Houston community to go for treatment.

Listed below are some facts regarding co-occurring diagnosis issues. These were taken from several sources and source information can be found through the Mental Health America website. Based upon the literature review seen below, there are clear indicators that there is a strong correlation between medical illnesses and psychiatric diagnosis. With that in mind, it would appear that treatment of these needs in an appropriate setting whereby both issues are addressed concurrently makes sense. This proposal is to treat both issues concurrently in the most appropriate setting. Most free-standing psychiatric facilities do not feel adequately equipped to address the medical issues and in-fact list the medical issues on their exclusionary admitting criteria. This leaves virtually (with the exception of two units) no options for people in the Houston community to go for treatment.

****Facts about co-occurring medical/psychiatry (reference: Mental Health America)**

-The rate of depression among those with medical illnesses in primary care settings is estimated at five to 10 percent. (2)
- Among those hospitalized, the rate is estimated at 10 to 14 percent. (2)
-The more severe the medical condition, the more likely that patient will experience clinical depression.(2)
-People with depression experience greater distress, an increase in impaired functioning and less ability to follow medical regimens, thus hindering the treatment of any other medical conditions. (2)
-Medical disorders may contribute biologically to depression.[3]
-Unfortunately, the diagnosis of depression is missed 50 percent of the time in primary care settings. (1)
-Depression occurs in 40 to 65 percent of patients who have experienced a heart attack, and in 18 to 20 percent of people who have coronary heart disease, but who have not had a heart attack. (4)
-After a heart attack, patients with clinical depression have a three to four times greater chance of death within the next six months. (4)
-One in four people with cancer also suffers from clinical depression. (8)
-Depression occurs in 10 to 27 percent of stroke survivors and usually lasts about one year. (6)
-An additional 15-40 percent of stroke survivors experience some symptoms of depression within two months after the stroke. (7)
-One in four people with cancer also suffers from clinical depression. (9)
-People with bipolar disorder are also at higher risk for thyroid disease, migraine headaches, heart disease, diabetes, obesity, and other physical illnesses (2)

Project Components:

We propose to meet all of the required project components as follows:

a) Identify sites for integrated care projects, which would have the potential to benefit a significant number of patients in the community.
b) Develop provider agreements whereby co-scheduling and information sharing between physical health and behavioral health providers could be facilitated.
c) Establish protocols and processes for communication, data-sharing, and referral between behavioral and physical health providers
d) Recruit a number of specialty providers (physical health, mental health, substance abuse, etc. to provide services in the specified locations.
e) Train physical and behavioral health providers in protocols, effective communication and team approach. Build a shared culture of treatment to include specific protocols and methods of information sharing that include:
- 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.

f) Acquire data reporting, communication and collection tools (equipment) to be used in the integrated setting, which may include an integrated electronic health record system or participation in a health information exchange – depending on the size and scope of the local project.

g) Explore the need for and develop any necessary legal agreements that may be needed in a collaborative practice.

h) Arrange for utilities and building services for these settings

i) Develop and implement data collection and reporting mechanisms and standards to track the utilization of integrated services as well as the health care outcomes of individual treated in these integrated service settings.

j) Conduct quality improvement for project using methods such as rapid cycle improvement.

Unique community needs identification numbers:

CN 3 - Inadequate access to behavioral health care

Related Category 3 Outcome Measure(s):
OD-9 Right Care, Right Setting, IT-9.4 Other Outcome Improvement Target

Reasons/rationale for selecting the outcome measures:

The goal is to ensure that all clients are treated in the most appropriate manner for their co-occurring mental health and medical issues. The measure selected would allow us to track if we are accomplishing this goal.

Relationship to other Projects: The increased access to primary care visits will naturally generate additional need of specialty care visits based on the condition and acuity of the patients served. Understanding that the patient base targeted through this initiative will generate significant specialty care visits due to chronic conditions and lack of previous treatments, this initiative and similar initiatives will focus to 30-day readmission rate reductions, improvement for patient satisfaction scores, and admission rates specific to chronic conditions. Numerous initiatives have been included in the RHP plan and the addendum of the Initiative Grid can directly tie all specialty care projects together by category.

Plan for Learning Collaborative: We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system.

Project Valuation:

Project is valued at $12,623,903 for the four years starting with DY2 – DY5. Extensive analysis was conducted to arrive at this valuation. Benefits to the community include the increase in available beds in the community to which patients with dual diagnoses (behavioral and medical) can be admitted. This coordinated care in the right setting will reduce readmissions, medical complication rates and overall length of stay, saving the unnecessary burdens of treating these patients.

Unique Category 2 Project Identifier: 181706601.2.2	*Project Area: 1.9.3*	*Project Option: 1.9.3*	**Design, implement and evaluate interventions to improve care transitions from the mental health and/or substance abuse disorder by creating a Med/Psych Unit on the campus of St Joseph Medical Center**
St Joseph Medical Center			*Texas TPI #: 181706601*
Related Category 3 Outcome Measure(s):	*Category 2 Project Link: 181706601.3.3*	*Outcome Measure: IT 9.4*	*Other Outcome Target*

Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
P-1. Milestone: Conduct specialty care gap assessment based on community need **P-1.1. Metric:** Documentation of gap assessment. Demonstrate improvement over prior reporting period (baseline for DY2). a. Data Source: Needs Assessment b. Rationale/Evidence: In order to identify gaps in high-demand specialty areas to best build up supply of specialists to meet demand for services and improve specialty care access **Milestone 1 Estimated Incentive Payment (*maximum amount*): $1,586,754**	**P-2. Milestone:** Train care providers and staff on processes, guidelines and technology for referrals and consultations into selected medical specialties **P-2.1. Metric:** Training of staff and providers on referral guidelines, process and technology a. Numerator: Number of staff and providers trained and documentation of training materials b. Denominator: Total number of staff and providers working in specialty care and medical specialty clinics	**Milestone 4 [I-8]:** Integrated Services: 25% of individuals receiving both physical and behavioral health care at the established locations **<u>Metric 1</u> [I-8.1]:** **Numerator:** Number of individuals receiving both physical and behavioral health care in project sites **Denominator:** Number of individuals receiving services in project site **Goal:** 50% of patients receiving both behavioral and acute care services are in the project setting **Data Source:** Project data, claims and encounter data, medical records	**Milestone 5 [I-9]:** Identify 50 percent of patients in defined population receiving innovative intervention consistent with evidenced- based model. **<u>Metric 1</u> [I-9.1]:** **Numerator:** 25% of individuals with treatment plans developed and implemented with primary care and behavioral health expertise. **Denominator:** Number of individuals receiving services at project site. **Goal** **Data Source:** Project data, Clinic Registry Data, Claims and encounter records, Patient Records

UNIQUE CATEGORY 2 PROJECT IDENTIFIER: 181706601.2.2	*PROJECT AREA: 1.9.3*	*PROJECT OPTION: 1.9.3*	**Design, implement and evaluate interventions to improve care transitions from the mental health and/or substance abuse disorder by creating a Med/Psych Unit on the campus of St Joseph Medical Center**	
St Joseph Medical Center				*Texas TPI #: 181706601*
Related Category 3 Outcome Measure(s):	*Category 2 Project Link: 181706601.3.3*	*Outcome Measure: IT 9.4*	*Other Outcome Target*	

Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Milestone 2 [P-7]: Evaluate and contiuously improve integration of primary and behavioral health services **Metric 1 [P-7.1]:** Project planning and implementation documentation demonstrates plan, do, study, act quality improvement cycles **Data Source:** Project Reports include examples of how real-time data is used for rapid cycle improvement to guide continuous quality improvement **Milestone 2 Estimated Incentive Payment: $1,586,753**	c. Data Source: Log of specialty care personnel trained and Curriculum for training. d. Rationale/Evidence: Training all staff and providers working in specialty care and in medical specialty clinics on referral guidelines, process, and technology creates the capacity to consistently and uniformly manage all referrals into medical specialties. **Goal:** Produce a comprehensive report documenting all points above. **Data Source:** catalogue of challenges, solutions, tests and progress shared by the participating	**Milestone 4 Estimated Incentive Payment: $3,472,190**	**Milestone 5 Estimated Incentive Payment: $2,516,080**

UNIQUE CATEGORY 2 PROJECT IDENTIFIER: 181706601.2.2	*PROJECT AREA: 1.9.3*	*PROJECT OPTION: 1.9.3*	**Design, implement and evaluate interventions to improve care transitions from the mental health and/or substance abuse disorder by creating a Med/Psych Unit on the campus of St Joseph Medical Center**	
St Joseph Medical Center				*Texas TPI #: 181706601*
Related Category 3 Outcome Measure(s):	*Category 2 Project Link: 181706601.3.3*	*Outcome Measure: IT 9.4*	*Other Outcome Target*	
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**		**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
	provider during each bi-weekly interaction • Could be summarized at quarterly intervals **Milestone 3 Estimated Incentive Payment: $3,462,126**			
Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone): $3,173,507	Year 3 Estimated Milestone Bundle Amount: $3,462,126		Year 4 Estimated Milestone Bundle Amount: $3,472,190	Year 5 Estimated Milestone Bundle Amount: $2,516,080
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over DYs 2-5)*: $12,623,903				

St. Luke's Episcopal Hospital

Pass 1

Project Option 2.12.1- Develop, implement and evaluate standardized clinical protocols and evidence-based care delivery model to improve care transitions : Transitional Care for Chronic Disease

Unique RHP Project Identification Number: 127300503.2.1
Performing Provider Name/TPI : St. Luke's Episcopal Hospital/127300503

Project Summary:

Provider:
St. Luke's Episcopal Hospital (SLEH) is a 718-bed tertiary and quaternary teaching hospital located in the heart of the Texas Medical Center and is home of the Texas Heart® Institute. Founded in 1954 by the Episcopal Diocese of Texas, St. Luke's is affiliated with multiple nursing schools and three medical schools.

Volume Statistics - FY2012 (November annualized)	**Patient Payor Mix**	**Patient Demographics**
Hospital admissions - 28,856 Emergency visits (including community emergency centers) - 85,631 Outpatient visits - 108,224	Self-Pay - 4.2% Medicaid and CHIP - 4.0% Medicare - 47.6% Other Funding - 3.2% Commercial Insurance- 41.0%	Caucasian - 48.2% African American - 29.8% Hispanic - 14.4% Asian - 2.5% American Indian - .2% Other - 4.9%

Intervention(s):
The purpose of this project is to build a bridge from the acute inpatient setting to a stable primary care-based medical home for patients with congestive heart failure (CHF). The targeted population is that group of patients with CHF cared for in the SLEH acute inpatient setting for an index admission. The goal is to reduce readmissions.

Need for the project:
Approximately one forth of patients discharged from the hospital with congestive heart failure are readmitted within 30 days of discharge. A primary cause for readmission is failure to gain rapid access post discharge to primary care. Evidence suggests that access within the first seven days post discharge can reduce readmission rates by up to 30%.

Target Population:
All patients discharged from St. Luke's Episcopal Hospital with congestive heart failure.

Category 1 or 2 expected patient benefits:
Reduction in readmission rate of 30%. Improve reported health days by 25%.

Category 3 outcomes:
Outcome Measure: OD-3/IT-3.2 Potentially Preventable Re-Admissions – 30-day Readmission Rates (PPRs)/Congestive Heart Failure 30-day Readmission Rate
Outcome Measure: OD-10 Quality of Life/Functional Status

Project Option 2.12.1- Develop, implement and evaluate standardized clinical protocols and evidence-based care delivery model to improve care transitions : Transitional Care for Chronic Disease

Unique RHP Project Identification Number: 127300503.2.1
Performing Provider Name/TPI : St. Luke's Episcopal Hospital/127300503

Project Description:
St Luke's Episcopal Hospital proposes to provide transitional care services to a targeted population with congestive heart failure (CHF).

The purpose of this project is to build a bridge from the acute inpatient setting to a stable primary care-based medical home for patients with congestive heart failure (CHF). The targeted population is that group of patients with CHF cared for in the SLEH acute inpatient setting for an index admission. The goal is to reduce readmissions.

Goals and Relationship to Regional Goals:

Congestive Heart Failure (CHF) is a high-cost chronic condition which affects many patients and their families in Harris County. It is a debilitating disease, though manageable in a primary care setting.

The goal of this project is to create a medical home structure for CHF patients, allowing them to maintain their health while in the community rather than a facility. For many patients, this will shift treatment from costly inpatient services, to primary care and outpatient settings, reducing costs, while enhancing each patient's quality of life.

This goal supports the region's efforts to increase reliance on primary care services, where feasible, and transform the delivery of health care services from one which emphasizes facility-based treatment, to one focused on non-acute care.

Project Goals:

The goal of the project is to reduce inpatient costs for CHF patients by providing comprehensive preventive care outside the hospital.

This project meets the following Region 3 goals:

- Transform health care delivery from a disease-focused model of episodic care to a patient-centered coordinated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary or duplicative services, and builds on the accomplishments of our existing health care system; and
- Develop a regional approach to health care delivery that leverages and improves on existing programs and infrastructure.

Challenges:

The greatest challenge will be to overcome the reliance on the part of patients and providers to treat CHF primarily in an acute care setting.

5-Year Expected Outcome for Provider and Patients:

St. Luke's expects to see improvements in CHF outcomes, specifically related to hospital admissions and readmissions.

Starting Point/Baseline:

This is a new initiative. A baseline will be developed once the program is operational.

Rationale:

The rationale for the project is to build a bridge from the acute inpatient setting to a stable primary care-based medical home for patients with congestive heart failure (CHF). The targeted population is that group of patients with CHF cared for in the SLEH acute inpatient setting for an index admission.

Project Components:

St. Luke's will address each of the required core components, including the following.

Review best practices from a range of models - The keys to achieving our goal begin with the development of a Transitional Care Clinic. This approach begins the facilitated patient connection process at the time of an index admission. Transitional Care Clinic based staff will overlap with the acute inpatient staff to reduce failures to coordinate care. This ensures that effective patient education and medications management occurs and brings focus on social barriers that contribute to failure.

A number of interventions aimed at building capacity for transitional care have demonstrated effectiveness (BOOST, Project RED, etc.). Generally based on Dr. Ed Wagner's model of chronic disease (http://www.grouphealthresearch.org/research/areas/chronic.aspx), a clinic specifically designed to provide access within the first 7 days (or sooner if necessary) can reduce readmissions by up to 30%. The same clinical function can provide interim care until a transition to a stable primary care relationship can occur for patients without an established relationship. Concurrent development of robust relationships with community-based providers provides the connection to stable primary care for at-risk populations.

Conduct an analysis of the key drivers of 30-day hospital readmissions using a chart review tool - The key driver of ED visits and early readmissions following acute care hospitalization is the failure to manage the inpatient transition to a stable primary care relationship. Access represents the major barrier to receiving stable care. The reasons for poor access can be financial, social or provider availability. The most vulnerable period occurs early following discharge with probability of readmission increasing with time from discharge to initial follow-up appointment. Without ready means of access, the Emergency Room is often the portal of entry. Risk assessment for readmission will be conducted using the IHI STAAR Tool.

Integrate information systems – Data sources will be Epic EHR and claims-based administrative databases (UHC, Crimson) as well as publically reported data sets (Hospital Compare).

Develop system to identify at-risk patients - Risk assessment for readmission will be conducted using the IHI STAAR Tool on admission.

Implement discharge planning and post discharge support - The first post hospitalization visit is the bridge to the next level of care and stable primary care in a medical home. Development of partnership relationships with community-based organizations is so important for patients who have otherwise been disenfranchised.

Embedded within the clinical operation are support services to address social determinants such as transportation, in-home support, lifestyle coaching and more traditional interventions such as nutritional status. The integration of services at one site of care ensures necessary collaboration and cooperation to address short-term markers of care process failure, such as ED visits and premature readmissions.

Develop a cross-continuum team - Currently St. Luke's Episcopal admits approximately 6000 patients annually for heart failure. Each patient would undergo a risk assessment on admission (IHI STAAR Tool) and a specific plan of care unique to each patient would be developed. The focus of the assessment is a determination of transitional care needs and facilitation at time of discharge into a stable primary care relationship. If a relationship currently exists, care will be coordinated with the existing provider focused on access to the first post-discharge visit within 7 days.

If the primary care provider cannot see the patient within seven days, an appointment can be arranged in the Transitional Care Clinic with consent of the patient and in coordination with the primary provider.

If the patient does not have a primary care provider, initial follow-up will be through the Transitional Care Clinic where facilitation occurs into a stable primary care relationship, taking into account the patient's wishes, location of residence, and other social determinants. Community based organizations provide an opportunity for transition to a stable primary care relationship (includes a qualified FQHC).

Conduct quality improvement - Significant focus is on the patient's assessment of Quality of Life as measured by the CDC-HRQOL, which includes embedded scales for Healthy Days Core Module, Activities Limitations Module, and Healthy Days Symptoms Modules.

The initial phases of the project recognize that short-term measures focused on process metrics may change before major outcomes changes, like readmissions or mortality begin to move. For this reason, days between admissions serves as a directional proxy in the first year of patient enrollment.

Data sources will come from Epic EHR and claims-based administrative databases (UHC, Crimson) as well as publically reported data sets (Hospital Compare). Process improvement methodologies will be based on The Model for Improvement (IHI) and will incorporate other tools as appropriate to include LEAN, Six Sigma, and Statistical Process Control tools. The project will have access to an IHI trained Improvement Advisor as a principle consultant.

Critical success factors and key challenges include:
Coordinated information flow
Shared ownership of patient population
Centralized registry of patients
Optimization from the patient's perspective
Common shared clinical care pathway
Common formulary

Milestone & Metrics:

The following milestones and metrics have been chosen for the transitional care program for CHF patients:

- Process Milestones: P-1, P-2 (P-2.1), P-4, (P-4.1), P-7, (P-7.1), P-9, P-9.1).
- Improvement Milestones: I-11

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

This project is a new initiative for St. Luke's Episcopal Hospital. The costs associated with providing this transitional care plan will all be new costs to the Hospital. The costs would include labor costs for developing and running the transitional care clinic.

Unique community need identification number the project addresses:

- CN.1 Inadequate access to primary care
- CN.2 Inadequate access to specialty care
- CN.9 High rates of preventable hospital readmissions
- CN.10 High rates of preventable hospital admissions

Related Category 3 Outcomes Measures:

OD-3 Potentially Preventable Readmissions – 30 day Readmission Rates
IT-3.2 Congestive Heart Failure 30-day Readmission Rate

OD-10 Quality of Life/Functional Status
IT-10.1 Quality of Life

Reasons/rationale for selecting the outcome measures:

The impact of this initiative can be measured by tracking readmission rates for the target population and assessing improvements in the patients' quality of life through use of a validated assessment tool.

Relationship to other Projects:

Primary Care/Ambulatory Care clinics are a top priority to Region 3 due to the acuity of the regional patient mix, population concentration, and lack of primary care access points for our patient base. The regional approach of collaboration as well as existing patient referral pattern relationships allowed our team to properly identify the community needs based on the necessity of population, uninsured, and medically underserved patient bases. This program is consistent with our region and similar to numerous initiatives in our RHP plan sharing both concepts as well as outcome measures focused to percent improvement over baseline of patient satisfaction scores, reduction of inappropriate ED utilization, and third next available appointment status. The Region 3 Initiative Grid attached as a RHP Plan addendum reflects a grid of relationship for all initiatives.

Plan for Learning Collaborative: We plan to participate in a region-wide learning collaborative as offered by the anchor for Region 3, Harris Health System. Our participation in this collaborative with other performing providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our region's health care system.

Project Valuation: The project scope includes all patients with an index admission of congestive heart failure at St. Luke's Episcopal Hospital. This is anticipated to be approximately 6,000 patients. The intervention begins with education upon admission. The care team will also provide information about the services of the Transitional Care Clinic. Prior to discharge, a follow-up appointment will be scheduled within seven days for each patient. In addition, the

care team providers will identify if the patient currently has consistent primary care support. If none is identified, the team will assist the patient in finding stable primary care.

All patients identified with CHF will be supported with this intervention; however, specific-focus will be given to those most at-risk, including the underserved and uninsured.

This addresses a high-priority community need due to the incidence of heart disease. The overall community, including Medicaid and indigent patients, will benefit by savings achieved by reducing the unnecessary and costly use of acute hospital services.

127300503.2.1	***2.12.1***	***A-G***	*Develop, implement and evaluate standardized clinical protocols and evidence-based care delivery model to improve care transitions : Transitional Care for Chronic Disease*
Performing Provider: St .Luke's Episcopal Hospital			*127300503*
Related Category 3 Outcome Measure(s):	*127300503.3.1* *127300503.3.2*	IT-3.2 IT-10.1	Potentially Preventable Re-Admissions – 30-day Readmission Rates (PPRs)/Congestive Heart Failure 30-day Readmission Rate Quality of Life
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 –[P-1]. Milestone: Develop or implement best practices or evidence-based protocols (such as Partnership for Patients) for effectively communicating with patients and families during and post-discharge to improve adherence to discharge and follow-up care instructions **[P-1.1]. Metric:** Care transitions protocols a. Submission of protocols b. Data Source: Submission of protocols, Care transitions program materials c. Rationale/Evidence: Protocols for discharge planning and post discharge follow-up will allow for wider and more affective system adoption of new practices. **Milestone 1** : Estimated incentive payment (Maximum Amount): $1,192,718 **Milestone 2-[P-4]. Milestone:** Conduct an assessment and establish linkages with community-based organizations to create a support network for targeted patients post-discharge	**Milestone 5 –[P-2]. Milestone:** Implement standardized care transition processes **[P-2.1]. Metric:** Care transitions policies and procedures a. Submission of protocols, b. Data Source: Policies and procedures of care transitions program materials c. Rationale/Evidence: In order to allow for system adoption of care transition processes, it is critical to develop policies and procedures identifying responsible parties, activities, timelines and anticipated outcomes related to a successful discharge and follow-up care. **Milestone 5** ; Estimated incentive payment (Maximum Amount): $1,740,985 **Milestone 6 –[I-11]. Milestone:** Improve the percentage of patients in defined population receiving standardized care according to the approved clinical protocols and care transitions policies **[I-11.1]. Metric:** Number over time of those patients in target population receiving standardized, evidence-	**Milestone 8 [P-2]. Milestone:** Implement standardized care transition processes **[P-2.1]. Metric:** Care transitions policies and procedures a. Submission of protocols, b. Data Source: Policies and procedures of care transitions program materials c. Rationale/Evidence: In order to allow for system adoption of care transition processes, it is critical to develop policies and procedures identifying responsible parties, activities, timelines and anticipated outcomes related to a successful discharge and follow-up care. **Milestone 8** ; Estimated incentive payment (Maximum Amount): $1,746,239 **Milestone 9 –[I-11]. Milestone:** Improve the percentage of patients in defined population receiving standardized care according to the approved clinical protocols and care transitions policies **[I-11.1]. Metric:** Number over time of those patients in target population receiving standardized, evidence-	**Milestone 11 [P-2]. Milestone:** Implement standardized care transition processes **[P-2.1]. Metric:** Care transitions policies and procedures a. Submission of protocols, b. Data Source: Policies and procedures of care transitions program materials c. Rationale/Evidence: In order to allow for system adoption of care transition processes, it is critical to develop policies and procedures identifying responsible parties, activities, timelines and anticipated outcomes related to a success ful discharge and follow-up care. **Milestone 11**; Estimated incentive payment (Maximum Amount): $1,430,951 **Milestone 12 – [I-11]. Milestone:** Improve the percentage of patients in defined population receiving standardized care according to the approved clinical protocols and care transitions policies **[I-11.1]. Metric:** Number over time of those patients in target population

127300503.2.1	**2.12.1**	***A-G***	*Develop, implement and evaluate standardized clinical protocols and evidence-based care delivery model to improve care transitions : Transitional Care for Chronic Disease*
Performing Provider: St .Luke's Episcopal Hospital			*127300503*
Related Category 3 Outcome Measure(s):	*127300503.3.1* *127300503.3.2*	IT-3.2 IT-10.1	Potentially Preventable Re-Admissions – 30-day Readmission Rates (PPRs)/Congestive Heart Failure 30-day Readmission Rate Quality of Life

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
[P-4.1]. Metric: Care transitions assessment a. Submission of care transitions assessment and resource planning documents b. Data Source: Care transitions assessment and resource planning documents c. Rationale/Evidence: It is important to try to coordinate care with facilities outside a provider's own delivery system so that patients going in and out of the delivery system can receive optimal care, wherever possible. The Community Based Care Transitions Program is an example of this innovative work. **Milestone 2** ; Estimated incentive payment (Maximum Amount): $1,192,718 **Milestone 3 –[P-7]. Milestone:** Develop a staffing and implementation plan to accomplish the goals/objectives of the care transitions program **[P-7.1]. Metric:** Documentation of the staffing plan. a. Data Source: Staffing and implementation plan.	based interventions per approved clinical protocols and guidelines a. Numerator: Number of patients that receive all recommended education, care and services as dictated by approved and evidence based care guidelines. b. Denominator: Number of patients discharged or eligible for care transition services c. Data Source: Registry or EHR report/analysis **Milestone 6** ; Estimated incentive payment (Maximum Amount): $1,740,985 **Milestone 7 –[P-9]. Milestone:** Implement a case management related registry **[P-9.1]. Metric:** Documentation of registry implementation a. Data source: Registry reports demonstrating case management functionality. b. Rationale/Evidence: Implementation of proactive and seamless case management services will improve patient outcomes around patient discharge and ensure better	based interventions per approved clinical protocols and guidelines a. Numerator: Number of patients that receive all recommended education, care and services as dictated by approved and evidence based care guidelines. b. Denominator: Number of patients discharged or eligible for care transition services c. Data Source: Registry or EHR report/analysis **Milestone 9** ; Estimated incentive payment (Maximum Amount): $1,746,239 **Milestone 10 [P-9]. Milestone:** Implement a case management related registry **[P-9.1]. Metric:** Documentation of registry implementation a. Data source: Registry reports demonstrating case management functionality. b. Rationale/Evidence: Implementation of proactive and seamless case management services will improve patient outcomes around patient discharge and ensure better	receiving standardized, evidence-based interventions per approved clinical protocols and guidelines a. Numerator: Number of patients that receive all recommended education, care and services as dictated by approved and evidence based care guidelines. b. Denominator: Number of patients discharged or eligible for care transition services c. Data Source: Registry or EHR report/analysis **Milestone 12**; Estimated incentive payment (Maximum Amount): $1,430,951 **Milestone 13 [P-9]. Milestone:** Implement a case management related registry **[P-9.1]. Metric:** Documentation of registry implementation a. Data source: Registry reports demonstrating case management functionality. b. Rationale/Evidence: Implementation of proactive and seamless case management services will improve patient outcomes around

127300503.2.1	**2.12.1**	**A-G**	*Develop, implement and evaluate standardized clinical protocols and evidence-based care delivery model to improve care transitions : Transitional Care for Chronic Disease*
Performing Provider: St .Luke's Episcopal Hospital			*127300503*
Related Category 3 Outcome Measure(s):	*127300503.3.1* *127300503.3.2*	IT-3.2 IT-10.1	Potentially Preventable Re-Admissions – 30-day Readmission Rates (PPRs)/Congestive Heart Failure 30-day Readmission Rate 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)**
b. Rationale/Evidence: This describes the number and types of staff needed and the specific roles of each participant **Milestone 2** ; Estimated incentive payment (Maximum Amount): $1,192,718 **Milestone 4 –[P-9]. Milestone:** Implement a case management related registry **[P-9.1]. Metric:** Documentation of registry implementation a. Data source: Registry reports demonstrating case management functionality. b. Rationale/Evidence: Implementation of proactive and seamless case management services will improve patient outcomes around patient discharge and ensure better coordinated care transitions. **Milestone 2** ; Estimated incentive payment (Maximum Amount): $1,192,718	coordinated care transitions. **Milestone 7** ; Estimated incentive payment (Maximum Amount): $1,740,984	coordinated care transitions. **Milestone 10** ; Estimated incentive payment (Maximum Amount): $1,746,240	patient discharge and ensure better coordinated care transitions. **Milestone 13**; Estimated incentive payment (Maximum Amount): $1,430,952
Year 2: Estimated Milestone Bundle Amounts: $4,770,872	**Year 3: Estimated Milestone Bundle Amounts: $5,222,954**	**Year 4: Estimated Milestone Bundle Amounts: $5,238,718**	**Year 5: Estimated Milestone Bundle Amounts: $4,292,854**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $19,525,398			

St. Luke's Episcopal Hospital

Pass 2

Project Option 2.2.2: Apply evidence based care management model to patients identified as having high-risk health care needs- Identification and Treatment of Patients with Hepatitis C

RHP Project Identification Number: 127300503.2.2 / Pass 2
Performing Provider Name: St. Luke's Episcopal Hospital / 127300503

Project Summary:
Provider:
St. Luke's Episcopal Hospital (SLEH) is a 718-bed tertiary and quaternary teaching hospital located in the heart of the Texas Medical Center and is home of the Texas Heart® Institute. Founded in 1954 by the Episcopal Diocese of Texas, St. Luke's is affiliated with multiple nursing schools and three medical schools.

Volume Statistics - FY2012 (November annualized)	**Patient Payor Mix**	**Patient Demographics**
Hospital admissions- 28,856 Emergency visits (including community emergency centers)- 85,631 Outpatient visits – 108,224	Self-Pay- 4.2% Medicaid and CHIP -4.0% Medicare- 47.6% Other Funding- 3.2% Commercial Insurance- 41.0%	Caucasian – 48.2% African American – 29.8% Hispanic – 14.4% Asian- 2.5% American Indian - .2% Other 4.9%

Intervention(s):
This project will provide screening and treatment for a defined population of patients at risk for and/or diagnosed with Hepatitis C.

Need for the project:
Hepatitis C is a potentially curable disease with significant morbidity leading to cirrhosis and liver failure. A small but significant fraction of affected patients develop hepatocellular carcinoma. These complications can be markedly reduced with active screening and aggressive treatment. CDC recommended Birth Cohort Screening of individuals born between 1945 and 1965 will overwhelm capacity without the development of alternate treatment models.

Target Population:
All patients with liver dysfunction or patients falling within the CDC recommended screening group.

Category 1 or 2 expected patient benefits:
Our DY4 goal is to triple the volume of patient screened during our baseline year. In DY 5 our goal is to quadruple screening volume over baseline and to enroll at least 50% of patients identified with active disease in treatment.

Category 3 outcomes:
Outcome Measure: OD-4/IT-4.1 Improvement in risk adjusted Potentially Preventable Complication rates (development of cirrhosis, frank liver failure) by 50%.

Project Option 2.2.2: Apply evidence based care management model to patients identified as having high-risk health care needs- Identification and Treatment of Patients with Hepatitis C

RHP Project Identification Number: 127300503.2.2 / Pass 2
Performing Provider Name: St. Luke's Episcopal Hospital / 127300503

Project Description:

The purpose of this project is to screen, identify, and provide high level care to individuals identified as having Hepatitis C using a distributed care model based on Project ECHO^{TM}.

Goals and relationship to regional goals:
Hepatitis C is a curable illness when identified and correctly treated. Estimates suggest that only a small fraction of patients with this illness are identified and an even smaller fraction are treated. Since the consequences are progressive cirrhosis, liver failure, and high risk for hepatocellular carcinoma, screening and access to effective treatment can achieve cure in up to 60% of patients. The major barriers are lack of widespread screening and access to providers knowledgeable in this field. By using newer technologies this project will partner with primary care providers throughout Region 3 to support screening, enhance the knowledge base, and support treatment in the patient's community by extending tertiary specialty support using telemedicine. This project supports Region 3 objectives by improving access to high level specialty care coordinated through primary care providers, leverages technology through use of telemedicine, and supports effective treatment in a vulnerable population where the incidence of disease may be as high as 8%.

Challenges:
Effective screening and appropriate referral for care represent the primary hurdles. The CDC recently recommended Birth Cohort Screening for all individuals born between 1945 and 1965 which will significantly increase patients identified with Hepatitis C. Our current system will be unable to manage the volume of new cases in need of active treatment.

5 Year Expected Outcome for Provider and Patient:

St. Luke's expects to increase annual screening of at-risk populations by a factor of 4 by the final year of the project (1976 patients screened in 2012). Of those identified with active disease St. Luke's hopes to engage 50% of this group in active community based treatment. Of those with active disease who remain in treatment, cure rates will match recently reported outcome data (60% cure rate).

Starting Point/Baseline:

In 2012 St. Luke’s Liver Health Outreach Department screened 1976 patients through partnerships with CBO’s and identified 155 individuals with active disease (Hepatitis C).

Rationale:

Provider

St. Luke’s Episcopal Hospital (SLEH) is a 718-bed tertiary and quaternary teaching hospital located in the heart of the Texas Medical Center and is home of the Texas Heart® Institute. Founded in 1954 by the Episcopal Diocese of Texas, St. Luke’s remains the only faith-based hospital within TMC. It is affiliated with multiple nursing schools and three medical schools, University of Texas - Houston, UTMB, and the Baylor College of Medicine. SLEH is the flagship hospital for St. Luke’s Episcopal Health System (SLEHS), comprised of six hospitals, serving all communities within the metropolitan area, and St. Luke’s Episcopal Health Charities, a charity devoted to assessing and enhancing community health, especially among the underserved.

St. Luke’s Center for Liver Disease (SLCLD) is a multidisciplinary program shared between Baylor College of Medicine and St. Luke’s Episcopal Hospital providing hepatology and liver transplantation services. SLCLD includes two transplant surgeons, seven hepatologists and five midlevel providers.

SLCLD houses the St. Luke’s Liver Health Outreach Department, which focuses on identifying, screening and testing patients at high risk for Hepatitis C within the underserved community. In 2012, the department ran 1976 HCV tests resulting in 217 (11%) antibody positive tests and 155 HCV RNA (active infection) positive tests (8%). SLCLD and the department maintain community partnerships with organizations including:

- The Association for the Advancement of Mexican Americans
- Coastal Bend AIDS Foundation (CBAF)
- Legacy Community Health Services
- Planned Parenthood of the Gulf Coast’s HIV program
- Houston Area Community Services (HACS)
- Tomagwa Health Ministries
- Brazos County Health

These partnerships have built a strong foundation for outreach within the greater Houston and Harris County area. Expansion throughout Region 3 will allow SLEH and the SLCLD to reach more high-risk individuals and create a greater health impact to the underserved individual.

Interventions:

Identification and Treatment of Patients with Hepatitis C extends high level medical skills throughout the region using telemedicine to improve care for patients with Hepatitis C. Active

identification and aggressive treatment of patients in the early stages of disease result in improved outcomes and lower cost in a population of patients at high risk.

Two factors will alter the impact of HCV infection in Region 3:

1) Patient Identification: Primary care is the front line in screening patients for HCV. Primary care providers must be educated to screen patients with risk factors for HCV, including those born between 1945 and 1965. BCS alone may identify 200,000 new cases in Texas.

2) Access to Treatment**:** Treatment has traditionally been the domain of the gastroenterologist. This is no longer tenable. Gastroenterologists in large and small communities are hard-pressed to provide all necessary GI support. HCV treatment is increasingly seen as a distraction and money-loser for GI practices. Infectious disease specialists have picked up some of the slack, but the answer is to increase the number of treating practitioners. This effect has been called a "force multiplier," and is the basis of Project ECHO™, a community outreach program established at the University of New Mexico.

In order to achieve improved identification and treatment of HCV, we will have to increase awareness of HCV infection, and we will have to train a large workforce of providers. The size of Region 3 makes this difficult to do in person (e.g. with outreach clinics), but the problem could be solved with the Project ECHO model described by Arora et al. .

Remote sites need only three IT resources: a computer, a webcam and high-speed Internet. Most practices have computers, and many computers have built-in webcams. Training each site to use the webcam and communication software will be done by phone or with Identification and Treatment of Patients with Hepatitis C resources.

Each weekly HCV clinic will consist of two portions, patient presentations and a short lecture — attendees will get two CME units per clinic.

Needs Assessment:

- *Primary care physicians are the first line providers in the community, but most do not know the risk factors for hepatitis C.*
  - *Gap: Patients in the community are not being screened for hepatitis C – only 25% of the HCV infected population in America has been diagnosed. Knowledge about appropriate screening and confirmatory testing is lacking.*
  - *Desired outcome: Community physicians will screen appropriate patients for HCV infection, confirm infected patients, and recommend treatment, when appropriate.*

- *Hepatitis C treatment is difficult, inconvenient, and associated with numerous side effects*
  - *Gap: Gastroenterologists are increasingly unwilling to treat HCV infection, so fewer patients are being treated, even though the efficacy of treatment is improving.*
  - *Desired outcome: Primary care providers will learn to provide appropriate, specialized treatment in the community.*

- *Patients with advanced liver disease may require specialized care at a referral center.*

- *Gap: Many communities do not have the resources to recognize advanced liver disease and/or implement appropriate measures. In addition, they fail to refer patients to an appropriate center in a timely fashion.*
- *Desired outcome: Community physicians learn to recognize cirrhosis, implement appropriate medical measures, and refer patients with advanced liver disease to a referral center.*

Target Population:

Based upon the St. Luke's Liver Center screening experience, we believe that between 4% - 8% of at risk populations are likely infected. If the prevalence reported in a recent Veterans Administration study (4.5%) is applied to the general population of Region 3, as many as 200,000 individuals could be infected. Enormous opportunity exists to significantly alter the disease trajectory of patients with Hepatitis C. Currently available therapies have the potential to cure up to 60% of those patients treated. This project would provide targeted funding to support dramatic expansion of screening programs along with the development of treatment capacity to meet this need. The dual problems of identifying infected patients and getting them treated is the goal of this proposal.

Milestone and Metrics:

The following milestones and metrics have been chosen for this program:

Process Milestones:

P-4.1. Metric: Increase the number of multi-disciplinary teams or number of clinic sites with formalized teams

P-10.1. Metric: Increase the number of group visits and/or telephone visits and/or other interaction types

Improvement Milestones:

I-21.1. Metric: Increase percentage of target population reached.

I-21.2. Metric: Documentation of increased number of unique patients served by innovative program. Demonstrate improvement over prior reporting period.

I-11. 1 Improve the percentage of patients in defined population receiving standardized care according to the approved clinical protocols and care transitions policies

I-21.3. Metric: Improved clinical outcomes of target population. The clinical outcomes can be either intermediate (e.g. in Diabetes: HbA1c, lipid profile, blood pressure, serum microalbumin) or end result (e.g. mortality, morbidity, functional status, health status, quality of life or patient satisfaction).

Unique Community Need identification number the project addresses:

- CN1 - Inadequate access to primary care
- CN2 - Inadequate access to specialty care
- CN10 - High rates of preventable hospitalizations
- CN11 - High rates of chronic disease and inadequate access to treatment programs and services for illnesses associated with chronic.

How the project represents a new initiative for the Performing Provider or significantly enhances an existing delivery system reform initiative: This project dramatically expands the capability and capacity of the St. Luke's Center for Liver Disease (SLCLD) and Advanced Liver Therapy program to extend screening and coordinated treatment to identified patients throughout Region 3. Furthermore, access to clinical trials is available for appropriate patients. The SLCLD in conjunction with the distributed primary care network builds a continuum from screening and initial diagnosis through liver transplant. By using telemedicine links patients avoid the need for travel and or finding high end specialty care. Since cure rates with appropriate therapy approach 60%, downstream complications of disease progression should be reduced.

Related category 3 Outcomes Measures:

OD-4 / IT-4.1 Improvement in risk adjusted Potentially Preventable Complication rates

Reasons/rationale for selecting the outcome measure(s):
Untreated Hepatitis C results in progressive destruction of liver cells with resulting cirrhosis and liver failure. Patients with this disease are at significantly increased risk for the development of hepatocellular carcinoma. Since identification and effective treatment can be curative, a reduction in the rate of Potentially Preventable Complications attests to the effectiveness of the interventions.

Relationship to Other Projects and Performing Providers' Projects in the RHP:
Healthcare costs are significantly increased within a patient base with such aggressive chronic conditions that have gone untreated. The initiatives focused to chronic disease management focus to conditions such as asthma, hypertension, and diabetes and are similar in the approach of managing & proactively treating chronic conditions in order to reduce 30-day readmission rates, inappropriate emergency department utilization, and healthcare costs. The Region 3 Initiative grid allows a cross reference of initiatives associated with chronic disease management. (addendum)

Plan for Learning Collaborative: We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system.

Project Valuation:

In Year 2 as partnerships are developed beyond current relationships, 2000 individuals will be screened. In Years 3(3500) and 4(5000) the volume of screening would increase incrementally with the expected volume of screening in Year 5 reaching 8000. As these individuals would be in an at-risk group, the number of individuals identified with disease in Year 2 would be 160, Year 3 - Screened 3500, 280 with disease, Year 4 - 5000 screened, 400, Year 5 - 8000 screened, 640 with disease. Total number of individuals identified with disease over project equals 1480. If approximately 50% of 1480 new patients are engaged in active community based treatment, we would expect 60% cure rate equaling 444 patients. The lifetime cost of Hepatitis C in the absence of liver transplant is $100,000, with liver transplant, the cost rises to $280,000. Within 5 years of diagnosis, 15-20% of patients with chronic Hepatitis C develop cirrhosis. Consequently, diagnosis, treatment and cure dramatically lower costs for treatment of a chronic disease.

127300503.2.2	**_2.2.2_**	_N/A_	**_IDENTIFICATION AND TREATMENT OF PATIENTS WITH HEPATITIS C_**
St. Luke's Episcopal Hospital			_127300503_
Related Category 3 Outcome Measure(s):	_127300503.3.3_	_IT-4.1_	_Improvement in risk adjusted Potentially Preventable Complication rates_

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-4]: Formalize multi-disciplinary teams, pursuant to the chronic care model defined by the Wagner Chronic Care Model or similar Metric [P-4.1]: Increase the number of multi-disciplinary teams or number of clinic sites with formalized teams Baseline/Goal: There will be 1 formal agreement in place with collaborative provider Data Source: TBD by Performing Provider Milestone 1 Estimated incentive payment: $385,040 **Milestone 2** [P-9]: Develop program to identify and manage chronic care patients needing further clinical intervention Metric [P-9.1]: Increase the number of patients identified as needing screening test, preventative tests, or other clinical services Baseline/Goal:2000 patients screened Data source: EHR, patient registry Milestone 2 Estimated incentive	**Milestone 3** [P-4]: Formalize multi-disciplinary teams, pursuant to the chronic care model defined by the Wagner Chronic Care Model or similar Metric [P-4.1]: Increase the number of multi-disciplinary teams or number of clinic sites with formalized teams Baseline/Goal: There will be 3 formal agreements in place with collaborative providers Data Source: TBD by Performing Provider Milestone 3 Estimated incentive payment: $286,206 **Milestone 4** [P-10]: Expand and document interaction types between patient and health care team beyond one-to-one visits to include group visits, telephone visits, and other interaction types Metric [P-10.1]: Increase the number of group visits and/or telephone visits and/or other interaction types Baseline/Goal: There will be 12 Telemedicine sessions conducted with participating provider teams	**Milestone 6** [P-4]: Formalize multi-disciplinary teams, pursuant to the chronic care model defined by the Wagner Chronic Care Model or similar Metric [P-4.1]: Increase the number of multi-disciplinary teams or number of clinic sites with formalized teams Baseline/Goal: There will be 5 formal agreements in place with collaborative providers Data Source: TBD by Performing Provider Milestone 6 Estimated incentive payment: $290,358 **Milestone 7** [I-21]: Improvements in access to care of patients receiving chronic care management services using innovative project option. Metric [I-21.2]: Documentation of increased number of unique patients served by innovative program. Demonstrate improvement over prior reporting period. Goal:5000 Data Source: Registry, EHR, claims or other Performing Provider source	**Milestone 9** [I-21]: Improvements in access to care of patients receiving chronic care management services using innovative project option. Metric [I-21.2]: Documentation of increased number of unique patients served by innovative program. Demonstrate improvement over prior reporting period. Goal:8000 Data Source: Registry, EHR, claims or other Performing Provider source receiving standardized, evidence-based interventions per approved clinical protocols and guidelines Milestone 9 Estimated incentive payment: $239,012 **Milestone 10** [P-10]: Expand and document interaction types between patient and health care team beyond one-to-one visits to include group visits, telephone visits, and other interaction types. Metric [P-10.1]: Increase the number of group visits and/or telephone visits and/or other interaction types Baseline/Goal: There will be36

127300503.2.2	**2.2.2**	*N/A*	***IDENTIFICATION AND TREATMENT OF PATIENTS WITH HEPATITIS C***
St. Luke's Episcopal Hospital			*127300503*
Related Category 3 Outcome Measure(s):	*127300503.3.3*	*IT-4.1*	*Improvement in risk adjusted Potentially Preventable Complication rates*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
payment: $385,039	Data source: EHR, billing records Milestone 4 Estimated incentive payment: $286,206 **Milestone 5** [I-21]: Improvements in access to care of patients receiving chronic care management services using innovative project option. Metric [I-21.2]: Documentation of increased number of unique patients served by innovative program. Demonstrate improvement over prior reporting period. Goal:3500 Data Source: Registry, EHR, claims or other Performing Provider source receiving standardized, evidence-based interventions per approved clinical protocols and guidelines Milestone 5 Estimated incentive payment: $286,207	receiving standardized, evidence-based interventions per approved clinical protocols and guidelines Milestone 7 Estimated incentive payment: $290,358 **Milestone 8** Expand and document interaction types between patient and health care team beyond one-to-one visits to include group visits, telephone visits, and other interaction types. Metric [P-10.1]: Increase the number of group visits and/or telephone visits and/or other interaction types Baseline/Goal: There will be 24 Telemedicine sessions conducted with participating provider teams Data source: EHR, billing records Milestone 8 Estimated incentive payment: $290,359	Telemedicine sessions conducted with participating provider teams Data source: EHR, billing records Milestone 10 Estimated incentive payment: $239,012 **Milestone 11** [I-21]: Improvements in access to care of patients receiving chronic care management services using innovative project option. Metric [I-21.3]: Improved clinical outcomes of target population. The clinical outcomes can be either intermediate or end result. Goal: 50% of patients identified with disease in active treatment Data Source: EHR **Milestone 11** ; Estimated incentive payment: $239,012
Year 2 Estimated Milestone Bundle Amount: $770,079	Year 3 Estimated Milestone Bundle Amount: $858,619	Year 4 Estimated Milestone Bundle Amount: $871,075	Year 5 Estimated Milestone Bundle Amount: $717,036
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:** $3,216,809			

Texana Center

Pass 1

Project Option 2.13.1 - Design, implement, and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population: Provide crisis stabilization intervention for the dually diagnosed population to prevent unnecessary use of services in State Supported Living Centers, emergency rooms, state mental hospitals and county jails.

Unique RHP Project Identification Number:081522701.2.1

Performing Provider Name/TPI: Texana Center / 081522701

Project Summary:

This project will create a crisis behavioral health care team to intervene to keep individuals in crisis out of the State Supported Living Centers, emergency rooms, state mental hospitals or jail.

Provider Description:

Texana Center is the Local Authority for Behavioral Healthcare and Intellectual Developmental Disabilities Services for 6 counties within the RHP 3 area: Austin, Colorado, Fort Bend, Matagorda, Waller and Wharton. Texana Center serves approximately 9,800 people annually (an estimated 7,000 in BH services and 3,000 in IDD services), employs 742, and has an annual operating budget of $39,211,988.

Intervention(s):

Design, implement and a research-supported and evidence-based crisis behavioral health care team. Interventions include assessment during acute crisis, treatment plan development by Board Certified Behavior Analyst, monitoring by psychiatrist and nurse, training individuals and care givers in Applied Behavior Analysis, and therapeutic respite. Interventions are to be provided by a clinical team with the purpose to avert institutional care and preserve community living through an innovative crisis behavioral health care team model.

Need for the Project:

As the Local Authority, we receive requests to assist families, and providers, dealing with acute crisis for individuals at risk for placement outside of their home. There is no therapeutic respite facility open to all providers in our area, and there is no crisis response team trained in the therapeutic assessment and treatment of the targeted population. There are over 200 active Medicaid providers of long term services and supports for the targeted population in our area. Most are small business operations, and many are new providers with limited resources and experience in the provision of crisis prevention services.

Target population:

Individuals dually diagnosed (intellectual and developmental disability (IDD: i.e., autism, pervasive developmental disorder (PDD) or mental retardation (MR)) who have a co-occurring serious and persistent mental illness and/or a history of challenging and harmful behaviors. The estimated baseline is 1,100 – 1,300 people with a dual diagnosis, with 600 of these people potentially experiencing an acute crisis during the project's 5 year period. Approximately 90% of persons served are currently Medicaid eligible and/or indigent. Based on these estimates, we expect that potentially 540 Medicaid eligible and/or indigent people would benefit from the project.

Category 2 expected patient benefits: The project seeks to provide acute crisis behavioral health care services through an innovative crisis team model in years three, four and five with an increase in the number of individuals served by the team and in therapeutic respite each year. The project seeks to promote the evidenced-based model through collaborative learning with other Local Authorities in the RHP area and in the state.

Category 3 Outcomes: The project seeks to reduce the number of potential admissions by the targeted population to state institutions (state mental hospitals and State Supported Living Centers) by 10% in Year 3 and 20% in Year 4.

Project Option 2.13.1 - Design, implement, and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population: Provide crisis stabilization intervention for the dually diagnosed population to prevent unnecessary use of services in State Supported Living Centers, emergency rooms, state mental hospitals and county jails.

Unique RHP Project Identification Number:081522701.2.1
Performing Provider Name/TPI: Texana Center / 081522701

Project Description:
Texana Center, the local authority for Behavioral Healthcare and Intellectual Developmental Disabilities services, proposes to create a crisis behavioral health care team to intervene to keep individuals in crisis out of the state supported living center, emergency room, state mental hospital or county jail.

The project will also expand respite care to respond to acute behavior events. It will also provide on-going supports to caregivers to avert crisis and establish stable living environments. The project will require the hiring of 15 staff members (7 professional/clinical and 8 behavioral certified direct care) and the addition of a 4 bed respite facility equipped with 2 clinical treatment rooms.

The project targets individuals with a diagnosis of intellectual and developmental disability (IDD: i.e., autism, pervasive developmental disorder (PDD) or mental retardation (MR)) who have a co-occurring serious and persistent mental illness and/or a history of challenging and harmful behaviors. In collaboration with MHMRA of Harris County, the project is intended to provide crisis stabilization services to the targeted population in all counties of the RHP 3 area. This project serves individuals who reside in one of the following seven counties: Austin, Calhoun, Colorado, Fort Bend, Matagorda, Waller and Wharton. The caregivers for this population are eligible recipients for training and education.

When a behavioral crisis occurs, this complex behavioral health population typically seeks crisis intervention services through the emergency room, psychiatric in-patient system or law enforcement. In these cases, a frequent long term solution is admission to a State Supported Living Center. Individuals with IDD who have a co-occurring SPMI/challenging behavior enter into a cycle of crisis driven care: the individual receives long term supports from a designated in-home caregiver who is unable to manage challenging behaviors; the behaviors result in an acute crisis; the treatment for the crisis is hospitalization or out of home institutional care, which does not involve the caregiver in the treatment plan; the crisis resolves and the individual returns home to the caregiver who still lacks competencies for managing the behaviors; the challenging behaviors reoccur and result in an acute crisis; the cycle repeats, and this complex population becomes a frequent user of local public health systems.

As a solution to the cyclic pattern of long term support and acute crisis intervention for the dually diagnosed IDD/SPMI population, this project proposes the development of a crisis behavioral healthcare team, expanded out-of-home respite care to respond to acute behavior crisis events, and on-going supports to avert crisis and establish stable living environments. The crisis behavioral health care team will respond to acute crisis and will design, implement, and monitor individualized treatment plans for individuals admitted to the project.

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Goals and Relationship to Regional Goals:

The project supports the RHP 3 regional goal for developing a culture of ongoing transformation and innovation that maximized the use of technology and best-practices, facilitates regional collaboration and sharing, and engages patients, providers, and other stakeholders in the planning, implementation, and evaluation processes. This project also supports regional goals to address the gaps in the service delivery system for individuals with complex mental health conditions. These individual require stable living environment integrated with community-based clinical psychosocial services to prevent continual cycling through less appropriate, more costly settings.

5-Year Expected Outcomes for Provider and Patients:

- A significant decrease in the number of behavioral health events resulting in hospitalization, incarceration or institutional care for individuals with IDD
- A significant increase in the number of individuals with IDD who have access to behavior supports provided by Board Certified Behavior Analyst and who have access to emergency respite

Starting Point/Baseline:

The NADD, an association for persons with developmental disabilities and mental health needs, reports that many professionals have adopted the estimate that 30-35% of all persons with an intellectual developmental disability have a psychiatric disorder.[241] By applying the NADD estimated percentage (30-35%) to the intellectual and developmental disabilities population in our area (3,650: 1,250 served; 2,400 not served), it is estimated that the baseline population is 1,100-1,300 people with potential needs for the crisis stabilization services proposed in this project. This number is consistent with state data source (CARE), which reported 1,427 individuals with IDD and a co-occurring SPMI or diagnosis of autism or PDD being screened, assessed or served through Texana Center in 2011. Based on provider service data for 2011, it is estimated that about 50% of the baseline population received some type of crisis stabilization encounter (i.e., intensive behavior supports and/or emergency respite), meaning that there were approximately 600 under-served individuals. Approximately 90% of the persons served are currently Medicaid eligible and/or indigent. Based on these estimates, we expect that potentially 540 Medicaid eligible and/or indigent people would benefit from the project.

There are over 200 active Medicaid providers of long term services and supports for the targeted population in our area, but there is no crisis response team and no therapeutic crisis respite facility. Most providers are small business operations, and many are new providers with limited resources and experience in the provision of crisis prevention and services.

Rationale:

The implementation of a long-term crisis intervention and stabilization services model is intended to promote health and safety, to promote self-management of challenging behaviors, and to avoid risks requiring hospitalization, incarceration or institutionalization. Texana Center selected this project for the following reasons:

- Data driven: As noted in the baseline above, local data demonstrates that there is a growing number of individuals with IDD with challenging behaviors and/or SPMI, who are seeking respite and behavioral supports in the community
- Community Need: This project addresses the community need for expanded behavioral healthcare: RHP CN 2 - Insufficient access to behavioral health care services, resulting in

[241] Source: NADD website: http://thenadd.org/resources/information-on-dual-diagnosis/

lack of care or delay of care, delivery of inappropriate and insufficient care, unnecessary and preventable complications, and increased demand on criminal justice system.

- Cost effective: This project's goal is to avert the cost of long term crisis intervention through provision of in-home and community setting care. The following cost savings were considered in the selection of this project: average annual cost for State Supported Living Center of $177,624 compared to average annual cost rate the Home and Community Based Care (HCS) Waiver of $39,588 [242]; the average stay cost for psychiatric in-patient care at a State Mental Hospital of $15,325 compared to the annual per person Behavioral health community center cost of $1,181[243] ; the average cost of an emergency room visit of $383 compared to primary care visit cost of $60[244]; and the annual cost for incarceration rate at State prison of $18,582[245] compared to the non incarceration cost of zero. The intent of this project is to ensure that patients utilize the most cost efficient service identified by these comparisons.
- State and Federal Initiatives: This project, through the implementation of behavioral support teams and access to respite for individuals in crisis, represents a significant enhancement to the long-term care IDD services and supports system and is consistent with current State and Federal initiatives.
    - In 2009, the Community Living Initiative was implemented by the U.S. Department of Health and Human Services (HHS).[246] Through this initiative, HHS partnered with State and Local authorities to develop strategies to create infrastructure to effectively serve individuals with IDD. This work helped advance systems of care to meet the directive of the 1999 *Olmstead* decision.
    - North Carolina implemented the NC START (North Carolina Systemic, Therapeutic Assessment, Respite and Treatment) Program as a partner in the Community Living Initiative, which, like this project, provided clinical behavior support teams and out of home respite to the IDD with SPMI/challenging behavior population.[247]
    - In 2011, the Texas Legislature directed the Texas Health and Human Services Commission to seek a Medicaid waiver that "allow[s] for the redesign of [IDD] long-term care services and supports to increase access to patient-centered care in the most cost –effective manner" (SB7, 82nd Texas Legislature, 1st Called Session). A key feature for the redesigned system for individuals with IDD is behavioral supports for individuals at risk of institutionalization.
    - There is an on-going agreement settlement between the Texas and the Department of Justice for ensuring access to community services for persons served in institutions.

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[242] Source: Legislative Budget Board Report: Fiscal Size Up 2012-2013

[243] Source: Legislative Budget Board Report: Managing and Funding State Mental Hospitals in Texas, February 2011

[244] Source: Blue Cross Blue Shield website: http://www.bcbstx.com/employer/cost/er.htm

[245] Source: Texas Public Policy Foundation website. February 17, 2011. House Appropriations Subcommittee on Criminal Justice Summary: http://www.texaspolicy.com/center/effective-justice/reports/written-testimony-house-appropriations-subcommittee-criminal-0

[246] Sources: U.S. Health and Human Services website.
http://www.hhs.gov/od/community/stakeholders_summary_report.html

[247] Source: North Carolina website:
http://www.durhamcenter.org/uploads/docs/documents_forms/system_of_care/developmental_disabilities/NC_START_Access_FAQ.pdf

Access to crisis intervention and stabilization services in the community is an expectation of the Department of Justice through this agreement.[248] This project, through the implementation of behavioral support teams and access to respite for individuals in crisis, represents a significant enhancement to the long-term care IDD services and supports system to provide the right service at the right time in a most cost-effective manner.

- Regional Pilot: MHMRA of Harris County implemented a behavioral healthcare crisis intervention team for this targeted IDD population in 2011. The model has been well received at the local and state level.
- Experience: As a starting point, Texana Center has the administrative support and clinical expertise to assess and develop a plan for a long term crisis intervention and stabilization model for this targeted population:
  - Out of home emergency respite: Texana Center has operated an out of home respite facility for over 20 years.
  - Applied Behavior Analysis: Texana Center employs Board Certified Behavior Analyst to assess, treat and monitor challenging programs in four program areas: day program, residential, site-based and outreach. These programs have an excellent reputation for successful treatment of challenging behaviors.

Consistent with the DSRIP Category 2 Behavioral Health Infrastructure menu, this project incorporates the required core components for Project Option 2.13.1: *Design, implement and evaluate research-supported and evidence-based interventions tailored towards individuals in the target population (IDD with SPMI/Challenging behaviors).*

- An assessment of size, characteristics and needs of the IDD with SPMI/Challenging behavior population.
- A review literature /experience with populations similar to the IDD with SPMI/Challenging behavior population.
- A project evaluation plan using qualitative and quantitative metrics to determine outcomes.
- A service delivery model to include the following community based interventions:
  - Referral paths for IDD Crisis Stabilization team through outreach and education with law enforcement, emergency rooms, and agencies providing residential supports to persons with IDD.
  - Behavioral healthcare intervention team consisting of project director, Board Certified Behavior Analysts, case coordinators and registered nurse to assess individuals in crisis, develop treatment plans and monitor care.
  - Visiting nursing and community health workers with crisis intervention expertise
  - Specialized behavioral therapies:
    - On-site assessments and interventions to stabilize acute crisis situations
    - Individualized treatment plans to help the individual return to his/her current living situation, and to successfully maintain that setting
    - Intensive training in Applied Behavior Analysis (ABA) techniques to individuals, family members and caregivers
  - Medication assessment with weekly psychiatric consultation.

[248] Source: Texas Department of Aging and Disability Services website: http://www.justice.gov/crt/about/spl/documents/TexasStateSchools_settle_06-26-09.pdf

- Out of home respite for crisis stabilization and based on population needs.
- Other community based interventions as determined by the project assessment.

- An assessment of the impact of the interventions based on standardized quantitative measures and qualitative analysis.
- A continuous quality improvement framework to include collaborative learning with other providers for the IDD with SPMI/Challenging behavior population.

Milestones & Metrics:
Milestones 2.13.1 (Assessment), 2.13.2 (Designing/Planning), 2.13.3 (Enrolling/Serving), 2.13.5 (Collaborative Learning) were selected to support the above listed required components. As an improvement measure, assessment of improvement in functional status was selected for Category 2. See section to follow regarding related Category 3 Outcome Measures.
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Related Category 3 Outcome Measures:
IT-9.4 Other Outcome Improvement Target- Mental health (IDD/SPMI or Challenging Behaviors) admissions and readmissions to state institutions (state mental hospitals and State Supported Living Centers)

This project supports and reinforces Quality Improvement projects in Category III related to potentially preventable admissions and readmissions for behavioral health populations. Contingent upon the baseline assessment completed in DSRIP Year 2, the following related Category 3 Outcome Measures, Outcome Domain 9 – Right Care, Right Setting, may apply:

- Decrease in mental health (by targeted population -IDD with co-occurring SPMI or Challenging Behaviors) admissions and readmissions to criminal justice settings such as jails or prisons
- Decrease in Emergency Department visits for target population (IDD with co-occurring SPMI or Challenging Behaviors)
- Decrease in admissions and readmissions to skilled Intermediate Care Facilities (ICF/ID)- State Supported Living Centers

This project's goal is to avert the cost of long term crisis intervention through provision of in-home and community setting care. Consistent with the project's goal for continuous quality improvement, Category 3 includes a Process for Plan, Do, Study, Act (PDSA). Admissions and readmissions to criminal justice settings and to long term care settings can help avert poor health and mental health outcomes, reduce long term medical costs and improve functioning. See Rationale section above for supporting data.
Relationship to other Projects: The development and improvement of services for patients with behavioral health disorders is a focus of multiple projects throughout the RHP, including those in Category I for expanding access and Category II for developing innovative solutions to priority issues. This project supports areas focusing on the expansion and development of medical home models, expansion and development of preventive and urgent care, and improvement in the quality of life for patients.

Relationship to Other Performing Providers Projects in the RHP:
Numerous community needs assessments reflect an extreme need for behavioral health services to include outpatient treatment centers, crisis stabilization units, inpatient beds, and much more. The lack of funding as well as complexity of the region's patient base has limited the amount of behavioral health treatments available to our region and continues to drive cost in emergent and inpatient situations. The Crisis Stabilization Unit has a direct correlation to all behavioral health

programs recommended in the RHP plan and will be a focus of two of the largest Local Mental Health Authorities of our region. Both CSU's share the outcome measures of mental health admissions & readmissions, and improvement of patient satisfaction scores. The Region 3 Initiative Grid attached in the addendum reflects the direct relationships of this initiative.

Local Authorities for IDD (Intellectual Developmental Disabilities) are a large focus of our community including our local mental health authorities in the region. The IDD concepts focus to outcome measures of patient satisfaction scores, and admission/re-admission rates. There are two initiatives in the RHP plan with a focus to IDD and are represented in the addendum (Region 3 Initiative Grid).

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Plan for Learning Collaborative:

Texana Center and MHMRA of Harris County share a network of providers for Medicaid services (Home and Community Based Services Waiver, Texas Home Living Program, and ICF/ID programs), and collaborate to meet monthly with the providers for an exchange of information. Through this project, Texana Center and MHMRA of Harris County will expand this collaboration to include monthly telephone conferences to share best practices, new ideas and solutions for the crisis stabilization projects. The established provider meetings will provide an effective forum for gathering input of stakeholders in the projects processes. Additionally, both Texana Center and MHMRA of Harris County meet with representatives of Local Authorities statewide on a quarterly basis, and will request that these meetings include information sharing about similar projects in other areas of the state.

Through this expanded learning collaborative, Texana Center and participating Local Authorities will share challenges, testing of new ideas and solutions. Additionally, Texana Center plans to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system. This exchange will facilitate effective processes, efficient use of resources, and consistent data benchmarking across similar projects statewide.

Project Valuation: This project addresses a priority need for the IDD/SPMI population to receive intensive crisis stabilization services in the community. By doing so, it also allows for cost avoidance, supporting individuals in the community at a lesser cost than institutional care in state hospitals and State Supported Living Centers, and avoiding costs in the criminal justice system and emergency rooms. This project was valued based on two studies completed by the UT Houston School of Public Health and the UT Austin Center for Social Work Research: "Valuing the Program to Create an Assertive Community Treatment (ACT) Team for People with Intellectual and Developmental Disabilities (IDD)" and "Valuing the Crisis Respite for Children Program". These studies were completed through a contract with Center for Health Care Services, and were based on cost-utility analysis measures and quality-adjusted life-years analysis.

Total Five Year Valuation: $5,574,005

081522701.2.1	*2.13.1*	*2.13.1.A-E*	*CRISIS STABILIZATION SERVICE MODEL FOR INDIVIDUALS WITH INTELLECTUAL DEVELOPMENTAL DISABILITY AND SERIOUS PERSISTENT MENTAL ILLNESS AND/OR CHALLENGING BEHAVIORS TO PREVENT UNNECESSARY USE OF SERVICES IN SPECIFIED SETTING*
Texana Center			*081522701*
Related Category 3 Outcome Measure(s):	**081522701.3.3**	*IT 9.4*	*Other Outcome Improvement Target- Mental health (IDD/SPMI or Challenging Behaviors) admissions and readmissions to state institutions (state mental hospitals and State Supported Living Centers)*

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1[P –1]: Conduct needs assessment of the IDD/SPMI population, a complex behavioral health population, who are frequent users of community public health resources. Metric 1[*P-1.1*]: Numbers of individuals, demographics, location, diagnoses, housing status, natural supports, functional and cognitive issues, medical utilization, ED utilization Data Source: 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. Milestone 1 Estimated Incentive Payment (*maximum amount*): $936,503.50 **Milestone 2**[P-2]: Design community-based specialized interventions for target population (IDD with SPMI/Challenging	**Milestone 3** [P-3]: Enroll and serve individuals with targeted complex needs (IDD/SPMI population with concomitant circumstances such as forensic involvement, emergency departments, psychiatric and institutional facilities). Metric 1 [P-3.1]: Number of targeted individuals enrolled/served in the project. Baseline/Goal: Baseline to be determined in Year 2 assessment/ Goal of 5% increase in number enrolled/served . Data Source: Project documentation. Milestone 3 Estimated Incentive Payment: $571,727.50 **Milestone 4** [P-5]: Participate in at least biweekly interactions (meetings, conference calls, or webinars) with other providers, and the RHP to promote collaborative learning around shared or similar projects. Participation includes: 1)sharing challenges and any solutions,; 2) sharing results and quantitative	**Milestone 5** [P-3]: Enroll and serve individuals with targeted complex needs (IDD/SPMI population with concomitant circumstances such as forensic involvement, emergency departments, psychiatric and institutional facilities). Metric 1 [P-3.1]: Number of targeted individuals enrolled/served in the project. Baseline/Goal: Baseline to be determined in Year 2 assessment/ Goal of 10% increase in number enrolled/served . Data Source: Project documentation. Milestone 5 Estimated Incentive Payment: $434,329.66 **Milestone 6** [P-5]: Participate in at least biweekly interactions (meetings, conference calls, or webinars) with other providers, and the RHP to promote collaborative learning around shared or similar projects. Participation includes: 1)sharing challenges and any solutions,; 2) sharing results and quantitative	**Milestone 8** [P-3]: Enroll and serve individuals with targeted complex needs (IDD/SPMI population with concomitant circumstances such as forensic involvement, emergency departments, psychiatric and institutional facilities). Metric 1 [P-3.1]: Number of targeted individuals enrolled/served in the project. Baseline/Goal: Baseline to be determined in Year 2 assessment/ Goal of 15% increase in number enrolled/served . Data Source: Project documentation. Milestone 8 Estimated Incentive Payment: $418,184.66 **Milestone 9** [P-5]: Participate in at least biweekly interactions (meetings, conference calls, or webinars) with other providers, and the RHP to promote collaborative learning around shared or similar projects. Participation includes: 1)sharing challenges and any solutions,; 2) sharing results and quantitative

081522701.2.1	2.13.1	2.13.1.A-E	CRISIS STABILIZATION SERVICE MODEL FOR INDIVIDUALS WITH INTELLECTUAL DEVELOPMENTAL DISABILITY AND SERIOUS PERSISTENT MENTAL ILLNESS AND/OR CHALLENGING BEHAVIORS TO PREVENT UNNECESSARY USE OF SERVICES IN SPECIFIED SETTING
Texana Center			081522701
Related Category 3 Outcome Measure(s):	**081522701.3.3**	*IT 9.4*	*Other Outcome Improvement Target- Mental health (IDD/SPMI or Challenging Behaviors) admissions and readmissions to state institutions (state mental hospitals and State Supported Living Centers)*
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Behaviors). Interventions will include specialized behavioral therapies (Applied Behavior Analysis), Respite care (short term); Visiting Nursing and/or community health worker services. Metric 1 [P-2]: Project plans which are based on evidence/experience and which address the project goals. Data Source: Project documentation Milestone 2 Estimated Incentive Payment: $936,503.50	progress on new improvement that the provider is testing; and 3) identifying a new improvement and publicly commit to testing it in the week to come. Metric 1 [P-5.1]: Number of bi-weekly meetings, conference calls, or webinars organized by the RHP that the provider participated in. Data Source: Documentation of weekly or bi-weekly phone meetings, conference calls, or webinars including agendas for phone calls, slides from webinars, and/or meeting notes. Metric 2 [P-5.2]: Share challenges and solutions successfully implemented during this bi-weekly interaction. Data Source: Catalogue of challenges, solutions, tests, and progress shared by the participating provider during each bi-weekly interaction, with at least quarterly summary. Milestone 4 Estimated Incentive Payment: $571,727.5	progress on new improvement that the provider is testing; and 3) identifying a new improvement and publicly commit to testing it in the week to come. Metric 1 [P-5.1]: Number of bi-weekly meetings, conference calls, or webinars organized by the RHP that the provider participated in. Data Source: Documentation of weekly or bi-weekly phone meetings, conference calls, or webinars including agendas for phone calls, slides from webinars, and/or meeting notes. Metric 2 [P-5.2]: Share challenges and solutions successfully implemented during this bi-weekly interaction. Data Source: Catalogue of challenges, solutions, tests, and progress shared by the participating provider during each bi-weekly interaction, with at least quarterly summary. Milestone 6 Estimated Incentive Payment: $434,329.66	progress on new improvement that the provider is testing; and 3) identifying a new improvement and publicly commit to testing it in the week to come. Metric 1 [P-5.1]: Number of bi-weekly meetings, conference calls, or webinars organized by the RHP that the provider participated in. Data Source: Documentation of weekly or bi-weekly phone meetings, conference calls, or webinars including agendas for phone calls, slides from webinars, and/or meeting notes. Metric 2 [P-5.2]: Share challenges and solutions successfully implemented during this bi-weekly interaction. Data Source: Catalogue of challenges, solutions, tests, and progress shared by the participating provider during each bi-weekly interaction, with at least quarterly summary. Milestone 9 Estimated Incentive Payment: $418,184.66

081522701.2.1	***2.13.1***	***2.13.1.A-E***	***CRISIS STABILIZATION SERVICE MODEL FOR INDIVIDUALS WITH INTELLECTUAL DEVELOPMENTAL DISABILITY AND SERIOUS PERSISTENT MENTAL ILLNESS AND/OR CHALLENGING BEHAVIORS TO PREVENT UNNECESSARY USE OF SERVICES IN SPECIFIED SETTING***
Texana Center			*081522701*
Related Category 3 Outcome Measure(s):	**081522701.3.3**	*IT 9.4*	*Other Outcome Improvement Target- Mental health (IDD/SPMI or Challenging Behaviors) admissions and readmissions to state institutions (state mental hospitals and State Supported Living Centers)*

Year 2 (10/1/2012 – 9/30/2013)	**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 7 [I-5]: Functional Status Metric 1 [I-5.1]: The percentage of individuals receiving specialized interventions who demonstrate improved functional status on standardized instrument (e.g., ANSA, CANS, or other determined by project planning in Year 2). 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. Data Source: Standardized functional assessment instruments (e.g., ANSA, CANS, or other determined by project planning in Year 2). Milestone 7 Estimated Incentive Payment: $434,329.66	**Milestone 10** I-5]: Functional Status Metric 1 [I-5.1]: The percentage of individuals receiving specialized interventions who demonstrate improved functional status on standardized instrument (e.g., ANSA, CANS, or other determined by project planning in Year 2). 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. Data Source: Standardized functional assessment instruments (e.g., ANSA, CANS, or other determined by project planning in Year 2). Milestone 10 Estimated Incentive Payment: $418,184.66
Year 2 Estimated Milestone Bundle Amount: $1,873,007	Year 3 Estimated Milestone Bundle Amount: $1,143,455	Year 4 Estimated Milestone Bundle Amount: $1,302,989	Year 5 Estimated Milestone Bundle Amount: $1,254,554

081522701.2.1	*2.13.1*	*2.13.1.A-E*	***CRISIS STABILIZATION SERVICE MODEL FOR INDIVIDUALS WITH INTELLECTUAL DEVELOPMENTAL DISABILITY AND SERIOUS PERSISTENT MENTAL ILLNESS AND/OR CHALLENGING BEHAVIORS TO PREVENT UNNECESSARY USE OF SERVICES IN SPECIFIED SETTING***
Texana Center			*081522701*
Related Category 3 Outcome Measure(s):	**081522701.3.3**	*IT 9.4*	*Other Outcome Improvement Target- Mental health (IDD/SPMI or Challenging Behaviors) admissions and readmissions to state institutions (state mental hospitals and State Supported Living Centers)*
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over DYs 2-5)***:**$5,574,005			

Texas Children's Hospital

Pass 1

Project Option-2.1.4 "Other" project option: Expand Medical Homes for Transition Population

Unique Project ID: 139135109.2.1

Performing Provider and TPI: Texas Children's Hospital/139135109

Project Summary:
Expand a medical home to serve additional adolescent/ young adults with significant chronic childhood conditions.
Provider:
Texas Children's Hospital, located in Houston, is the largest free standing children's hospital in the county specializing in the care of medically fragile children in Houston and across the country as a regional safety net provider. We currently are licensed for 564 beds and in 2011 we had over 2.7 million patient encounters. Our mission is to provide the finest possible pediatric and women's patient care, education, and research. Texas Children's is an integrated delivery system comprising of a health plan for Medicaid and CHIP pregnant women and children, the nation's largest general pediatrician group and two world class hospitals.

Volume Statistics - FY2012	Patient Payor Mix	Patient Demographics
Hospital Admissions- 25,966 Births (babies delivered)- 2,181 Emergency visits-113,586 Outpatient visits- 3,066,765	Medicaid and CHIP- 53.6% Commercial Insurance- 40.6% Self-Pay- 1.8% Medicare- 1.2%	Hispanic- 35.9% African American- 16.6% Caucasian- 31.0% Asian- 3.8% Other- 12.4% American Indian- 0.3%

Intervention(s):
The project will offer a medical home to adolescent/young adults with significant chronic childhood conditions. The clinic will not only offer health care and prevention services but also proactive care coordination and case management to a very vulnerable population of patients. The clinic will emphasis quality of care, increase patient satisfaction and address patient safety by preventing emergency room visits and acute hospital stays.
Need for the project:
The majority of adolescent/young adults with chronic childhood conditions have difficulty engaging in adult health care services as they age out of the pediatric health care system because of numerous barriers they face such as adult health care providers who haven't been trained to care for pediatric conditions, unfunded or poorly funded insurance and time consuming care. Many of these patients end of using the emergency room for episodic care.
Target Population:
All adolescent/young adults, age 17 and up who have a life threatening chronic childhood condition in Harris County could benefit from having a medical home with adult health care providers who are dedicated to caring for this vulnerable population of patients.
Category 1 or 2 expected patient benefits:
Our DY 3 goal is to increase patient visits by 20% from the baseline in fiscal year 2012. DY4 goal is to increase patient visits by 30% from the baseline in fiscal year 2012. DY 5 goal is to increase patient visits by 40% from the baseline in fiscal year 2012.
Category 3 outcomes:
IT-6.1 Our goal is improve patient satisfaction

Project Option-2.1.4 "Other" project option: Expand Medical Homes for Transition Population

Unique Project ID: 139135109.2.1
Performing Provider and TPI: Texas Children's Hospital/139135109

Project Description:
Texas Children's Health will establish a patient centered medical home for medically fragile children in order to provide proactive care coordination, chronic disease management, and a multi-disciplinary approach that educates patients and providers on appropriate transition processes.

Texas Children's Hospital, located in Houston, is the largest free standing children's hospital in the county specializing in the care of medically fragile children in Houston and across the country as a regional safety net provider. We currently are licensed for 564 beds at our main campus and West Houston facilities. In 2011 we had over 2.7 million patient encounters. Our mission is to provide the finest possible pediatric patient care, education, and research. Texas Children's is an integrated delivery system comprising of a health plan for Medicaid and CHIP pregnant women and children, the nation's largest general pediatrician group and two world class hospitals. Texas Children's supports a commitment to quality service and cost-effective care to enhance the health and well-being of children locally, nationally and internationally.

Due to recent advancements in health care, over 90% of children with special health care needs now live into adulthood.[249] Over 11.2 million children with special health care needs, including those with chronic illnesses and disabilities, live in the United States, and, nationally, only 40% successfully transition from the pediatric to the adult health care setting. [250] Texas accounts for 9% of this total with over 1 million children with special health care needs, and, of this population, only 35% successfully transition into the adult health care environment. Across the country, approximately 500,000 adolescents and young adults with chronic, pediatric-onset diseases such as spina bifida, Down syndrome, cerebral palsy, congenital heart disease, autism, and numerous genetic disorders will reach the age of necessary transition this year (18-21 years of age).[251] Patients who do not transition to appropriate adult providers end up seeking care at Texas Children's emergency room. For children and adults, especially those with health care needs that exceed the abilities of the primary care provider, access to and coordination with subspecialty care is critical to ensuring the provision of efficient and effective health care and in securing a comprehensive medical home. This project will expand a Meds/Peds primary care approach for this patient population and establish a patient centered medical home for the

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[249] Data Resource Center for Children & Adolescent Health, 2010. http://childhealthdata.org/browse/snapshots/cshcn-profies?geo=45&rpt=9.

[250] Pollack, Lauren and Peggy McManus. "Health Care Transition from Pediatric to Adult Health Care: National and State Tables from the 2009/2010 National Survey of Children with Special Health Care Needs." *The National Alliance to Advance Adolescent Health*. February 2012.

[251] Newachek P, Taylor W. Childhood chronic illness: Prevalence, severity, and impact. *Am J Public Health*. 1992; 82 (3): 364-371.

population in order to provide proactive care coordination, chronic disease management, and a multi-disciplinary approach that educates patients and providers on appropriate transition processes.

Goals and Relationship to Regional Goals:

Project Goals: To meet the growing demand for medical home services TCH will:

1. Improve data exchange between hospitals and affiliated medical home sites
2. Develop best practices plan to eliminate gaps in the readiness assessment
3. Hire and train team members to create multidisciplinary teams including social workers, patient navigators, care managers, and nurses with a diverse skill set that can meet the needs of the shared, high-risk patients
4. Implement a comprehensive, multidisciplinary intervention to address the needs of the shared, high-risk patients
5. Evaluate the success of the intervention at decreasing ED and inpatient hospitalization by shared, high-risk patients and use this data in rapid-cycle improvement to improve the intervention.

This project meets the following Region 3 Goals:

- Inadequate access to treatment and services designed for special needs populations, including disabled, homeless, children, elderly
- Insufficient access to care coordination practice management and integrated care treatment programs

Increased access to appropriate care leads to better long term outcomes in children and reduction in unnecessary health care costs.[252]

Challenges:

In Texas, limited Medicaid reimbursement is an ongoing challenge for children's hospitals and the workforce that provides health care services for the pediatric population enrolled in this program and even more so for this patient population as they are moved over into the adult Medicaid system of care. As advocates for improving and sustaining quality children's health care, our organization informs and educates elected officials and community leaders about the importance of Medicaid and the need to adequately fund the program. We will continue these efforts throughout the duration of waiver to ensure existing programs and services will be maintained and expanded. In addition to the inadequate reimbursement model for Medicaid, another challenge with this population of patients is adult health care providers are not familiar with chronic childhood conditions such as Down syndrome and spina bifida as they are not adequately trained as medical students and residents on how to provide care for them. A large percentage of these patients are underinsured (Medicaid) and require labor intensive and time consuming care.

[252] *Reducing Costs Through the Appropriate Use of Specialty Services*. Cambridge: Institute for Healthcare Improvement, 2007.

By having this clinic in an academic setting we are addressing provider readiness by training adult health care providers such as internal medicine residents and family residents and in addition exposing medical students and other allied health care providers to this patient population. Efforts to add transition healthcare to medical student and resident curriculum are ongoing and in the future, CME (continuing medical education) opportunities for practicing physicians are being planned. We are also recruiting Med-Peds residents into the practice of transition medicine as they are uniquely qualified to care for this population of patients. Because of the possible opportunity to care for this population of patients, interest from Med-Peds physicians is growing to championing this effort. Another barrier is family readiness. Many of patients and their families will have significant health care issues superimposed on a developing child resulting in health care needs that are constantly changing in the pediatric health care system. This leaves no time for health care providers and their patients to start the transition process as they age out of the pediatric health care system.

Five year expected outcome for provider and patients:
Texas Children's Hospital expects to see improvements in coordination of care provided to the individuals enrolled in the patient centered medical home. We expect this in turn will improve patient satisfaction due to the delivery of the right care at the right place at the right time.

Starting Point/Baseline: The transition clinic will increase the number of patients seen from 400.

Rationale:
Inadequate access to primary and specialty care has contributed to the limited scope and size of safety net health systems. This project will establish a "home base" for patients, where patients have a health care team that is tailored to the patient's health care needs, coordinates the patient's care, and proactively provides preventive, primary, routine and chronic care, so that patients may see their health improve, rely less on costly emergency department (ED) visits, incur fewer avoidable hospital stays, and report a greater patient experience of care. Since the targeted population includes adolescents and young adults with chronic and/or special health care needs, staff will focus great energy in appropriate care coordination and disease management in order to eliminate the historical drop of care for this patient group.

Furthermore, proactive care coordination across multiple sub-specialties, along with access to medical home physicians and staff, will reduce the number of unnecessary EC visits and hospital admissions while simultaneously reducing the associated costs. Additionally, this project will enhance the patient experience by providing care in an appropriate setting for the patient's age and educating the patient and/or family as they transition into the role of primary health care decision maker. For adolescents with health care needs that exceed the abilities of the primary care provider, access to and coordination of specialty care is critical to ensuring the provision of efficient and effective health care and in securing a comprehensive medical home. Increasing pediatric population living into adulthood with chronic pediatric diseases is driving the need for increased access. Our project significantly enhances the existing transition services available to this growing population.

Project Components: Through the expanded access to the transition medicine medical home, we propose to meet all required project components listed. These selected milestones and metrics do relate to project components.

www. Expand Transition Medicine Medical Home Services
xxx. Implement transparent standardized referrals across the system
yyy. Increase service availability hours

Milestones and Metrics
The following milestones and metrics have been chosen for the project based on the core components and the needs of the targeted pediatric population.

- Process milestone and metrics: P-X, P-8 (P-8.1)
- Improvement milestones and metrics: I-15 (1-15.1)

Unique community need identification numbers the project addresses:

- CN. 2 Inadequate access to specialty care
- CN. 6 Inadequate access to treatment and services designed for special needs populations, including disabled, homeless, children, elderly

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
Currently the Baylor Transition Medicine Clinic is only one of a hand full of clinics in the United States that is specifically serving adolescent/young adults with significant childhood conditions as they move out of the pediatric into the adult healthcare system. This project will allow the clinic to significantly expand the scope of services across the city of Houston and Harris County so that this patient population will have a seamless transition into accessible healthcare that is coordinated, comprehensive and compassionate.

Related Category 3 Outcome Measure(s):
OD-6 Patient Satisfaction
IT-6.1 Percent improvement over baseline of patient satisfaction scores
Reasons/rationale for selecting the outcome measures:
Our project will increase appropriate access to patient centered coordinated care. Increased access to appropriate care leads to better long term outcomes in children and reduction in unnecessary health care costs.[253] This population will still need to be hospitalized but we believe that through appropriate access and care coordination we will be able to reduce the cost of care.

Relationship to other Projects: All of Texas Children's projects are working to expand appropriate access to subspecialty care for the pediatric population. Texas continues to have a growing pediatric population and a shortage of specialized pediatric providers. This project will help those patients who grow up at Texas Children's to transition to appropriate adult providers.

Primary Care/Ambulatory Care clinics are a top priority to Region 3 due to the acuity of the regional patient mix, population concentration, and lack of primary care access points for our patient base. The regional approach of collaboration as well as existing patient referral pattern

[253] *Reducing Costs Through the Appropriate Use of Specialty Services*. Cambridge: Institute for Healthcare Improvement, 2007.

relationships allowed our team to properly identify the community needs based on the necessity of population, uninsured, and medically underserved patient bases. This program is consistent with our region and similar to numerous initiatives in our RHP plan sharing both concepts as well as outcome measures focused to percent improvement over baseline of patient satisfaction scores, reduction of inappropriate ED utilization, and third next available appointment status. The Region 3 Initiative Grid attached as a RHP Plan addendum reflects a grid of relationship for all initiatives.

Plan for Learning Collaborative: We plan to participate in a region-wide learning collaborative as offered by the anchor for Region 3, Harris Health System. Our participation in this collaborative with other performing providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our region's health care system.

Project Valuation: This project's value is based on the benefits related to cost avoidance of medical expenses and improved quality of life. For example, increased provider capacity leads to reduction in emergency room visits and reduction in inpatient hospital visits.[254] Our valuation also includes an increase in the patient's quality of life. We are using a conservative Quality Adjusted Life Year ("QALY") per year and a percentage of that QALY for the pediatric population.[255] The QALY is used as a one-time improvement in the quality of life, even though we know the patient's quality of life will be improved for many years. We recognize that this is a government funded waiver and thus we chose to have conservative valuations out of respect for the taxpayer funded program. We have academic literature citing the link between access to appropriate pediatric subspecialty care and decrease in hospital visits, both inpatient and emergency room.[3]

[254] Smith, John T, Price, Christopher, Stevens Peter M., Masters, Kevin S., and Young, Mark. "Selected Topics - Does Pediatric Orthopedic Subspecialization Affect Hospital Utilization and Charges?" *Journal of Pediatric Orthopedics*. 19.4 (1999): 553-555.

[255] Brannon, Ike. "Risk - What Is a Life Worth? Despite Its Prima Facie Callousness, Determining the Value of a Human Life Is Necessary for Good Public Policy." *Regulation*. 27.4 (2004): 60-63.

139135109.2.1	*2.1.4*	*N/A*	***"OTHER" PROJECT OPTION: EXPAND MEDICAL HOMES FOR TRANSITION POPULATION***
Texas Children's Hospital			*139135109*
Related Category 3 Outcome Measure(s):	139135109.3.43	*IT- 6.1*(2) how well their doctors communicate;	*Percent improvement over baseline of patient satisfaction scores*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-X] Expand the medical home centered on patients transitioning out of pediatric care and into adult care who have chronic pediatric conditions. Add providers and support staff to meet the most immediate needs of the growing patient population. Metric 1 [P-X]: Hire additional providers Milestone 1 Estimated Incentive Payment *:* $749,773 **Milestone 2 (P-8)** Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements. Metric 1 [P-8.1]: Participate in semi-annual face-to-face meetings or	**Milestone 3** [I-15]: Increase the number or percent of medical home patients that are able to identify their usual source of care as being managed in medical homes Metric 1 [I-15.1]: Usual source of care a. Numerator: Number of medical home patients that are able to identify their medical home as their usual source of care b. Denominator: Total number of patients enrolled in the medical home Data Source: Patient survey, EPIC medical record Goal: Increase patient volumes by 20% Milestone 3 Estimated Incentive Payment: $817,962 **Milestone 4 (P-8)** Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating	**Milestone 5** [I-15]: Increase the number or percent of medical home patients that are able to identify their usual source of care as being managed in medical homes Metric 1 [I-15.1]: Usual source of care a. Numerator: Number of medical home patients that are able to identify their medical home as their usual source of care b. Denominator: Total number of medical home patients Data Source: Patient survey EPIC medical record Goal: Increase patient volumes by 30% Milestone 5 Estimated Incentive Payment: $820,339.50 **Milestone 6 (P-8)** Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple	**Milestone 7** [I-15]: Increase the number or percent of medical home patients that are able to identify their usual source of care as being managed in medical homes Metric 1 [I-15.1]: Usual source of care a. Numerator: Number of medical home patients that are able to identify their medical home as their usual source of care b. Denominator: Total number of medical home patients Data Source: Patient survey, EPIC medical record Goal: Increase patient volumes by 40% Milestone 7 Estimated Incentive Payment: $677,672 **Milestone 8 (P-8)** Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers

139135109.2.1	2.1.4	N/A	*"OTHER" PROJECT OPTION: EXPAND MEDICAL HOMES FOR TRANSITION POPULATION*
Texas Children's Hospital			*139135109*
Related Category 3 Outcome Measure(s):	139135109.3.43	*IT- 6.1*(2) how well their doctors communicate;	*Percent improvement over baseline of patient satisfaction scores*
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
seminars organized by the RHP. Goal: Participate in all semi-annual face-to-face meetings or seminars. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Milestone 2 Estimated Incentive Payment: $749,773	provider should publicly commit to implementing these improvements. Metric 1 [P-8.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: Participate in all semi-annual face-to-face meetings or seminars. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Milestone 4 Estimated Incentive Payment: $817,962	initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements. Metric 1 [P-8.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: Participate in all semi-annual face-to-face meetings or seminars. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Milestone 6 Estimated Incentive Payment: $820,339.50	can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements. Metric 1 [P-8.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Goal: Participate in all semi-annual face-to-face meetings or seminars. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Milestone 8 Estimated Incentive Payment: $677,672
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone):* $1,499,546	Year 3 Estimated Milestone Bundle Amount: $1,635,924	Year 4 Estimated Milestone Bundle Amount: $1,640,679	Year 5 Estimated Milestone Bundle Amount: $1,355,344
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)**:*** $6,131,493			

The Methodist Hospital

Pass 1

Project Option 2.17.1 - Design, implement, and evaluate interventions to improve care transitions from the inpatient setting for individuals with mental health and/or substance abuse disorders: Implement Care Transition Coordination

Unique Project ID#: 137949705.2.1

Performing Provider Name / TPI: *The Methodist Hospital / 137949705*

Project Summary:

Provider: Methodist is a delivery system comprised of 4 community hospitals, 1 academic medical center in the Texas Medical Center, research institute, physician organization which employs 350 physicians and operates multiple ancillary care sites throughout the Houston metropolitan area. Methodist has 13,867 employees and has 4,185 associated physicians. Methodist has been recognized as the top hospital system in Houston & Texas by US News & World Report and honored as the top ranked healthcare provider to work for by Fortune Magazine. The Methodist Hospital's payor mix for Medicaid is 4.94% and 2.87% self-pay and San Jacinto's payor mix for Medicaid is 12.87% and 11.31% for self-pay. The Methodist Hosptial is the only private hospital that provides acute psychiatric services in the Texas Medical Center as is San Jacinto in its community.

Intervention(s): By facilitating effective transitions of care to behavioral health and primary care through locations within Harris County including HARRIS HEALTH SYSTEM, MHMRA, private physicians, and SJMH Family Medicine Residency physicians we seek to help patients navigate a complicated health-care landscape, participate in mental health choices, increase their self-efficacy, provide better quality of life and prevent readmissions and prevent adverse outcomes of incarceration, chemical dependency or suicide. Outpatient Service Availability is limited, and so we hope to leverage the community mental health workers to connect and encourage care within existing primary care and mental health resources. The program will advocate primary care expansion for mental health, through the use of treatment algorithms and perhaps by embedding counselors within a primary practice who could bill "incident to" for supervised service.

Target Population: About 140,000 adults in Harris County suffer from severe mental illness, while almost half of these adults had no access to treatment from the public or private health system. Our target population is defined as those individuals who suffer from any behavioral health related condition and who are seeking care in our facilities, more specifically those who are covered by Medicaid or without insurance coverage. At The Methodist Hospital & San Jacinto Methodist Hospital we serve those with behavioral health as detailed below:

ED Visits - Self Pay & Medicaid	32,319
ED Visits - Behavioral Health - Self Pay & Medicaid	879
ED Admissions - Self Pay & Medicaid	3,596
ED Admissions - Behavioral Health - Self Pay & Medicaid	278
P Admissions - Self Pay & Medicaid	8,024
P Admissions - Behavioral Health - Self Pay & Medicaid	540

Category 1 or 2 expected patient benefits: Our project will include a number program innovation and redesign efforts. These include ensuring we have recruiting qualified people to intervene and guide care, educate staff, identify community partners, re-engineering our discharge planning process to ensure patients transition into the ambulatory care setting successfully, setting up care coordination protocols to make sure we identify patient accurately who need our assistance and following our system's CQI efforts of plan, do, check and act to ensure we're achieving our expected outcomes for this target population.

Category 3 outcomes: Our goal is that in the first year we will coordinate care follow-up post discharge to 20% and increase this to 80% by year 5.

Project Option 2.17.1 - Design, implement, and evaluate interventions to improve care transitions from the inpatient setting for individuals with mental health and/or substance abuse disorders: Implement Care Transition Coordination

Unique Project ID#: 137949705.2.1
Performing Provider Name / TPI: *The Methodist Hospital / 137949705*
Project Description:
Preventing Behavioral Health Readmissions by Implementing Care Transition Coordination
According to Healthy Peoples 2010 Mental Illness is on par with heart disease and cancer as a cause for disability. 140,000 residents of Harris County suffer from Mental Illness.[xii] Many have no access to treatment from the public or private health system. Almost 20,000 youths in Harris County are in need of treatment while only 24% of cases were addressed.[xiii]

Currently in Harris County there are limited locations for follow-up mental health care services. The MHMRA services are provided through an office in Pasadena or League City, which is more than 30-45 minutes away and many patients have limited transportation and other barriers to follow up mental health care. Care can be received at the Harris Health System clinic in Baytown where existing patients have access to a visiting Psychiatrist on site 1 half-day per week. This same scenario of limited facilities and physicians to provide ongoing chronic behavioral health care services plays itself out in Central and Northwest Harris County.

There are many barriers to effective mental health care provision. These can be grouped as patient factors, physician factors and system factors. Primary care and primary care psychiatry working together are necessary to address the care of affective and other mental illnesses.[xiv]
The intervention proposed will involve the use of community mental health workers with Behavioral Health Education who can coordinate the care of adult patients through the transition from inpatient care to outpatient levels of care including both mental health and primary care follow up. It will also include promoting and monitoring attendance at community settings such as chemical dependency programs. The community mental health workers will be located at The Methodist Hospital, San Jacinto Methodist Hospital and Methodist Willowbrook Hospital and will receive their case load from hospital discharges, referred discharges from HARRIS Harris Health Systemwho reside in these communities, and referrals from the Emergency Department. The community mental health workers will have access to hospital medical records including discharge planning. Ideally the information from SJMH and Harris Health System may be available through shared information systems between EPIC software and Methodist IT platforms. This will involve a software program called Medicity, which is contained in Methodist Connect and Harris County Health Connect. It will also involve securing patient consent for this level of information exchange.
The community mental health worker will then follow recognized treatment protocols to query patient compliance with treatment and contact the primary care physician or mental health specialist. The care transition manager may refer to specialized disease management programs, such as those for alcohol or chemical dependency. To assist primary care physicians providing mental health follow up, treatment algorithms can guide treatment selection and increased quality and consistency of treatment, provide better clinical outcomes, and more efficient use of health care resources. The care will be directed toward the use guidelines including the Texas Medication Algorithm Project, (TMAP).[xv] It will also include recommending sequenced care

such as the Sequenced Treatment Alternatives to Relieve Depression, (STAR-D), which assist patients and clinicians implementing "next step" treatment options.[xvi] It involves patient-choice and buy-in as well as use of patient-completed rating scales such as the "Quick Inventory for Depressive Symptoms" to monitor response to treatment and alert when urgent outpatient mental health care or crisis intervention is necessary.[xvii] Objective measurements such as this can assist the transitions nurse in evaluating severity or priority.

By facilitating effective transitions of care to behavioral health and primary care through locations within Harris County including Harris Health System, MHMRA, private physicians, and SJMH Family Medicine Residency physicians we seek to help patient navigate a complicated health-care landscape, participate in mental health choices, increase their self-efficacy, provide better quality of life and prevent readmissions and prevent adverse outcomes of incarceration, chemical dependency or suicide.

The costs associated with this program will include IT costs, Space Costs and Salary Costs.

Goals and Relationship to Regional Goals:

This project meets the following regional goals:

This program would meet the following three regional health goals #1 by leveraging and improving on existing programs and infrastructure. #2 by increasing access to primary and specialty care services, with a focus on underserved and the Medicaid populations. It will ensure patients receive the most appropriate and accessible care for their condition, regardless of where they live or their ability to pay. #3 It will transform from disease-centered emergency room care to patient-centered preventive approach to behavioral health care. It also reduced duplication of uncoordinated services currently received from county and private health care.

Challenges:

- Recruitment of qualified community mental health workers
- Recruitment of psychiatrists & acute care nurse practitioners
- Patient compliance

5-Year expected outcome for Performing Provider and Patient:

Focused effort to transition patients from the acute and ED setting with behavioral health conditions will improve outcomes and reduce costs. We aim to reduce repeated admission to our inpatient psychiatric units and reduce repeat emergency room visits from our targeted population. Patients will benefit from a more hands-on, compassionate and integrated care coordination system for behavioral healthcare. This should translate to a reduction of demand for incarcerated patients with mental illness and an improvement in the daily productivity from those who benefit from our program.

Starting Point/ Baseline:

We can get a partial measure of the problem based on recent ED and inpatient admissions. To this we may add utilization at nearby facilities, but the data is not available at present.

At San Jacinto Methodist Hospital in 2011 there were 443 ED admissions with a primary diagnosis of a Mental Health condition, (187 were self-pay and Medicaid) resulting in a financial loss of $119k. At The Methodist Hospital there were 612 ED admissions with a primary diagnosis of a Mental Health condition resulting in a loss of $1.154M. At Methodist Willowbrook Hospital there were 160 ED admissions with a primary diagnosis of a Mental

Health condition resulting in a loss of $6k. This may be an underestimate since it only captures primary diagnoses. There were 709 behavioral health admissions, 296 of which were self-pay and Medicaid, for a net financial loss of $324k.
It is estimated that 30-50% are readmitted within a one-year period based on national literature. Outpatient Service Availability is limited, and so we hope to leverage the community mental health workers to connect and encourage care within existing primary care and mental health resources. The program could advocate primary care expansion for mental health, through the use of treatment algorithms and perhaps by embedding counselors within a primary practice who could bill "incident to" for supervised service.

Rationale:

As referenced above, residents of Harris County have difficulty accessing mental health services.

The stated principles of the Harris County behavioral health system include quick, easy and convenient entry into services, full range of services and minimal financial barriers to necessary services. The principles promote recovery, continuity of care, family integration in care, evidence based care, and where possible co-location of behavioral health and general health care. HC Behavioral Health promotes stability of behavioral health conditions by decreasing relapse of mental illness and substance abuse.
A designated mental health professional provides oversight to the care-management team to provide this collaborative care.[xviii] There are many examples of collaborative care management.[xix],[xx],[xxi]

Project Components:

h. *Develop a cross-continuum team comprised of clinical and administrative representatives from acute care, ambulatory care, behavioral health and community-based non-medical supports*
   a. *We will develop a team of clinical leaders from various care settings to ensure care delivery is integrated and coordinated.*
i. *Conduct an analysis of the key drivers of 30-day hospital readmissions for behavioral health conditions using a chart review tool*
   a. *We will review each chart and develop a trending report of complications from each patient who is readmitted. Our teams will use this information to ensure we are incorporating the appropriate care pathways while the patients are in the hospital and we will also make any changes to our discharge planning process as needed to reduce readmissions.*
j. *Identify baseline mental health and substance abuse conditions at high risk for readmissions*
   a. *We will begin with a retrospective review of all behavioral health related readmissions to identify trends. On a go-forward basis, we will review each chart and develop a trending report of complications from each patient who is readmitted. These reports will be updated to ensure we are identifying those patients who are at high risk for readmissions.*
k. *Review best practices for improving care transitions from a range of evidence-based or evidence-informed models*
   a. *Our teams will work collaboratively with other groups focused on reducing readmissions and incorporate their best practices to our patient population.*

l. *Identify and prioritize evidence-based strategies and clinical protocols that support seamless care transitions and reduce preventable 30-day readmissions.*
    a. *Our teams will utilize the plan, do, check, act approach of continuous quality improvement for this project. Using this approach will ensure that we are identifying and prioritizing care transactions and reduce readmissions.*

m. *Implement two or more pilot intervention(s) in care transitions targeting one or more patient care units or a defined patient population.*

n. *Conduct quality improvement for project using methods such as rapid cycle improvement.*

The project will focus primarily on items b, c, d and e of the above listed components.

Unique community need identification number the project addresses: CN.3 - Inadequate access to behavioral health care

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

This project represents the first time a focused, coordinated care navigation effort has been targeted at patients who suffer from behavioral health conditions. We feel that this project will significantly reduce unnecessary emergency department utilization & repeat admissions into inpatient psychiatric units.

Related Category 3 Outcome Measures:
OD-1: Primary Care and Chronic Disease Management
IT-1.18 Follow-Up After Hospitalization for Mental Illness- NQF 0576236 (Standalone measure)
Reasons/rationale for selecting the outcome measures:
Rationale for choice of using one standalone measure is that is most specific for the intervention. It has been well established that unnecessary readmissions can be prevented by implementing various measures to ensure outpatient follow-up.[xxii]
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.
Our goal is that by year four we will have 60% with follow up within 30 days, and by year 5 we will have 80%.
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.
As it is difficult to arrange appointments so close to discharge because of patient and physician factors, our goal is that by the fourth year we will have 40% follow up within seven days and by the fifth year, 50%.
Relationship to other Performing Providers Projects within the RHP:
The behavioral health crisis in Region 3 is considerable and the proposed initiatives in our RHP plan will only imply a small impression into the overall community need for treatment, but is a good start. The outpatient focus of many RHP Plan initiatives will help numerous facilities focus

to treating the patients in an ambulatory setting as well as continued navigation of services with a focus to keeping patients from the inpatient unit. This initiative is similar to many others in the sense of the category of behavioral health. The Region 3 Initiative Grid attached in the addendum will show the relationship to other programs.

Multiple other Behavioral Health Innovations include care navigators, transition coaches, or case managers. We seek to participate in lessons-learned with all of these programs. We also plan to collaborate with entities receiving Federal SAMSHA funding such as Community Mental Health services block grant, Substance Abuse Prevention and Treatment Block Grant or other mental health and substance abuse grants, (Harris County Adult Treatment STAR Drug Courts, TI021529). The transition nurse would be reaching out to connect the patient with right source of care.

Plan for Learning Collaborative:

We plan to participate in a region-wide learning collaborative as offered by the anchor for Region 3, Harris Health System. Our participation in this collaborative with other performing providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our region's health care system.

Project Valuation:

All milestones and metrics were given equal weight and valuation for this project based on our Pass 1 workbook.

137949705.2.1	2.17.1	A-G	PREVENTING BEHAVIORAL HEALTH READMISSIONS BY IMPLEMENTING CARE TRANSITION COORDINATION (Mental Health Program Innovation and Redesign through use of Psychiatric Care Managers)
The Methodist Hospital			137949705
Related Category 3 Outcome Measure(s):	**IT 1.18**	137949705.3.1	*Follow up after Hospitalization for Mental Illness*

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Milestone 1 [P-1] Establish Team to support or lead project Metric 1[P-1.1]: Establishment of Team Baseline/Goal: 100% complete Data Source: program documents. List of team members Milestone 1 Estimated Incentive Payment: 549,639 **Milestone 2** [P-2]: Collect information and /or analyze data on factors contributing to preventable readmissions within 30 days. Metric 1 [P-2.4]: Develop an electronic report on readmission data Baseline: Report developed and criteria established. Data Source: program documents. Metric 2 [P-2.5]: Chart review Reports Baseline: List of reports used on a daily basis to improve transition coordination. Data Source: program documents.	**Milestone 8** [P-11]: Evaluate and continuously improve care transitions programs Metric 1 [P-11.1]: Project planning and implementation documentation demonstrates plan, do, study act (PDSA) quality improvement cycles Project reports include examples of how real-time data is used for rapid cycle improvement to guide continuous quality improvement Baseline/Goal: A monthly assessment of PDSA efforts in meeting minutes or other documentation. Data Source: Project reports Milestone 8 Estimated Incentive Payment: $905,288 **Milestone 9** [P-15]: Educate appropriate clinical staff on key contributing factors to preventable readmissions. Metric 1: [P-15.1] X % of key clinical staff completing educational sessions Baseline/Goal: 50% of emergency	**Milestone 13:** [P-23] Train care transition nurses on standard use of evidence-based care transition tool and framework. Metric 1 [P-23.1]: X% of post-acute partners trained Baseline/Goal: 100 % of 4 transition nurses trained Data Source: Internal Hospital Records. Milestone 13 Estimated Incentive Payment:$848,707.25 **Milestone 14** [P-28]: Gap analysis regarding patient communication with doctors, nurses, and/or discharge information. Metric 1 [P-28.1]: Analysis complete Baseline/Goal: 100% complete Data Source: Internal hospital records/documentation Milestone 14 Estimated Incentive Payment:$848,707.25 **Milestone 15** [P-30]: Participate in bi-weekly interactions (conference calls, or webinars) with other	**Milestone 17** (P-32) Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements. Metric 1: (P-32.1) Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Baseline/Goal: Participate in learning collaborative Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. ***Milestone 17: Estimated Incentive Payment (maximum amount):*** $1,290,035 **Milestone 18**:[I-42] Follow up after Hospitalization

137949705.2.1	*2.17.1*	A-G	***PREVENTING BEHAVIORAL HEALTH READMISSIONS BY IMPLEMENTING CARE TRANSITION COORDINATION*** (Mental Health Program Innovation and Redesign through use of Psychiatric Care Managers)
The Methodist Hospital			137949705
Related Category 3 Outcome Measure(s):	**IT 1.18**	137949705.3.1	*Follow up after Hospitalization for Mental Illness*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Metric 3 [P-2.6]: Determine baseline metric for all cause 30 day readmissions Data Source: program documents. Metric 4 [P-2.7]: Identification of key factors that increase the likelihood of preventable 30 day readmissions for individuals with mental health and substance use disorders Baseline: Development of factors that increase likelihood of readmission by working committee. Data Source: program documents Milestone 2 Estimated Incentive Payment: $549,639 **Milestone 3:** [P-4]: Hire clinician(s) with care transition/disease management expertise. Metric 1 [P-4.1]: Position offer letters. Baseline/Goal: 100% completion of budgeted hiring (15 FTEs) or appropriate FTEs based on realized	medicine, internal medicine & behavioral health clinicians complete education.. Data Sources: Internal hospital records/documentation; Training curricula Milestone 9 Estimated Incentive Payment : $905,288 **Milestone 10** (P-17): Re-engineer hospital discharge process for all admitted patients. Metric 1: Development of high-risk tool and discharge checklist a. Data Source: EMR Documentation of high risk tool and discharge check list including medication reconciliation **Milestone 10: Estimated Incentive Payment (*maximum amount*):** $905,288 **Milestone 11:** (P-20) Identify community-based care transition partners. Metric1: (P-20.1) Number of care	providers and the RHP to promote collaborative learning around shared or similar projects. Including: 1) sharing challenges & solutions 2) sharing results and quantitative progress on new improvements that the provider is testing; and 3) identifying a new improvement and publicly commit to testing it in the week to come. Metric 1 [P-30.1]: Number of bi-weekly meetings, conference calls, or webinars organized by the RHP that the provider participated in. Baseline / Goal: 100% complete Data Source: Attendance record logs and conference call meeting minutes Metric 2 [P-30.2]: Share challenges and solutions successfully during this bi-weekly interaction. Baseline / Goal: 100% complete Data Source: Catalogue of challenges, solutions, tests, and progress shared by the participating provider, summarized at quarterly intervals Milestone 15 Estimated Incentive Payment: $848,707.25	Metric 1 [I-42.1]: 20% increase in number of patients receiving Follow-up After Hospitalization for Mental Illness within 7 and 30 days (NQF#-576) Goal: 10% above baseline Data Source: EMR **Milestone 18 Estimated Incentive Payment:** $1,290,035

137949705.2.1	2.17.1	A-G	PREVENTING BEHAVIORAL HEALTH READMISSIONS BY IMPLEMENTING CARE TRANSITION COORDINATION (Mental Health Program Innovation and Redesign through use of Psychiatric Care Managers)
The Methodist Hospital			137949705
Related Category 3 Outcome Measure(s):	**IT 1.18**	137949705.3.1	*Follow up after Hospitalization for Mental Illness*

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
patient demand. Data Source: Documentation of position of offer letters/ Human Resources records Milestone 3 Estimated Incentive Payment: $549,639 **Milestone 4: Milestone 4:** [P-5] Develop an assessment tool to identify patients who are at high risk for readmission. Metric 1 [P-5.1]: Multidisciplinary committee approves assessment tool Baseline/Goal: 100% complete Data Source: Approved sample tool and meeting minutes Milestone 4 Estimated Incentive Payment $549,639 **Milestone 5:** [P-6] Identify evidence-based frameworks that support seamless care transitions and impact preventable 30-day readmissions. Metric 1: [P-6.1] Selection of an	transition partners Metric 2: (P-20.2) Number of partner post-acute facilities **Milestone 11 Estimated Incentive Payment (*maximum amount*):** $905,288 **Milestone 12:** (P-23) Train care transition nurses on standard use of evidence-based care transition tool and framework. Metric 1: 50 % of 4 transition nurses trained Data Source: Internal Hospital Records. **Milestone 12 Estimated Incentive Payment (*maximum amount*):** $905,288	**Milestone 16**:[I-42] Follow up after Hospitalization Metric1 [I-42.1]: 10% increase in number of patients receiving Follow-up After Hospitalization for Mental Illness within 7 and 30 days (NQF#-576) Goal: 10% above baseline Data Source: EMR Milestone 16 Estimated Incentive Payment**:** $848,707.25	

137949705.2.1	***2.17.1***	A-G	***PREVENTING BEHAVIORAL HEALTH READMISSIONS BY IMPLEMENTING CARE TRANSITION COORDINATION*** (Mental Health Program Innovation and Redesign through use of Psychiatric Care Managers)
The Methodist Hospital			137949705
Related Category 3 Outcome Measure(s):	**IT 1.18**	137949705.3.1	*Follow up after Hospitalization for Mental Illness*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
evidence based framework. Baseline/Goal: 100% developed Data source: Meeting minutes selecting an evidence based framework. Milestone 5 Estimated Incentive Payment $549,639 **Milestone 6** [P-7]: Develop operations manual for care transitions intervention with administrative protocols and clinical guidelines <u>Metric 1</u> [P-7.1]: Develop a written operations manual. Baseline/Goal: 100% complete Data Source: Written operations manual Milestone 6 Estimated Incentive Payment: $549,639 **Milestone 7** [P-10]: Develop plan for hospital care transition process <u>Metric 1</u>: [P-10.1] Care management tool Baseline / Goal: 100% complete Data Source: Written process & protocol			

137949705.2.1	***2.17.1***	A-G	***PREVENTING BEHAVIORAL HEALTH READMISSIONS BY IMPLEMENTING CARE TRANSITION COORDINATION*** (Mental Health Program Innovation and Redesign through use of Psychiatric Care Managers)
The Methodist Hospital			137949705
Related Category 3 Outcome Measure(s):	**IT 1.18**	137949705.3.1	*Follow up after Hospitalization for Mental Illness*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Metric 2: [P-10.2] Transition Process Improvement Plan Baseline / Goal: 100% complete Data Source: Written process & protocol Milestone 7 Estimated Incentive Payment: $549,639			
Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone): $3,847,472	Year 3 Estimated Milestone Bundle Amount: $3,621,150	Year 4 Estimated Milestone Bundle Amount: $3,394,829	Year 5 Estimated Milestone Bundle Amount: $2,580,070
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over DYs 2-5)***:** $13,443,521			

The University of Texas Health Science Center - Houston

Pass 1

Project Option 2.1.3- 2.1 Enhance/Expand Medical Homes: UT Health Regional Specialty Care Centers

Unique RHP Project ID: 111810101.2.1
Performing Provider Name/TPI: UTHealth, UTPhysicians / 111810101

Project Summary:

Provider:
UT Physicians is the clinical practice of The University of Texas Medical School at Houston. With more than 900 physicians certified in 80 medical specialties and subspecialties, 906 residents and fellows, and 283,920 patient visits in 2011, it is the fastest growing academic practice in the nation for the last five years. In addition to our flagship location in the Texas Medical Center, UT Physicians has 4 neighborhood locations throughout the Greater Houston area, and also offers specialty clinics at several Memorial Hermann Hospital locations.

Intervention(s):
The UT medical homes will include services in the areas of dentistry, womens' health, maternal-fetal health, trauma and rehabilitation, sports medicine/orthopedics, behavioral and mental health, cardiovascular diseases, neurosceinces, pediatrics and geriatrics. This Multispecialty Physician Group will provide an extensive network of specialty support centers for primary care providers, built on the concept of an "advanced medical home". Patients will be assigned to a primary care provider within the UT Physicians system of primary and specialty care physicians.

Need for the project:
In our region there is inadequate access to primary care, insufficient access to care coordination practice management and integrated care treatment programs, and lack of access to programs providing health promotion education, training and support. Medical Home models provide accessible, continuous, coordinated and comprehensive patient-centered care that is managed centrally by a primary care physician with the active involvement of non-physician practice staff.

Target Population:
The service areas of our 4 outlying clinics include health professional shortage areas, and medically underserved areas and populations. In FY 2012, UTP provided 321,716 patient visits and expects to add another 80,000 (most, of which are expected to be Medicaid clients) by DY5 for over 400,000 patient visits. Using the Harris County rate (14.5%) of Medicaid clients, there are an estimated 1,423,176 Medicaid clients living within our service areas.

Category 1 or 2 expected patient benefits:
By DY4 the aim will be to improve the number of eligible patients that are assigned to the medical homes, and by DY5 to increase number or percent of enrolled patients' scheduled primary care visits that are at their medical home.

Category 3 outcomes:
IT-6.1 (1): Our goal is to improve by 3% in DY4 and 5% in DY5, the percent improvement over baseline of patient satisfaction scores for getting timely care, appointments, and information (using the supplemental module for the adult CG-CAHPS survey) for patients of UT Physician Clinics, who are not cancer surgery patients and who were assigned to a medical home.

Project Option 2.1.3 – Enhance/Expand Medical Homes: C1-2 UT Health Regional Specialty Care Centers

Unique RHP Project Identification Number: 111810101.2.1
Performing Provider Name/TPI: UTHealth, UTPhysicians/111810101

Project Description: 2.1 Enhance/Expand Medical Homes (Option 2.1.3)

The practice at UT Physicians' Clinics serves areas designated as primary care health professional shortage areas (HPSAs), medically underserved areas (MUAs), and medically underserved populations (MUPs). The Bayshore Clinic service area includes several HPSAs (CT 3207, CT 3208, CT 3218, CT 3219, CT 3220, CT 3333). The Bellaire Clinic service area includes several MUPs (CT 4211, CT 4213, CT 4214, CT 4215, CT 4216). Also, the Cinco Ranch Clinic (CT 6731, CT 6733) and the Sienna Clinic (CT 6746) service areas include MUAs. The practice at UT Physicians' clinics will be transformed to operate on the concept of patient-centered medical homes. The medical homes will include services in the areas of dentistry, womens' health, maternal-fetal health, trauma and rehabilitation, sports medicine/orthopedics, behavioral and mental health, cardiovascular diseases, neurosceinces, pediatrics and geriatrics. UT Health already has and/or will establish state-of-the-art top-ranking Regional Centers in Dental Health, Maternal-Fetal Health, Women, Child and Adolescent Health, Healthy Aging, Neurosciences, Sports Medicine, Trauma and Rehabilitation, Behavioral and Mental Health, Heart and Vascular Disorders and Students' Health. This Multispecialty Physician Group will provide an extensive network of specialty support centers for primary care providers, built on the concept of an "advanced medical home".

Patients will be assigned to a primary care provider within the UT Physicians system of primary and specialty care physicians. Members of staff will be placed into multidisciplinary care teams that manage a panel of patients; each with a defined role and tasks would be divided among care team members to reflect the skills, abilities, and credentials of team members. Patients will be linked to a provider and care team so both patients and provider/care team recognizes each other as partners in care. By means of phone, e-mail, or in-person visits, patients will have continuous access to their medical home. This program will rely on the National Committee for Quality Assurance (NCQA) guidelines (http://www.ncqa.org/Portals/0/Programs/Recognition/RPtraining/PPCPCMH_Training.pdf), which include: 1. improved access and communication, 2. use of data systems to enhance safety and reliability, 3. care management, 4. patient self-management support, 5. electronic prescribing, 6. test tracking, 7. referral tracking, 8. performance reporting and improvement, and 9. advanced electronic communications. (See related project MS1 UT-Health Regional Systems Engineering Center and UT Health Quality Improvement Dashboard Development Center, and projects C5-C9 and CL3 for chronic disease management programs for asthma, COPD, CHF, diabetes, and hypertension.) Finally, through project MS1 (UT Health Regional Systems Engineering Center and UT Health Quality Improvement Dashboard Development Center), the systems engineering and QI teams at UT Health will identify QI targets and methods needed to achieve continuous quality improvement for this project, especially as it relates to identifying challenges for expansion, and building on lessons learned.

Goal and Relationship to Regional Goals:

Project Goal:

To provide a primary care "home base" for patients, who will be assigned a health care team that tailors services to their unique health care needs, effectively coordinates their care across inpatient and outpatient settings, and proactively provides preventive, primary, routine and chronic care.

This project addresses the following regional goal:

Redesigning of the practice at UT Health on the PCMH concept fits right with the regional goal to "transform health care delivery from a disease-focused model of episodic care to a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary or duplicative services, and builds on the accomplishments of our existing health care system."

Challenges:

Need: 1) Inadequate access to primary care. 2) Insufficient access to care coordination and integrated care treatment programs. 3) Lack of access to programs providing health promotion education, training and support, including screenings, nutrition counseling, patient education programs.

Implementation: 1) Staff motivation and ability to work as a care team. 2) Availability of manpower to implement staffing plan.

With the Medical Homes project patients will have access to comprehensive care in a coordinated manner, including preventive and self-management education programs. Providers will be assembled to work in teams to deliver personalized and effective care to enrolled patients.

5-Year Expected Outcome for Provider and Patients:

Our practice will have been transformed based on the concept of the patient centered medical homes, leading to better coordination of patient care, increased acccess, and improved patient satisfaction. In addition to benefiting the current Medicaid (23% as of 2011, or 65,302 patient visits) and low-income client base of UTP clinics, this model of care will be available to another potential 1,423,176 Medicaid and Medicaid-eligible residents living within the service areas of the UT Physician Clinics, to whom our services will be marketed. With the expansion of primary and specialty care access, we expect to provide patient care to an additional 80,000 patient visits by the end of DY5, most of which are expected to be Medicaid/Medicaid-eligible clients (based on the demographics of the UTP clinics service areas). The transition to the team-based, proactive healthcare delivery model of medical homes, all conveniently located where there is great need, will help to address many of the barriers that the low-income population typically encounter in getting the appropriate care, facilitating better health outcomes.

Starting Point/Baseline:

To be determined during DY3.

Rationale:

A Patient Centred Medical Home is designed to provide a single point of coordination for all health care, including primary care, specialty care, hospital, and post-acute care. Medical Home models provide accessible, continuous, coordinated and comprehensive patient-centered care and are managed centrally by a primary care physician with the active involvement of non-physician

practice staff. The model is based on the reasoning that care coordination can reduce fragmentation in patient care in ways that lower costs and lead to better overall patient outcomes. (O'Mallley, A., Peikes, D., & Ginsburg, P. (2008). "Making Medical Homes Work: Moving from Concept to Practice & Qualifying a Physician Practice as a Medical Home." Policy Perspective 1:1-19. Bailit, M. and C. Hughes. "The Patient-Centered Medical Home: A Purchaser Guide." Patient Centered Primary Care Collaborative. 2008. Rosenthal, T. (2008). "The Medical Home: Growing Evidence to Support a New Approach to Primary Care." Journal of the American Board of Family Medicine 21 (5): 427-440.) By providing the right care at the right time and in the right setting, over time, patients may see their health improve, rely less on costly ED visits, incur fewer avoidable hospital stays, and report greater patient satisfaction.

Project Components:

Through the UT Health Regional Specialty Care Centers Program, we propose to meet all required project components listed below.

a) UTP will develop and implement policies and systems to enhance patient access to the medical home. This enhanced access will include open scheduling, expanded hours to include evening and Saturday hours, a new online patient portal, and the ability for patients to communicate with their healthcare team via email.
b) Based on staff capacity, demographics, and diseases, practice supply and demand, UTP will determine the appropriate panel size for primary care provider teams and assign patients to a primary care provider within the medical home.
c) UTP will restructure the current organization of care into multidisciplinary care teams that will manage a panel of patients where providers and staff operate at the top of their license. Roles and tasks of care team members will reflect their skills, abilities, and credentials.
d) UTP will link patients to a provider and care team so both patients and provider/care team recognizes each other as partners in care.
e) Using the enhanced access policies and systems, UTP will assure that patients are able to see their provider or care team whenever possible. By promoting the expanded access available through the medical home model (open scheduling, nurse advise line, the online patient portal, and email contact with the care team) established patients will have 24/7 continuous access to their care teams.
f) UTP's quality improvement office will conduct QI for each of the clinics providing specialty care using methods such as rapid cycle improvement.

Milestones and Metrics:

For the UT Health Regional Specialty Care Centers Program, we have chosen the below milestones and metrics based upon the above project components and relationship to project goals and population needs. All baselines and goals will be determined during DY2.

<u>Process Milestones and Metrics</u>:

Milestone 1 [P-2.]: Put in place policies and systems to enhance patient access to the medical home. Enhanced access to care is available through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician, and practice staff.

Metric 1 [P-2.1.]: UT Physicians policies on medical home

Milestone 2 [P-5.]: Determine the appropriate panel size for primary care provider teams, potentially based on staff capacity, demographics, and diseases.
Metric 1 [P-5.1.]: Determine Panel size
Milestone 3 [P-4.]: Develop staffing plan to expand primary care team roles; Expand and redefine the roles and responsibilities of primary care team members.
Metric 1 [P-4.1.]: Expanded primary care team member roles
Milestone 4 [P-3.]: Reorganize staff into primary care teams responsible for the coordination of patient care.
Metric 1 [P-3.1.]: Primary care team
Milestone 5 [P-9.] : Train medical home personnel on PCMH change concepts.
Metric 1 [P-9.1.]: Number of medical home personnel trained

Improvement Milestones and Metrics:

Milestone 6 [I-12.]: Based on criteria, improve the number of eligible patients that are assigned to the medical homes.
Metric 1 [I-12.1.]: Number or percent of eligible patients assigned to medical homes, where "eligible" is defined by the UT Physicians
Milestone 7 [I-16.]: Increase number or percent of enrolled patients' scheduled primary care visits that are at their medical home
Metric 1 [I-16.1.]: Percent of primary care visits at medical home

Unique community need identification numbers the project addresses:

This project addresses community needs CN.1 (Inadequate access to primary care), CN.7 (Insufficient access to care coordination practice management and integrated care treatment programs), and CN.20 (Lack of access to programs providing health promotion education, training and support, including screenings, nutrition counseling, patient education programs).

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

This project represents a new initiative. UT Physicians practice is not currently organized on the medical home model. Hence, UT Physicians proposes to provide better coordinated care for its patients by transitioning to a patient-centered and team-based model of care.

Related Category 3 Outcome Measure(s):

OD-6 Patient Satisfaction

- IT-6.1 (1) Percent improvement over baseline of patient satisfaction scores (1) are getting timely care, appointments, and information (stand alone measure)

Percent improvement over baseline of patient satisfaction scores (all questions within a survey need to be answered to be a stand-alone measure). Percent improvement over baseline of patient satisfaction scores for one or more of the patient satisfaction domains that the provider targets for improvement in a specific tool. Certain supplemental modules for the adult CG-CAHPS survey may be used to establish if patients: (1) are getting timely care, appointments, and information (already established patients at UTP Clinics, who are not cancer surgery patients and who were assigned to a medical home)

Relationship to other Projects:

1.1 (C3) - The expanded capacity to deliver primary care will be necessary for the redesign of the UT Physician practice as patient-centered medical homes, ensuring that there are enough primary care physicians for patient panels.
1.2 (A2, SPH1) - The innovative residency program and the training of community health workers will ensure availability of human resources to staff the medical homes.
1.3 (C12) - The disease management registry will be a useful resource for efficient medical home assignment and disease management within the medical homes.
1.7 (A1) - Telemedicine increases the capacity of UT Medical Homes to deliver both primary and specialty care services to patients when and where needed.
1.10 (MS1) - With QI support from project MS1, UT Health will be better equipped to deliver optimum care to patients.
2.2 (C5-9,CL3)- A significant number of patients seen regularly in primary care have chronic diseases requiring more effective care for patients enrolled in UT Medical Homes, for which the chronic care model is well suited.
2.9 (A4) - The care navigation project will facilitate the move into a primary care setting for frequent ED users by getting them enrolled in primary care within the UT Medical Homes.
2.11 (C10) - The medication management program will be a useful resource for all care providers in the UT Medical Homes practice.
2.12 (A3, CL1, CL2, MS4) - The various care transitions projects will ensure there is no interruption in the care continuum for patients as they transit from one form of care to the other within the medical homes .

Relationship to Other Performing Providers' Projects in the RHP:

Primary Care/Ambulatory Care clinics are a top priority to Region 3 due to the acuity of the regional patient mix, population concentration, and lack of primary care access points for our patient base. The regional approach of collaboration as well as existing patient referral pattern relationships allowed our team to properly identify the community needs based on the necessity of population, uninsured, and medically underserved patient bases. This program is consistent with our region and similar to numerous initiatives in our RHP plan sharing both concepts as well as outcome measures focused to percent improvement over baseline of patient satisfaction scores, reduction of inappropriate ED utilization, and third next available appointment status. The Region 3 Initiative Grid attached as a RHP Plan addendum reflects a grid of relationship for all initiatives.

Plan for Learning Collaborative:

UTHealth will participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system.

Project Valuation:

The anchor, Harris Health, provided a spreadsheet which contained 6 criteria, which could be used to rate each project on a 10-point scale. The ratings for each criterion were weighted, summed for each project to arrive at a total score (value weight) for each project. The sum of all the project's total scores were then divided by the percent of total DSRIP funds to be secured for

that year to arrive at a dollar value multiplier to be applied towards each project's total score (value weight), thereby allocating a greater proportion of the funds towards those projects valued highest based upon the 6 criteria. UTHealth used this approach, with one exception—we did not use two of the criteria. Following are the criteria, the considerations for awarding points for projects using that criteria, and the reasons two of the criteria were not used:

1. Transformational Impact (Weight = 20%): Points were awarded for projects that meet the community benefit criteria, such as: improving access; improving quality; improving costs (long-term cost-savings); transformative (Innovative), collaborative (partners with other organization(s)). This project's score for this criterion: **6**

2. Population Served/Project Size (Weight = 20%): Points were awarded based on the size of the population affected and whether the target population is uninsured or on Medicaid. This project's score for this criterion: **5**

3. Aligned with Community Needs (Weight = 20%): Points were awarded based on judgments in two categories: whether or not the CNA indicates a need in the area of the project and the severity of the health/healthcare need(s) the project addresses. This project's score for this criterion: 111810101.2.1 X 2 = **4**

4. Cost Avoidance (Weight = 15%): Points were awarded based on judgment of project's cost effectiveness relative to similar projects. This project's score for this criterion: **2**

5. Partnership/Collaboration (Weight = 10%): ***This was not rated***, because UTHealth planned to partner with Harris Health to perform many similar projects, so the rating would have been the same for all projects. This would have diluted the scores, hiding the more significant variations in other value criteria.

6. Sustainability (Weight = 15%): ***This was also not rated***, because UTHealth does not consider any of the projects to be unsustainable, or at the very least do not consider one project less sustainable than another. Giving the projects the same, or very similar ratings on this criteria again would have had a diluting effect, hiding the more significant variations in other value criteria.

Total Valuation Score for this project: **3.3**

111810101.2.1	***OPTION 2.1.3***	***2.1.3 (A-F)***	***C1-2 UT HEALTH REGIONAL SPECIALTY CARE CENTERS***
UTHealth, UTPhysicians			*111810101*
Related Category 3 Outcome Measure(s):	*111810101.3.14*	*IT-6.1 (1)*	*Percent improvement over baseline of patient satisfaction scores (1) are getting timely care, appointments, and information (stand alone 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.]: 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. Metric 1 [P-2.1.]: UT Physicians policies on medical home Baseline/Goal: TBD Data Source: UT Physicians's "Policies and Procedures" documents Milestone 1 Estimated incentive payment: $ 1,053,630 **Milestone 2** [P-5.]: Determine the appropriate panel size for primary care provider teams, potentially based on staff capacity, demographics, and diseases. Metric 1 [P-5.1.]: Determine Panel size Baseline/Goal: TBD Data Source: Panel size determination tool, patient registry, EHR, or needs assessment tool to assess appropriate panel size based on patient needs (as determined by the clinic) for	**Milestone 4** [P-3.]: Reorganize staff into primary care teams responsible for the coordination of patient care. Metric 1 [P-3.1.]: Primary care team Baseline/Goal: TBD Data Source: UT Physicians staffing records and other program documentation Milestone 4 Estimated incentive payment: $ 1,782,457 **Milestone 5** [P-9.] : Train medical home personnel on PCMH change concepts. Metric 1 [P-9.1.]: Number of medical home personnel trained Baseline/Goal: TBD Data Source: Training records and HR documents Milestone 5 Estimated incentive payment: $ 1,782,457	**Milestone 6** [I-12.]: Based on criteria, improve the number of eligible patients that are assigned to the medical homes. Metric 1 [I-12.1.]: Number or percent of eligible patients assigned to medical homes, where "eligible" is defined by the UT Physicians Goal: TBD Data Source: Practice management system, EHR, or other documentation as designated by UT Physicians Milestone 6 Estimated incentive payment: $ 3,707,510	**Milestone 7** [I-16.]: Increase number or percent of enrolled patients' scheduled primary care visits that are at their medical home Metric 1 [I-16.1.]: Percent of primary care visits at medical home Goal: TBD Data Source: Practice management system, EHR, or other documentation as designated by Performing Provider Milestone 7 Estimated incentive payment: $ 3,549,069

111810101.2.1	***Option 2.1.3***	***2.1.3 (A-F)***	***C1-2 UT Health Regional Specialty Care Centers***
UTHealth, UTPhysicians			*111810101*
Related Category 3 Outcome Measure(s):	*111810101.3.14*	*IT-6.1 (1)*	*Percent improvement over baseline of patient satisfaction scores (1) are getting timely care, appointments, and information (stand alone 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)**
proactive panel management Milestone 2 Estimated incentive payment: $ 1,053,630 **Milestone 3** [P-4.]: Develop staffing plan to expand primary care team roles; Expand and redefine the roles and responsibilities of primary care team members. Metric 1 [P-4.1.]: Expanded primary care team member roles Baseline/Goal: TBD Data Source: Revised job descriptions Milestone 3 Estimated incentive payment: $ 1,053,630			
Year 2 Estimated Milestone Bundle Amount: $3,160,890	Year 3 Estimated Milestone Bundle Amount: $3,564,914	Year 4 Estimated Milestone Bundle Amount: $3,707,510	Year 5 Estimated Milestone Bundle Amount: $3,549,069
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*:* $13,982,383			

Project Option 2.2.1- 2.2 Expand Chronic Care Management Models: Redesign the Outpatient Delivery System of Harris Health to Coordinate Care for Patients with Chronic Diseases

Unique RHP Project ID: 111810101.2.2
Performing Provider Name/TPI: UTHealth, UTPhysicians / 111810101

Project Summary:

Provider:
UT Physicians is the clinical practice of The University of Texas Medical School at Houston. With more than 900 physicians certified in 80 medical specialties and subspecialties, 906 residents and fellows, and 283,920 patient visits in 2011, it is the fastest growing academic practice in the nation for the last five years. In addition to our flagship location in the Texas Medical Center, UT Physicians has 4 neighborhood locations throughout the Greater Houston area, and also offers specialty clinics at several Memorial Hermann Hospital locations.

Intervention(s):
The outpatient delivery system of UT Physicians will be redesigned to coordinate care for patients with chronic diseases (asthma, CHF, COPD, diabetes, and hypertension), based on Wagner's chronic care model and using evidence-based standards of care for each of the targeted diseases.

Need for the project:
There are high rates of chronic diseases in our population. Because chronic care requires ongoing interaction between patients and the health system, there often arises challenges in care coordination. The evidence-based Chronic Care Model summarizes the basic elements for improving care of chronic disease patients, and there is need to apply such a model, if care outcomes are to be improved for patients with these conditions.

Target Population:
This project targets people in our service area with diabetes, hypertension, asthma, COPD, or CHF. Patients of lower socioeconmic status (which number approximately 448,583 for the UTP clinics service areas) are known to have worse disease control due to the inability to maintain compliance in the long run, hence this project will be beneficial to the Medicaid population in the UTP clinics service areas.
Category 1 or 2 expected patient benefits:
Our DY4 goal is to increase the number of addtional patients receiving care under the Chronic Care Model for Asthma, COPD, CHF, Diabetes, and Hypertension. The DY5 goal is to improve the percentage of patients with targeted chronic diseases that have self-management goals.
Category 3 outcomes:
IT-9.2: Our goal is to reduce by 3% in DY4 and 5% in DY5, the percentage of Emergency Department visits for asthma, COPD, CHF, Diabetes, and Hypertension.

Project Option 2.2.1 – Expand Chronic Care Management Models: C5-9,CL3 Redesign the Outpatient Delivery System of UT Physicians to Coordinate Care for Patients with Chronic Diseases

Unique RHP Project Identification Number: 111810101.2.2
Performing Provider Name/TPI: UTHealth, UTPhysicians/111810101

Project Description: 2.2 Expand Chronic Care Management Models (Option 2.2.1)

Almost half of all Americans live with a chronic condition, and almost half of all people with chronic illness have multiple conditions. This also the situation in our region, as our community needs assessment shows that there are high rates of chronic diseases in our population, including asthma, CHF, COPD, diabetes, and hypertension. Because chronic care requires ongoing interaction between patients and the health system, there often arises challenges in care coordination. The evidence-based Chronic Care Model (Coleman et al. Evidence On The Chronic Care Model In The New Millennium, Health Affairs 28, no. 1 (2009): 75–85; 10.1377/hlthaff.28.1.75), summarizes the basic elements for improving care of chronic disease patients, and there is need to apply such a model, if care outcomes are to be improved for patients with these conditions.

The outpatient delivery system of UT Physicians will be redesigned to coordinate care for patients with chronic diseases (asthma, CHF, COPD, diabetes, and hypertension), based on Wagner's chronic care model (CCM) and using evidence-based standards of care as follows: The National Asthma Education and Prevention Program Expert Panel Report 3 guidelines, The National Institute for Clinical Excellence (NICE) COPD clinical guidelines, The Heart Failure Model of Care guidelines, The American Diabetes Association (ADA) Standards of Medical Care in Diabetes, and the JNCVII guidelines for hypertension. Wagner's CCM identifies the essential elements of a health care system that encourage high-quality chronic disease care; these are self-management support, delivery system design, decision support, clinical information systems, and the community. Evidence-based change concepts under each element, in combination, foster productive interactions between informed patients who take an active part in their care and providers with resources and expertise. Reforms to be implemented using this model include: designing and implementing care teams (including non-physician health professionals) that are tailored to the patient's health care needs, scheduling of next appointment before patient leaves office, use of appointment reminders, follow up of patients who missed appointments, regular review of all medications from all sources, ensuring patients can access their care teams by phone or email as well as access their medical information through an electronic patient portal, and referral of selected patients for more intensive counseling. Also, regular disease self-management education and support sessions will be provided free of charge to patients of Harris Health, and this will be tailored to the literacy levels and cultures of the patients.

Finally, through project MS1 (UT Health Regional Systems Engineering Center and UT Health Quality Improvement Dashboard Development Center), the systems engineering and QI teams at UT Health will identify QI targets and methods needed to achieve continuous quality improvement for this project, especially as it relates to identifying challenges for expansion, and building on lessons learned.

Goal and Relationship to Regional Goals:

Project Goal:

To develop and implement chronic disease management interventions that are geared toward improving effective management of chronic conditions and ultimately improving patient clinical indicators, health outcomes and quality, and reducing unnecessary acute and emergency care utilization.

This project addresses the following regional goal:

The implementation of the chronic care management model will ensure better outcomes for patients with chronic diseases, which is in line with the regional goal to "transform health care delivery from a disease-focused model of episodic care to a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary or duplicative services, and builds on the accomplishments of our existing health care system."

Challenges:

Need: 1) High rates of chronic disease and inadequate access to treatment programs and services for illnesses associated with chronic disease. 2) Lack of access to programs providing health promotion education, training and support, including screenings, nutrition counseling, patient education programs

Implementation: 1) Willigness of physicians to transit to a 'team-based' model of care that gives greater roles to other providers. 2) Low health literacy levels and low economic resources can influence patients' ability to be effective partners in their own care.

With training on the chronic care model and its application to chronic care, physicians and other providers will be better motivated to work as a team to deliver proactive care that keeps chronic disease patients stable and without a need for urgent care. The care team will also be made up of support personnel that will provide education and other support services that will help to assist patients in overcoming barriers to their participation in self-care.

5-Year Expected Outcome for Provider and Patients:

Successful implementation of the chronic care model will lead to better monitoring by the patient's care team and increased patient engagemment in self-care, thereby reducing the need for acute episodic care. In addition to benefiting the current Medicaid (23% as of 2011, or 65,302 patient visits) and low-income client base of UTP clinics, this model of chronic care management will be available to another estimated 80,000 patient visits (due to UTPs primary and specialty care expansion projects), most of which are expected to be Medicaid clients (based on the demographics of UTP clinics service areas and the additional 1,423,176 Medicaid and Medicaid-eligible residents living within these specific areas). This project will benefit all Medicaid and low-income clients in addressing many of the barriers encountered in being compliant with chronic disease management plans, facilitating better health outcomes. Improved patient compliance is expected to produce a decrease in ED usage for the chronic diseases targeted.

Starting Point/Baseline:

To be determined during DY3.

Rationale:

Asthma is increasing every year in the US; the proportion of people with asthma in the United States grew by nearly 15% in the last decade. There are significant disparities in asthma prevalence in the US. Adults with an annual household income of $75,000 or less are more likely to have asthma than adults with higher incomes. (Asthma's Impact on the Nation: Data from the CDC National Asthma Control Program. Available at: http://www.cdc.gov/asthma/ impacts_nation/AsthmaFactSheet.pdf. Accessed 10/15/12). People with asthma can often prevent asthma attacks if they are taught to use inhaled corticosteroids and other long-term control medicines correctly and to avoid asthma triggers. In 2008 less than half of people with asthma reported being taught how to avoid triggers. (CDC 2011: Asthma in the US. Available at: http://www.cdc.gov/vitalsigns/Asthma/#. Accessed 10/15/12).

Chronic lower respiratory diseases, primarily COPD, are the third leading cause of death in the United States, and 5.1% of U.S. adults report a diagnosis of emphysema or chronic bronchitis (Morbidity and Mortality Weekly Report (MMWR) March 2, 2012 / 61(08);143-146. Available at: http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6108a3.htm?s_cid=mm6108a3_w. Accessed 10/15/12). Excess health-care expenditures are estimated at nearly $6,000 annually for every COPD patient in the United States (Deaths from Chronic Obstructive Pulmonary Disease - United States, 2000--2005. November 14, 2008 / 57(45);1229-1232. Available at: http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5745a4.htm. Accsessed 10/15/12). Uncontrolled COPD leads to deterioration in lung function and eventually death.

Around 5.8 million people in the United States have heart failure and about 670,000 people are diagnosed with it each year. About one in five people who have heart failure die within one year from diagnosis but early diagnosis and treatment can improve quality of life and life expectancy for people who have heart failure. Heart failure results in significant costs to the system; it cost the US nearly $40 billion in 2010 (CDC 2010: healrt failure facts. Available at: http://www.cdc.gov/dhdsp/data_statistics/fact_sheets/docs/fs_heart_failure.pdf. Accessed on 10/15/12).

Uncontrolled diabetes can result in complications with dire consequences for the patient. For example, the risk of stroke is 2 - 4 times higher among people with diabetes; diabetes is the leading cause of new onset blindness among adults aged 20 - 74 years in the US; nearly half of all cases of kindey failure can be attributed to diabetes; and more than half of all caes of nontraumatic lower limb amputations are because of poorly controlled diabetes. Diabetes also predisposes patients to dental diseases, pregnancy complications, among other problems. Studies in the United States have shown that improved glycemic control benefits people with either type 1 or type 2 diabetes. In general, every percentage point drop in HbA1c blood test results (e.g., from 8.0% to 7.0%) can reduce the risk of microvascular complications (eye, kidney, and nerve diseases) by 40%.

In 2009-2010, the age-adjusted percentage of US adults with hypertension whose blood pressure was contolled was 53.3%. Hypertension is a leading cause of stroke, coronary artery disease, heart attack, and heart and kidney failure in the United States, all of which contribute to the rising costs of health care. Aggressive treatment of hypertension significantly decreases the risk of coronary artery disease, congestive heart failure, stroke, and resulting disability. Low-income individuals without prescription drug coverage are significantly more likely to skip doses to save money or make their hypertension medication prescriptions last longer. (Rein DB, Constantine RT, Orenstein D, Chen H, Jones P, Brownstein JN, et al. A cost evaluation of the Georgia Stroke and Heart Attack Prevention Program. Prev Chronic Dis [serial online] 2006 Jan

[date cited]. Available from: URL: http://www.cdc.gov/pcd/issues/2006/jan/05_0143.htm. Accessed on 10/15/12).

Project Components:

Through the Redesign the Outpatient Delivery System of Harris Health to Coordinate Care for Patients with Chronic Diseases Program, we propose to meet all required project components listed below.

a) UTP will design and implement care teams that are tailored to the health care needs of patients with asthma, COPD, CHF, diabetes, and hypertension.
b) UTP care teams will include non-physician health professionals, such as pharmacists, case managers, nutritionists, health educators, and health coaches.
c) In addition to accessing their care team by appointment, patients will have 24/7 continuous access to their care teams wherever possible via expanded access points such as open scheduling, the nurse advise line, the online patient portal, and email.
d) Patient engagement will be further increased through patient education, group visits, self-management support, and coordination with community resources. UTP will empower patients to make lifestyle changes to stay healthy and manage their chronic conditions.
e) UTP's quality improvement office will conduct QI for each of the clinics providing specialty care using methods such as rapid cycle improvement.
f) UTP will monitor project impacts and identify opportunities to expand the project to broader patient populations, including safety-net populations.

Milestone and Metrics:

For the Redesign the Outpatient Delivery System of Harris Health to Coordinate Care for Patients with Chronic Diseases Program, we have chosen the below milestones and metrics based upon the above project components and relationship to project goals and population needs. All baselines and goals will be determined during DY2.

Process Milestones and Metrics:

Milestone 1 [P-3.]: Develop a comprehensive care management program for asthma, COPD, CHF, Diabetes, and Hypertension.

Metric 1 [P-3.1.]: Documentation of Care management program. The Wagner Chronic Care Model will be utilized in program development.

Milestone 2 [P-2.]: Train staff in the Chronic Care Model, including the essential components of a delivery system that supports high-quality clinical and chronic disease care for Asthma, COPD, CHF, Diabetes, and Hypertension.

Metric 1 [P-2.1.]: Increase percent of staff trained

Milestone 3 [P-4.]: Formalize multi-disciplinary teams, pursuant to the chronic care model defined by the Wagner Chronic Care Model.

Metric 1 [P-4.1.]: Increase the number of multi-disciplinary teams (e.g., teams may include physicians, mid-level practitioners, dieticians, licensed clinical social workers, psychiatrists, and other providers) or number of clinic sites with formalized teams.

Improvement Milestones and Metrics:

Milestone 4 [I-17.]: Apply the Chronic Care Model to targeted chronic diseases, which are prevalent locally.

Metric 1 [I-17.1.]: X additional patients receive care under the Chronic Care Model for Asthma, COPD, CHF, Diabetes, and Hypertension.

Milestone 5 [I-18.]: Improve the percentage of patients with targeted chronic diseases that have self-management goals.
Metric 1 [I-18.1.]: Patients with targeted chronic diseases with self-management goals.

Unique community need identification numbers the project addresses:
This project addresses community needs CN.11 (High rates of chronic disease and inadequate access to treatment programs and services for illnesses associated with chronic disease) and CN.20 (Lack of access to programs providing health promotion education, training and support, including screenings, nutrition counseling, patient education programs).

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
This project represents a new initiative. UT Physicians proposes to provide chronic care management to its patients with chronic diseases, based upon Wagner's Chronic Care Model, which is a comprehensive, pro-active, patient-centered model of care.

Related Category 3 Outcome Measure(s):
OD-9 Right Care, Right Setting

- IT-9.2 ED appropriate utilization (Stand-alone measure)

Reduce Emergency Department visits for Asthma, COPD, CHF, Diabetes, Hypertension

Relationship to other Projects:

1.1 (C3) - Expanded capacity in primary care will ensure the availability of staff to implement the expansion of the chronic care management model for patients with asthma.
1.2 (A2, SPH1) - Part of the innovative training of primary care providers will be centered on the chronic care model with emphasis on team-based practice.
1.3 (C12) - The disease management registry (Information Technology support) is a very important component of Wagner's Chronic Care Model.
1.7 (A1) - Telemedicine will help to ensure that chronic care patients will get specialist input into their care when and where needed.
1.9 (C4) - Also, the expansion of specialty care in the primary care setting will help to ensure that chronic care patients will get specialist input into their care when and where needed.
1.10 (MS1) - The QI project will aid in the adoption of a 'whole systems' approach to chronic management, enabling the implementation of a comprehensive and proactive approach to chronic care in which the patient is kept in continuos contact with the care team.
2.1 (C1) - The expansion of chronic care management models will ensure more effective care for patients enrolled in UT Medical Homes.

Relationship to Other Performing Providers' Projects in the RHP:

Healthcare costs are significantly increased within a patient base with such aggressive chronic conditions that have gone untreated. The initiatives focused to chronic disease management focus to conditions such as asthma, hypertension, and diabetes and are similar in the approach of managing & proactively treating chronic conditions in order to reduce 30-day readmission rates, inappropriate emergency department utilization, and healthcare costs. The

Region 3 Initiative grid allows a cross reference of initiatives associated with chronic disease management. (addendum)

Plan for Learning Collaborative:

UTHealth will participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system.

Project Valuation:

The anchor, Harris Health, provided a spreadsheet which contained 6 criteria, which could be used to rate each project on a 10-point scale. The ratings for each criteria were weighted, summed for each project to arrive at a total score (value weight) for each project. The sum of all the project's total scores were then divided by the percent of total DSRIP funds to be secured for that year to arrive at a dollar value multiplier to be applied towards each project's total score (value weight), thereby allocating a greater proportion of the funds towards those projects valued highest based upon the 6 criteria. UTHealth used this approach, with one exception—we did not use two of the criteria. Following are the criteria, the considerations for awarding points for projects using that criteria, and the reasons two of the criteria were not used:

1. Transformational Impact (Weight = 20%): Points were awarded for projects that meet the community benefit criteria, such as: improving access; improving quality; improving costs (long-term cost-savings); transformative (Innovative), collaborative (partners with other organization(s)). This project's score for this criterion: **4**

2. Population Served/Project Size (Weight = 20%): Points were awarded based on the size of the population affected and whether the target population is uninsured or on Medicaid. This project's score for this criterion: **4**

3. Aligned with Community Needs (Weight = 20%): Points were awarded based on judgments in two categories: whether or not the CNA indicates a need in the area of the project and the severity of the health/healthcare need(s) the project addresses. This project's score for this criterion: 111810101.2.2 X 2 = **4**

4. Cost Avoidance (Weight = 15%): Points were awarded based on judgment of project's cost effectiveness relative to similar projects. This project's score for this criterion: **2**

5. Partnership/Collaboration (Weight = 10%): ***This was not rated***, because UTHealth planned to partner with Harris Health to perform many similar projects, so the rating would have been the same for all projects. This would have diluted the scores, hiding the more significant variations in other value criteria.

6. Sustainability (Weight = 15%): ***This was also not rated***, because UTHealth does not consider any of the projects to be unsustainable, or at the very least do not consider one project less sustainable than another. Giving the projects the same, or very similar ratings on this criteria again would have had a diluting effect, hiding the more significant variations in other value criteria.

Total Valuation Score for this project: **2.7**

111810101.2.2	*Option 2.2.1*	*2.2.1 (A-E)*	*C5-9,CL3 Redesign the Outpatient Delivery System of Harris Health to Coordinate Care for Patients with Chronic Diseases*
UTHealth, UTPhysicians			*111810101*
Related Category 3 Outcome Measure(s):	*111810101.3.15*	*IT-9.2*	*ED appropriate utilization (Stand-alone measure)*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-3.]: Develop a comprehensive care management program for asthma, COPD, CHF, Diabetes, and Hypertension. Metric 1 [P-3.1.]: Documentation of Care management program. The Wagner Chronic Care Model will be utilized in program development. Baseline/Goal: TBD Data Source: Program materials Milestone 1 Estimated incentive payment: $ 2,586,183	**Milestone 2** [P-2.]: Train staff in the Chronic Care Model, including the essential components of a delivery system that supports high-quality clinical and chronic disease care for Asthma, COPD, CHF, Diabetes, and Hypertension. Metric 1 [P-2.1.]: Increase percent of staff trained. Baseline/Goal: TBD Data Source: HR, training program materials Milestone 2 Estimated incentive payment: $ 1,458,374 **Milestone 3** [P-4.]: Formalize multi-disciplinary teams, pursuant to the chronic care model defined by the Wagner Chronic Care Model. Metric 1 [P-4.1.]: Increase the number of multi-disciplinary teams (e.g., teams may include physicians, mid-level practitioners, dieticians, licensed clinical social workers, psychiatrists, and other providers) or number of clinic sites with formalized teams. Baseline/Goal: TBD Data Source: TBD by UT Physicians	**Milestone 4** [I-17.]: Apply the Chronic Care Model to targeted chronic diseases, which are prevalent locally. Metric 1 [I-17.1.]: X additional patients receive care under the Chronic Care Model for Asthma, COPD, CHF, Diabetes, and Hypertension. Goal: TBD Data Source: Registry Milestone 4 Estimated incentive payment: $ 3,033,417	**Milestone 5** [I-18.]: Improve the percentage of patients with targeted chronic diseases that have self-management goals. Metric 1 [I-18.1.]: Patients with targeted chronic diseases with self-management goals. Goal: TBD Data Source: Registry Milestone 5 Estimated incentive payment: $ 2,903,784

<table>
<tr><td>111810101.2.2</td><td colspan="2">Option 2.2.1</td><td>2.2.1 (A-E)</td><td colspan="2">C5-9,CL3 Redesign the Outpatient Delivery System of Harris Health to Coordinate Care for Patients with Chronic Diseases</td></tr>
<tr><td colspan="5">UTHealth, UTPhysicians</td><td>111810101</td></tr>
<tr><td>Related Category 3 Outcome Measure(s):</td><td colspan="2">111810101.3.15</td><td>IT-9.2</td><td colspan="2">ED appropriate utilization (Stand-alone measure)</td></tr>
<tr><th colspan="2">Year 2
(10/1/2012 – 9/30/2013)</th><th colspan="2">Year 3
(10/1/2013 – 9/30/2014)</th><th>Year 4
(10/1/2014 – 9/30/2015)</th><th>Year 5
(10/1/2015 – 9/30/2016)</th></tr>
<tr><td colspan="2"></td><td colspan="2">Milestone 3 Estimated incentive payment: $ 1,458,374</td><td></td><td></td></tr>
<tr><td colspan="2">Year 2 Estimated Milestone Bundle Amount: $2,586,183</td><td colspan="2">Year 3 Estimated Milestone Bundle Amount: $2,916,748</td><td>Year 4 Estimated Milestone Bundle Amount: $3,033,417</td><td>Year 5 Estimated Milestone Bundle Amount: $2,903,784</td></tr>
<tr><td colspan="6">TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $11,440,132</td></tr>
</table>

Project Option 2.9.1- 2.9 Establish/Expand a patient Care Navigation Program: UTHealth Regional Patient Navigation

Unique RHP Project ID: 111810101.2.3
Performing Provider Name/TPI: UTHealth, UTPhysicians / 111810101

Project Summary:

Provider:
UT Physicians is the clinical practice of The University of Texas Medical School at Houston. With more than 900 physicians certified in 80 medical specialties and subspecialties, 906 residents and fellows, and 283,920 patient visits in 2011, it is the fastest growing academic practice in the nation for the last five years. In addition to our flagship location in the Texas Medical Center, UT Physicians has 4 neighborhood locations throughout the Greater Houston area, and also offers specialty clinics at several Memorial Hermann Hospital locations.

Intervention(s):
This project target patients at high risk of disconnect from institutionalized health care; specifically, patients that entered Memorial Hermann Hospital-TMC through the emergency department (ED). Care navigators will support these patients to navigate through the continuum of health care services, ensuring that patients receive coordinated, timely, and site-appropriate health care services.

Need for the project:
Our region has high rates of inappropriate use of the ED and there is a lack of patient navigation, patient and family education and information programs. Frequent ED users do so for various reasons that often include inability to afford care, lack of knowledge on how to navigate the health care system, poor access to good quality primary care, and so on. Care navigators can help patients and their families navigate the fragmented maze of doctors' offices, clinics, hospitals, out-patient centers, payment systems, support organizations and other components of the healthcare system.

Target Population:
Patients that enter Memorial Hermann Hospital-TMC through the ED.

Category 1 or 2 expected patient benefits:
Our DY4 goal is to increase the percent of patients without a primary care provider (PCP) who received education about a PCP while in the ED, and by DY5 to increase the percent of patients without a PCP who are given a scheduled primary care provider appointment.

Category 3 outcomes:
IT-3.9: Our goal is to reduce by 3% in DY4 and 5% in DY5, the percentage of readmissions (for patients 18 years and older), for any cause, within 30 days of discharge from the index COPD admission.

Project Option 2.9.1 – Establish/Expand a Patient Care Navigation Program: A4 UTHealth Regional Patient Navigation

Unique RHP Project Identification Number: 111810101.2.3
Performing Provider Name/TPI: UTHealth, UTPhysicians/111810101

Project Description: 2.9 Establish/Expand a Patient Care Navigation Program: (Option 2.9.1)

A patient care navigation program will be designed and implemented within the UT Health system of medical homes. The program will target patients at high risk of disconnect from institutionalized health care. Specifically, patients that entered Memorial Hermann Hospital-TMC through the ED, and then referred from the UT Health Hospitalist Service, will be sought after by the care navigators. Care navigators - community health workers (CHWs) - recruited and trained to deliver culturally competent care will assist the patients in linking up with a primary care provider within the UT Health medical homes. The patient navigators will help and support these patients to navigate through the continuum of health care services, ensuring that patients receive coordinated, timely, and site-appropriate health care services, by assisting in connecting patients to primary care physicians and/or medical home sites, as well as diverting nonurgent care from the Emergency Department to site-appropriate locations. By linkage with primary care, these patients will also be given access to chronic-disease self-management programs as deemed appropriate. Finally, through project MS1 (UT Health Regional Systems Engineering Center and UT Health Quality Improvement Dashboard Development Center), the systems engineering and QI teams at UT Health will identify QI targets and methods needed to achieve continuous quality improvement for this project, especially as it relates to identifying challenges for expansion, and building on lessons learned.

Goal and Relationship to Regional Goals:

Project Goal:

Help and support patients especially in need of coordinated care navigate throught the continuum of health care services so that patients can receive coordinated, timely services when needed with smooth transitions between health care settings.

This project addresses the following regional goal:

The care navigation project will make it easier for patients to access the right care in the right place, thereby attaining the regional goal to "transform health care delivery from a disease-focused model of episodic care to a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary or duplicative services..."

Challenges:

Need: 1) High rates of inappropriate emergency department utilization. 2) Lack of patient navigation, patient and family education and information programs.

Implementation: 1) Access to Memorial Hermann Hospital ED data. 2) Recruitment and retention of care navigators.

UT Physicians have had good working relationship with the Memorial Hermann Hospital System and this project will enable further collaboration to tackle one of the greatest challenges of the US health care system - inappropriate emergency department use.

5-Year Expected Outcome for Provider and Patients:

We expect to achieve increased uptake of primary care services by people who tend to rely on the ED for their health care needs. In addition to benefiting the current Medicaid (23% as of 2011, or 65,302 patient visits) and low-income client base of UTP clinics, this project will specifically target patients at high risk of disconnect from institutionalized health care that enter the healthcare system via the Memorial Hermann Hospital ED. These patients are typically idigent individuals (Medicaid, or Medicaid-eligible) who need additional assistance in maintaining their health via ambulatory care settings. While we expect to see improved outcomes for these patients in a number of conditions, we will be measuring 30 day readmission rates for discharges with an index COPD admission.

Starting Point/Baseline:

To be determined during DY3.

Rationale:

Our region has high rates of inappropriate use of the ED. Frequent ED users do so for various reasons that often include inability to afford care, lack of knowledge on how to navigate the health care system, poor access to good quality promary care, and so on. Care navigators can help patients and their families navigate the fragmented maze of doctors' offices, clinics, hospitals, out-patient centers, payment systems, support organizations and other components of the healthcare system. There are different kinds of services that could be offered by navigators and this may include: setting up contacts with primary care, facilitating communication among patients, family members, survivors and healthcare providers, coordinating care among providers, arranging financial support and assisting with paperwork, and facilitating follow-up appointments.

Community health workers have close ties to the local community and serve as important links between underserved communities and the healthcare system, hence they will amke excellent care navigators. They also possess the linguistic and cultural skills needed to connect with patients from underserved communities.

Project Components:

Through the UTHealth Regional Patient Navigation Program, we propose to meet all required project components listed below.

a) UTP will work with Memorial Hermann Hospital (MHH) and the UT School of Public Health to conduct a needs assessment to identify the patient population(s) to be targeted with the Patient Navigator program (frequent ED users, including those at risk of disconnect from institutionalized ambulatory care). Those patient population(s) identified will be targeted for our preventable ED reduction program using trained health care navigators.
b) UTP will work with MHH to establish a health care navigation program to provide support to patient populations who are most at risk of receiving disconnected and fragmented care.

c) UTP and MHH will collaborate to provide appropriate training for navigators, which will include case managers/workers, community health workers, and other types of health professionals.
d) Navigators will be deployed to connect patients to primary and preventive care in the UT Physicians medical homes, or the Memorial Hermann Medical Group's pediatric practices (staffed and managed by UT Physicians) to increase access to care management, including education in chronic disease self-management.
e) UTP's quality improvement office will conduct QI for each of the clinics providing specialty care using methods such as rapid cycle improvement.

Milestones and Metrics:

For the UTHealth Regional Patient Navigation Program, we have chosen the below milestones and metrics based upon the above project components and relationship to project goals and population needs. All baselines and goals will be determined during DY2.

<u>Process Milestones and Metrics</u>:

Milestone 1 [P-1.]: Conduct a needs assessment to identify the patient population(s) to be targeted with the Patient Navigator program.

Metric 1 [P-1.1.]: Provide report identifying the following:

- Targeted patient population characteristics (e.g., patients with no PCP or medical home, frequent ED utilization, homelessness, insurance status, low health literacy).
- Gaps in services and service needs.
- How program will identify, triage and manage target population (i.e. Policies and procedures, referral and navigation protocols/algorithms, service maps or flowcharts).
- Ideal number of patients targeted for enrollment in the patient navigation program
- Number of Patient Navigators needed to be hired
- Available site, state, county and clinical data including flow patients, cases in a given year by race and ethnicity, number of cases lost to follow-up that required medical treatment, percentage of monolingual patients

Milestone 2 [P-2.]: Establish a health care navigation program to provide support to patient populations who are most at risk of receiving disconnected and fragmented care including program to train the navigators, develop procedures and establish continuing navigator education.

Metric 1 [P-2.1.]: Number of people trained as patient navigators, number of navigation procedures, or number of continuing education sessions for patient navigators.

<u>Improvement Milestones and Metrics</u>:

Milestone 3 [I-6.]: Increase number of PCP referrals for patients without a medical home who use the ED, urgent care, and/or hospital services.

Metric 1 [I-6.2.]: Percent of patients without a primary care provider (PCP) who received education about a primary care provider in the ED

Milestone 4 [I-6.]: Increase number of PCP referrals for patients without a medical home who use the ED, urgent care, and/or hospital services.

Metric 1 [I-6.4.]: Percent of patients without a primary care provider who are given a scheduled primary care provider appointment

Unique community need identification numbers the project addresses:

This project addresses community needs CN.8 (High rates of inappropriate emergency department utilization) and CN.23 (Lack of patient navigation, patient and family education and information programs).

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

This project represents a new initiative. This program does not currently exist in the UT Physicians and Memorial Hermann Hospital-TMC system. This project proposes to target patients at high risk of disconnect from institutionalized health care with an intervention for getting them into primary care settings, where they can receive regularized care and avoid the need for episodic acute care.

Related Category 3 Outcome Measure(s):

OD-3 Potentially Preventable Re-Admissions- 30 day Readmission Rates (PPRs)

- IT-3.9 Chronic Obstructive Pulmonary Disease 30 day readmission rate (Standalone measure)

Numerator: The number of readmissions (for patients 18 years and older), for any cause, within 30 days of discharge from the index COPD admission. If an index admission has more than 1 readmission, only first is counted as a readmission.

Denominator: The number of admissions (for patients 18 years and older), for patients discharged from the hospital with a principal diagnosis of COPD and with a complete claims history for the 12 months prior to admission.

Relationship to other Projects:

1.1 (C3) - Expanded primary care services will ensure there is reserve capacity to handle the increased demand anticipated by the succesful diversion of nonurgent care from the Emergency Department to primary care settings.

1.2 (A2, SPH1) - The SPH1 project will ensure their is sufficient supply of CHWs to serve as care navigators and the training received by residents (A2) will help the physicians understand how to integrate CHWs as members of the health care team.

1.3 (C12) - The disease management registry will enable the identification of patients who default from care so that they can be actively sought and brought into compliance, which will help to reduce frequent ED use.

1.6 (C11)- Navigators will be a resource available to the nurse triage line to help ensure patients get the right care at the right time and and in the right setting.

1.9 (C4) - The expansion of specialty care in the primary care setting will help patient navigators ensure that patients get appropriate specialist input into their care when and where needed.

2.1 (C1-2) - Care navigators will assist frequent ED users in getting enrolled with a primary care team at UT Medical Homes, which will aid in reducing inappropriate ED use.

2.2 (C5-9,CL3) - Getting frequent ED users enrolled in a UT Medical Home, where they can receive guidance and regular evidence-based care for chronic diseases will reduce the need for acute care services being received in the ED.

Relationship to Other Performing Providers' Projects in the RHP:

The ability to properly identify and monitor specific patients with chronic conditions or frequent emergency department utilization trends will allow the region to accurately mange the very large patient base. Patient navigation includes a comprehensive list of tasks as well as unique provider types based on the focus of the initiative and will help the focus of cost containment, emergency department utilization, and chronic disease management. The Region 3 Initiative Grid in the addendum allows for a cross reference of all initiatives proposed within this concept.

Plan for Learning Collaborative:

UTHealth will participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system.

Project Valuation:

The anchor, Harris Health, provided a spreadsheet which contained 6 criteria, which could be used to rate each project on a 10-point scale. The ratings for each criterion were weighted, summed for each project to arrive at a total score (value weight) for each project. The sum of all the project's total scores were then divided by the percent of total DSRIP funds to be secured for that year to arrive at a dollar value multiplier to be applied towards each project's total score (value weight), thereby allocating a greater proportion of the funds towards those projects valued highest based upon the 6 criteria. UTHealth used this approach, with one exception—we did not use two of the criteria. Following are the criteria, the considerations for awarding points for projects using that criteria, and the reasons two of the criteria were not used:

1. Transformational Impact (Weight = 20%): Points were awarded for projects that meet the community benefit criteria, such as: improving access; improving quality; improving costs (long-term cost-savings); transformative (Innovative), collaborative (partners with other organization(s)). This project's score for this criterion: **6**

2. Population Served/Project Size (Weight = 20%): Points were awarded based on the size of the population affected and whether the target population is uninsured or on Medicaid. This project's score for this criterion: **3**

3. Aligned with Community Needs (Weight = 20%): Points were awarded based on judgments in two categories: whether or not the CNA indicates a need in the area of the project and the severity of the health/healthcare need(s) the project addresses. This project's score for this criterion: 111810101.2.3 X 2 = **3**

4. Cost Avoidance (Weight = 15%): Points were awarded based on judgment of project's cost effectiveness relative to similar projects. This project's score for this criterion: **4**

5. Partnership/Collaboration (Weight = 10%): ***This was not rated***, because UTHealth planned to partner with Harris Health to perform many similar projects, so the rating would have been the same for all projects. This would have diluted the scores, hiding the more significant variations in other value criteria.

6. Sustainability (Weight = 15%): ***This was also not rated***, because UTHealth does not consider any of the projects to be unsustainable, or at the very least do not consider one project less sustainable than another. Giving the projects the same, or very similar ratings on this criteria again would have had a diluting effect, hiding the more significant variations in other value criteria.

Total Valuation Score for this project: **3**

111810101.2.3	***OPTION 2.9.1***	***2.9.1 (A-E)***	***A4 UTHEALTH REGIONAL PATIENT NAVIGATION***
UTHealth, UTPhysicians			*111810101*
Related Category 3 Outcome Measure(s):	*111810101.3.16*	*IT-3.9*	*Chronic Obstructive Pulmonary Disease 30 day readmission rate (Standalone measure)*
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-1.]: Conduct a needs assessment to identify the patient population(s) to be targeted with the Patient Navigator program. Metric 1 [P-1.1.]: Provide report identifying the following: Targeted patient population characteristic, Gaps in services and service needs, how program will identify, triage & manage target pop'n, ideal number targeted for enrollment, number of navigators needed, available site, state, county, and clinical data. Baseline/Goal: TBD Data Source: Program documentation, EHR, claims, needs assessment survey Milestone 1 Estimated incentive payment: $ 2,873,536	**Milestone 2** [P-2.]: Establish a health care navigation program to provide support to patient populations who are most at risk of receiving disconnected and fragmented care including program to train the navigators, develop procedures and establish continuing navigator education. Metric 1 [P-2.1.]: Number of people trained as patient navigators, number of navigation procedures, or number of continuing education sessions for patient navigators. Baseline/Goal: TBD Data Source: Program records, training records, policies and procedures Milestone 2 Estimated incentive payment: $ 3,240,831	**Milestone 3** [I-6.]: Increase number of PCP referrals for patients without a medical home who use the ED, urgent care, and/or hospital services. Metric 1 [I-6.2.]: Percent of patients without a primary care provider (PCP) who received education about a primary care provider in the ED Goal: TBD Data Source: UT Physicians administrative data on patient encounters and scheduling records from patient navigator program. Milestone 3 Estimated incentive payment: $ 3,370,464	**Milestone 4** [I-6.]: Increase number of PCP referrals for patients without a medical home who use the ED, urgent care, and/or hospital services. Metric 1 [I-6.4.]: Percent of patients without a primary care provider who are given a scheduled primary care provider appointment Goal: TBD Data Source: UT Physicians administrative data on patient Milestone 4 Estimated incentive payment: $ 3,226,427
Year 2 Estimated Milestone Bundle Amount: $2,873,536	Year 3 Estimated Milestone Bundle Amount: $3,240,831	Year 4 Estimated Milestone Bundle Amount: $3,370,464	Year 5 Estimated Milestone Bundle Amount: $3,226,427
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*:* $12,711,258			

Project Option 2.10.1- 2.10 Use of Palliative Care Programs: Integrating Palliative Care into Critical Care

Unique RHP Project ID: 111810101.2.4
Performing Provider Name/TPI: UTHealth, UTPhysicians / 111810101

Project Summary:

Provider:
UT Physicians is the clinical practice of The University of Texas Medical School at Houston. With more than 900 physicians certified in 80 medical specialties and subspecialties, 906 residents and fellows, and 283,920 patient visits in 2011, it is the fastest growing academic practice in the nation for the last five years. In addition to our flagship location in the Texas Medical Center, UT Physicians has 4 neighborhood locations throughout the Greater Houston area, and also offers specialty clinics at several Memorial Hermann Hospital locations.

Intervention(s):
Patients admitted to any adult ICU at Memorial Herman Hospital-TMC who are at high risk of death in or soon after hospitalization will receive a palliative care consultation to supplement their clinical therapy and assist in determination of goals of care which may include transitioning the patients from acute hospital care into home care, hospice or a skilled nursing facility.

Need for the project:
While end-of-life care was once associated almost exclusively with terminal cancer, today there is need for end-of-life care for a number of other conditions, such as congestive heart failure. In addition to providing improved care and comfort for dying patients and their families, palliative care programs have been shown to provide considerable cost savings.

Target Population:
Patients admitted to any adult ICU at Memorial Herman Hospital-TMC who are at high risk of death in or soon after hospitalization.

Category 1 or 2 expected patient benefits:
Our goal for DY4 is to increase the percentage of hospice or palliative care patients who were screened for pain during the hospice admission evaluation/palliative care initial encounter. For DY5 the goals will be to and to implement a patient/family experience survey regarding the quality of care, pain and symptom management, and degree of patient/family centeredness in care, and to increase the number of palliative care patients transitioned from acute hospital care into hospice, home care, or a skilled nursing facility.

Category 3 outcomes:
IT-13.1: Our goal is to increase by 3% in DY4 and 5% in DY5, the percentage of patients enrolled in hospice OR receiving palliative care who received a comprehensive clinical assessment to determine the severity, etiology and impact of their pain within 24 hours of screening positive for pain on the admission evaluation/initial encounter.

Project Option 2.10.1 – Use of Palliative Care Programs: MS3 Integrating Palliative Care into Critical Care

Unique RHP Project Identification Number: 111810101.2.4
Performing Provider Name/TPI: UTHealth, UTPhysicians/111810101

Project Description: 2.10 Use of Palliative Care Programs (Option 2.10.1)

The project will entail identifying patients admitted to any adult ICU at Memorial Herman Hospital-TMC who are at high risk of death in or soon after hospitalization. Patients will be screened based on meeting one or more of the following criteria: severe life-threatening acute illness, progressive terminal illness, significant exacerbation of chronic debilitating illness, or declining quality of life and independent functioning in the past 6 months. In collaboration with the primary clinical team, these patients will receive a palliative care consultation to supplement their clinical therapy and assist in determination of goals of care which may include transitioning the patients from acute hospital care into home care, hospice or a skilled nursing facility. Patient/family experience surveys regarding the quality of care, pain and symptom management, and degree of patient/family centeredness in care will also be implemented.

UTHealth will recruit additional physicians trained in palliative care and other team staff to expand the existing palliative care program. The current partnership of UTHealth and Memorial Hermann Hospital-TMC has been a successful program, which is seeing increased demand and needs further expansion. Since the start of the program in 2004, over 1,000 patients have received palliative care related to cancer, heart failure, and various other illnesses, including infants in the NICU. In 2010, palliative care was provided to 84 cancer patients, 467 non-cancer patients, and 25 patients for whom the illness is unknown. In 2011, 203 patients with heart failure (DRGS 291,292, 293) received palliative care. (Data from the UTHealth Medical School, Geriatric & Palliative Medicine Division, Palliative Fact Sheet August 2012.)

Finally, through project MS1 (UT Health Regional Systems Engineering Center and UT Health Quality Improvement Dashboard Development Center), the systems engineering and QI teams at UT Health will identify QI targets and methods needed to achieve continuous quality improvement for this project, especially as it relates to identifying challenges for expansion, and building on lessons learned.

Goal and Relationship to Regional Goals:

Project Goal:

Patients receive dignified and culturally appropriate end-of-life care, which is provided for patients with terminal illnesses in a manner that prioritizes pain control, social and spiritual care, and patient/family preferences.

This project addresses the following regional goal:

One of the goals of the region is "to develop a regional approach to health care delivery that leverages and improves on existing programs and infrastructure, is responsive to patient needs throughout the entire region, and improves health care outcomes and patient satisfaction". The palliative care project when successfully implemented will make the health system bettr suited to attend to patients' needs at the end-of-life thereby invcreasing satisfaction

Challenges:

Need: 1) Education and information about the dying process and the various options for care. 2) Support and navigation in acting upon their preferences for care.

Implementation: 1) Staff recruitment and retention. 2) Willingness of patients, or their families, to embrace palliative care.

The project will mitigate the challenges patientts and their families face due to lack of access to information to enable informed end-of-life decisions that are satisfactory. Gradually as the program gets establishe, the learning process will enable development of best practices in palliative care and increased likelihood of patients to embrace care options

5-Year Expected Outcome for Provider and Patients:

Increased uptake of palliative care services, greater involvement of patients and/or their families in end-of-life decisions, and increased satisfaction with end-of-life care. These services will be available to the Medicaid and Medicaid-eligible populations receiving care at Memorial Hermann Hospital that meet the intervention criteria.

Starting Point/Baseline:

To be determined during DY3.

Rationale:

While end-of-life care was once associated almost exclusively with terminal cancer, today we are providing end-of-life care for a number of other conditions, such as congestive heart failure and infants and their families in the NICU. Our experience has shown that that palliative and hospice care could be more widely embraced for many dying patients. The goal of palliative medicine is to improve or maintain quality of life in patients with life-limiting or life-threatening diseases. Palliative medicine is a recognized medical subspecialty of both the American Board of Medical Specialties and American Osteopathic Association. Palliative medicine involves the control of symptoms associated with chronic disease such as nausea, pain and shortness of breath for example, as well as management of the symptoms that are part of the dying process. Along with symptom control, palliative medicine teams provide comfort, social and spiritual interventions for patients & their families. Palliative care, unlike hospice, is provided simultaneously with all other appropriate disease-directed treatments (Morrison RS, Meier DE. Clinical practice: palliative care. N Engl J Med. 2004;350(25): 2582-2590). Palliative medicine programs markedly reduce lengths of stay in hospitals on both wards and ICU settings. Data from the 2009 American Hospital Association Annual Survey showed that between 2000 and 2008, the number of hospitals with palliative medicine programs grew by 125.8% from 658 to 1486 (Center for the Advancement of Palliative Care. http://www.capc.org/news-and-events/releases/04-05-10 accessed April 15, 2010). U.S. News and World Report has included palliative medicine as a criterion in its rankings of America's Best Hospitals since 2003 (Center for the Advancement of Palliative Care. http://www.capc.org/support-from-capc/capc_publications/JCAHO-crosswalk-new.pdf accessed January 21, 2008). In 2007, the National Quality Forum released a national framework and preferred practices for quality palliative and hospice care and in 2008 identified palliative care as one of seven priorities for rapid action (National Quality Forum. http://www.qualityforum.org/Projects/n-r/Palliative_and_Hospice_CareFramework/Palliative_Hospice_Care_Framework_and_Practices.aspx accessed April 15, 2010).

In addition to providing improved care and comfort for dying patients and their families, palliative care programs have been shown to provide considerable cost savings. According to a study of 5,354 subjects conducted by Morrison, et al. (Archives of Internal Medicine, 2008), palliative care teams saved $1,696 in direct costs per admission (P = .004) for patients discharged alive and $4,908 in direct costs per admission (P=.003) for patients who died. For a 400-bed hospital seeing 500 patients a year, this translates into a net savings of $1.3 million per year after adding physician revenues and subtracting personnel costs (Morrison RS, Penrod JD, Cassel JB, et al. Cost savings associated with United States hospital palliative care consultation programs. Arch Intern Med. 2008;168(16): 1783-1790). The palliative medicine service provided by UTHealth at Memorial Hermann Hospital-TMC has seen consistent growth in consult numbers since the program's inception in 2004. For the 532 patients receiving care in 2008, we saw a median per person per day savings of $5,292 after the palliative care consult (with a reduction in the average length of stay from 9.5 to 2.3 days) and for the 698 patients receiving palliative care consults in 2009, we realized a median per person per day savings of $4,727 (with a reduction in the average length of stay from 8.5 to 2.5 days). (Data from white paper: CBDyer, MD, GVaras, DO, N Walter. Palliative Medicine: A Critical Component of Modern Health Care. April, 2010.)

Project Components:

Through the Integrating Palliative Care into Critical Care Program, we propose to meet all required project components listed below.

a) UTP will develop a business case for palliative care
b) UTP will conduct the necessary planning activities prior to implementing the expanded palliative care program.
c) UTP will recruit additional physicians to provide palliative care at MHH.
d) UT Palliative Care Physicians will deliver palliative care to those patients with terminal illness at MHH and transition patients from acute hospital care into home care, hospice, or a skilled nursing facility wherever possible.
e) UTP will conduct patient/family experience surveys regarding the quality of care, pain and symptom management, and degree of patient/family centeredness in care with the aim to use this information to improve scores over time.
f) UTP's quality improvement office will conduct QI for each of the clinics providing specialty care using methods such as rapid cycle improvement.

Milestones and Metrics:

For the Integrating Palliative Care into Critical Care Program, we have chosen the below milestones and metrics based upon the above project components and relationship to project goals and population needs. All baselines and goals will be determined during DY2.

Process Milestones and Metrics:

Milestone 1 [P-1.]: Develop a hospital-specific business case for palliative care and conduct planning activities necessary as a precursor to implementing a palliative care program

Metric 1 [P-1.1.]: Business case

Milestone 2 [P-5.]: Implement a palliative care program

Metric 1 [P-5.1.]: Implement comprehensive palliative care program

Improvement Milestones and Metrics:

Milestone 3 [P-6.]: Increase the number of palliative care consults

Metric 1 [P-6.1.]: Palliative care consults meet targets established by the program
Milestone 4 [I-11.]: Establish the comfort of dying for patients with terminal illness within their end-of-life stage of care
Metric 1 [I-11.1.]: Pain screening (NQF-1634) Percentage of hospice or palliative care patients who were screened for pain during the hospice admission evaluation / palliative care initial encounter.
Milestone 5 [I-12.]: Implement a patient/family experience survey regarding the quality of care, pain and symptom management, and degree of patient/family centeredness in care and improve scores over time
Metric 1 [I-12.1.]: Survey developed and implemented; scores increased over time
Milestone 6 [I-9.]: Palliative care patients transitioned from acute hospital care into hospice, home care, or a skilled nursing facility (SNF) with and without hospice services.
Metric 1 [I-9.1.]: Transitions accomplished

Unique community need identification numbers the project addresses:
This project addresses community needs CN.7 (Insufficient access to care coordination practice management and integrated care treatment programs) and CN.23 (Lack of patient navigation, patient and family education and information programs).

How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:
This project represents an expansion of a currently existing program. This project proposes to expand palliative care services to patients beyond cancer, congestive heart failure, and infants and their families in the NICU, to any patients and their families admitted to any adult ICU.

Related Category 3 Outcome Measure(s):
OD-13 Palliative Care
- IT-13.1 Pain assessment (NQF-1637) (Non-standalone measure)
  Increase the number of patients enrolled in hospice OR receiving palliative care who received a comprehensive clinical assessment to determine the severity, etiology and impact of their pain within 24 hours of screening positive for pain on the admission evaluation / initial encounter.
  Exclusion: patients with length of stay < 1 day in palliative care or <7 days in hospice, patients who were not screened for pain. Patients who screen negative for pain are excluded from the denominator.

OD-13 Palliative Care
- IT-13.2 Treatment Preferences (NQF 1641) (Non-standalone measure)
  Percentage of seriously ill patients enrolled in hospice OR receiving specialty palliative care in an acute hospital setting with chart documentation of preferences for life sustaining treatments.
  Exclusions: patients with length of stay < 1 day in palliative care or <7 days in hospice.

OD-13 Palliative Care
- IT-13.5 Percentage of patients receiving hospice or palliative care services with documentation in the clinical record of a discussion of spiritual/religions concerns or documentation that the patient/caregiver did not want to discuss. (NQF 1647 modified) (Non-standalone)

Increase the number of patients discharged from hospice or palliative care with clinical record documentation of spiritual/religious concerns or documentation that the patient/family did not want to discuss during the reporting period.

Relationship to other Projects:

1.9 (C4) - The disease management registry will serve as a useful resource to every provider, including palliative care providers, involved in caring for the enrolled patients.

2.11 (C10) - The medication management program will serve as a useful resource to palliative care providers, as they work to help the patient and their family achieve their care goals.

Relationship to Other Performing Providers' Projects in the RHP:

The regional need for palliative care is that of upmost priority and is addressed in this initiative. This initiative is unique to Pass 1 initiatives and focuses to outcome measures of pain assessments, treatment preferences, and patients receiving hospice and palliative care. The Region 3 Initiative Grid (addendum) can provide a cross reference to all other initiatives.

Plan for Learning Collaborative:

UTHealth will participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system.

Project Valuation:

The anchor, Harris Health, provided a spreadsheet which contained 6 criteria, which could be used to rate each project on a 10-point scale. The ratings for each criterion were weighted, summed for each project to arrive at a total score (value weight) for each project. The sum of all the project's total scores were then divided by the percent of total DSRIP funds to be secured for that year to arrive at a dollar value multiplier to be applied towards each project's total score (value weight), thereby allocating a greater proportion of the funds towards those projects valued highest based upon the 6 criteria. UTHealth used this approach, with one exception—we did not use two of the criteria. Following are the criteria, the considerations for awarding points for projects using that criteria, and the reasons two of the criteria were not used:

1. Transformational Impact (Weight = 20%): Points were awarded for projects that meet the community benefit criteria, such as: improving access; improving quality; improving costs (long-term cost-savings); transformative (Innovative), collaborative (partners with other organization(s)). This project's score for this criterion: **2**

2. Population Served/Project Size (Weight = 20%): Points were awarded based on the size of the population affected and whether the target population is uninsured or on Medicaid. This project's score for this criterion: **1**

3. Aligned with Community Needs (Weight = 20%): Points were awarded based on judgments in two categories: whether or not the CNA indicates a need in the area of the project and the severity of the health/healthcare need(s) the project addresses. This project's score for this criterion: 111810101.2.4 X 2 = **1**

4. Cost Avoidance (Weight = 15%): Points were awarded based on judgment of project's cost effectiveness relative to similar projects. This project's score for this criterion: **5**

5. Partnership/Collaboration (Weight = 10%): ***This was not rated***, because UTHealth planned to partner with Harris Health to perform many similar projects, so the rating would have been the same for all projects. This would have diluted the scores, hiding the more significant variations in other value criteria.

6. Sustainability (Weight = 15%): ***This was also not rated***, because UTHealth does not consider any of the projects to be unsustainable, or at the very least do not consider one project less sustainable than another. Giving the projects the same, or very similar ratings on this criteria again would have had a diluting effect, hiding the more significant variations in other value criteria.

Total Valuation Score for this project: **1.55**

111810101.2.4	*OPTION 2.10.1*	*2.10.1 (A-D)*	*MS3 INTEGRATING PALLIATIVE CARE INTO CRITICAL CARE*
UTHealth, UTPhysicians			*111810101*
Related Category 3 Outcome Measure(s):	*111810101.3.17* *111810101.3.18* *111810101.3.19*	*IT-13.1* *IT-13.2* *IT-13.5*	*Pain assessment (NQF-1637) (Non-standalone measure)* *Treatment Preferences (NQF 1641) (Non-standalone measure)* *Percentage of patients receiving hospice or palliative care services with documentation in the clinical record of a discussion of spiritual/religions concerns or documentation that the patient/caregiver did not want to discuss. (NQF 1647 modified) (Non-st*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-1.]: Develop a hospital-specific business case for palliative care and conduct planning activities necessary as a precursor to implementing a palliative care program Metric 1 [P-1.1.]: Business case Baseline/Goal: TBD Data Source: Business case write-up; documentation of planning activities Milestone 1 Estimated incentive payment: $ 1,484,661	**Milestone 2** [P-5.]: Implement a palliative care program Metric 1 [P-5.1.]: Implement comprehensive palliative care program Baseline/Goal: TBD Data Source: Palliative care program Milestone 2 Estimated incentive payment: $ 1,674,429	**Milestone 3** [P-6.]: Increase the number of palliative care consults Metric 1 [P-6.1.]: Palliative care consults meet targets established by the program Goal: TBD Data Source: EHR, palliative care database Milestone 3 Estimated incentive payment: $ 870,703 **Milestone 4** [I-11.]: Establish the comfort of dying for patients with terminal illness within their end-of-life stage of care Metric 1 [I-11.1.]: Pain screening (NQF-1634) Percentage of hospice or palliative care patients who were screened for pain during the hospice admission evaluation/ palliative care initial encounter. Goal: TBD Data Source: EHR, palliative care database Milestone 4 Estimated incentive	**Milestone 5** [I-12.]: Implement a patient/family experience survey regarding the quality of care, pain and symptom management, and degree of patient/family centeredness in care and improve scores over time Metric 1 [I-12.1.]: Survey developed and implemented; scores increased over time Goal: TBD Data Source: Patient/family experience survey Milestone 5 Estimated incentive payment: $ 833,493 **Milestone 6** [I-9.]: Palliative care patients transitioned from acute hospital care into hospice, home care, or a skilled nursing facility (SNF) with and without hospice services. Metric 1 [I-9.1.]: Transitions accomplished Goal: TBD Data Source: EHR, data warehouse, palliative care database

111810101.2.4	***Option 2.10.1***	***2.10.1 (A-D)***	***MS3 Integrating Palliative Care into Critical Care***	
UTHealth, UTPhysicians				*111810101*
Related Category 3 Outcome Measure(s):	*111810101.3.17* *111810101.3.18* *111810101.3.19*	*IT-13.1* *IT-13.2* *IT-13.5*	*Pain assessment (NQF-1637) (Non-standalone measure)* *Treatment Preferences (NQF 1641) (Non-standalone measure)* *Percentage of patients receiving hospice or palliative care services with documentation in the clinical record of a discussion of spiritual/religions concerns or documentation that the patient/caregiver did not want to discuss. (NQF 1647 modified) (Non-st*	

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
		payment: $ 870,703	Milestone 6 Estimated incentive payment: $ 833,494
Year 2 Estimated Milestone Bundle Amount: $1,484,661	Year 3 Estimated Milestone Bundle Amount: $1,674,429	Year 4 Estimated Milestone Bundle Amount: $1,741,406	Year 5 Estimated Milestone Bundle Amount: $1,666,987
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*:* $6,567,483			

Project Option 2.11.1- 2.11 Conduct Medication Management: Patient-Centered Medication Therapy Management Program

Unique RHP Project ID: 111810101.2.5
Performing Provider Name/TPI: UTHealth, UTPhysicians / 111810101

Project Summary:

Provider:
UT Physicians is the clinical practice of The University of Texas Medical School at Houston. With more than 900 physicians certified in 80 medical specialties and subspecialties, 906 residents and fellows, and 283,920 patient visits in 2011, it is the fastest growing academic practice in the nation for the last five years. In addition to our flagship location in the Texas Medical Center, UT Physicians has 4 neighborhood locations throughout the Greater Houston area, and also offers specialty clinics at several Memorial Hermann Hospital locations.
Intervention(s):
This project will implement a technologically driven patient-centered medication therapy management program. Allscripts analytics tool will enable staff to identify patients at high risk for developing complications and co-morbidities, and patients that have not refilled their medications. Patients will also have access to the patient portal, which will have detailed information on all their medications. Root cause analysis will be used to identify potential medication errors and quality improvement processes will be used to address the causes.
Need for the project:
Drug-related morbidity and mortality costs exceed $200 billion annually in the U.S. Patients with multiple chronic conditions are likely to be on multiple medications for long periods of time thereby increasing the risk of medication errors. Considering the high rates of chronic diseases in our region, this project willd lead to improved outcomes and cost savings for the health system.
Target Population:
This project primarily targets patients in our service areas with diabetes, hypertension, asthma, COPD, or CHF. Patients of lower socioeconmic status are known to have worse disease contol due to inability to maintain compliance in the long run, hence this project will be beneficial to the Medicaid population. UTP provided 321,716 patient visits in 2012 (20% were Medicaid clients) and expects to add another 80,000 patient visits (most are expected to be Medicaid clients) by the end of DY5, due to the UTP expansion of primary and specialty care services.
Category 1 or 2 expected patient benefits:
Our goal for DY4 is to increase the number of patients (meeting criteria for chronic condition) contacted or receiving medication management, and by DY5 to record improvement in selected clinical measures in target population.
Category 3 outcomes:
IT-1.2: Our goal is to improve by 3% in DY4 and 5% in DY5, the percentage of members 18 years of age and older who received at least 180 treatment days of ACE inhibitors or ARBs during the measurement year and had at least one serum potassium and either a serum creatinine or a blood urea nitrogen therapeutic monitoring test in the measurement year.

Project Option 2.11.1 – Conduct Medication Management: C10 Patient-Centered Medication Therapy Management Program

Unique RHP Project Identification Number: 111810101.2.5
Performing Provider Name/TPI: UTHealth, UTPhysicians/111810101

Project Description: 2.11 Conduct Medication Management (Option 2.11.1)

UT Physicians will implement a patient-centered medication therapy management program. Using the Allscripts analytics tool, staff will identify patients at high risk for developing complications and adverse effects from possible interactions, or non-compliance. Related patient information in the EMR will be used to review the complete medication regimen and history to assess compliance. Where there is an indication that a patient might not be compliant (Rx wasn't filled, etc.), or there are other reasons for concern, the appropriate member of the patient's healthcare team will follow up with the patient. Patients of UTP will receive counseling and education about the medications they are prescribed and an action plan will be developed that includes any further patient education needed, goal setting, and follow up appointments for potential adjustments in the medication regimen. Patient response will then be monitored and adjustments made accordingly. Patients will also have access 24/7 to the Jardogs patient portal, which will have a complete list of all current medications, including dosage information, information on how and why it is being used, and the prescribing physician. Patients will be educated on accessing the patient portal. The patient's healthcare team continue to work with the patient in resolving any barriers to compliance that could include any number of things. Root cause analysis will be done to identify reoccuring barriers to compliance and potential medication errors, and quality improvement processes will be used to address the causes.

Finally, through project MS1 (UT Health Regional Systems Engineering Center and UT Health Quality Improvement Dashboard Development Center), the systems engineering and QI teams at UT Health will identify QI targets and methods needed to achieve continuous quality improvement for this project, especially as it relates to identifying challenges for expansion, and building on lessons learned.

Goal and Relationship to Regional Goals:

Project Goal:

To provide information to physicians, care teams, and patients that facilitates the appropriate use of medications in order to control illness and promote health

This project addresses the following regional goal:

Part of the goals of the region is to develop a culture of ongoing transformation and innovation that maximizes the use of technology and best-practices; the medication management project ties closely with this aspiration by using technological support to reduce medication errors and improve drug compliance

Challenges:

Need: 1) High rates of chronic disease. 2) High risk of medication errors with polypharmacy.

Implementation: 1) Choosing the parameters that will be used to initiate action. 2) Implementing clinical processes to support proactive care. 3) Patient compliance with medication management efforts.

The medication management project will reduce the risk of medication errors in patients with multiple chronic conditions

5-Year Expected Outcome for Provider and Patients:

Acheivement of reduction in medication errors and drug interactions, resulting in improved adherence to chronic care medication therapy. By adopting a proactive medication therapy management program, potential dangerous interactions and ineffective treatment regimines can be avoided. Patients of UT Physicians, including the current Medicaid (23% as of 2011, or 65,302 patient visits) and low-income client base, will be safer and experience better health outcomes. In FY 2012, UTP provided 321,716 patient visits and expects to add another 80,000 (most, of which are expected to be Medicaid clients) by DY5 for over 400,000 patient visits. Using the Harris County rate (14.5%) of Medicaid clients, there are an estimated 1,423,176 Medicaid clients living within our service areas. We expect this program will help ensure these clients will also get the best health outcomes possible from their medication therapies.

Starting Point/Baseline:

To be determined during DY3.

Rationale:

More than 3.5 billion prescriptions are written annually in the United States (Sommers JP. Prescription drug expenditures in the10 largest states for persons under age 65, 2005.2008. Agency for Healthcare Research and Quality. Available at: http://meps.ahrq.gov/mepsweb/data_files/publications/st196/stat196.pdf. Accessed 10/11/12). Medications are involved in 80 percent of all treatments and impact every aspect of a patient's life. According to the World Health Organization, adherence to therapy for chronic diseases in developed countries averages 50%, and the major consequences of poor adherence to therapies are poor health outcomes and increased health care costs (WHO. 2003. Adherence to long-term therapies: Evidence for action. Available at: http://whqlibdoc.who.int/publications/ 2003/9241545992.pdf. Accessed 10/11/12). Drug-related morbidity and mortality costs exceed $200 billion annually in the U.S., exceeding the amount spent on the medications themselves (Johnson J, Bootman JL. Drug-related morbidity and mortality. Arch Intern Med. 1995; 155(18):1949-1956; Johnson JA, Bootman JL. Drug-related morbidity and mortality. Am J Health Syst Pharm. 1997; 54(5):554-558; Ernst, FR, Grizzle AJ. Drug related morbidity and mortality: Updating the cost-of-illness model. J Am Pharm Assoc. 2001; 41(2):192-199)).

Patients with chronic diseases and multiple chronic conditions are likely to be on multiple medications for long periods of time thereby increasing the risk of medication errors. Considering the high rates of chronic diseases in our region, this projects would potentially lead to improved outcomes and cost savings for the health system.

Project Components:

Through the Patient-Centered Medication Therapy Management Program, we propose to meet all the required project components listed below.

a) UTP will develop criteria and identify targeted patient populations (e.g. chronic disease patient populations that are at high risk for developing complications, co-morbidities, and/or utilizing acute and emergency care services) using evidence-based criteria for medication management planning.
b) UTP will develop written medication management plans and tools to provide education and support to those patients at highest risk of non-compliance, an adverse drug event, or medication error.
c) UTP will implement an electronic tracking and alert system using Allscripts. UTP will recruit additional staff where necessary to conduct periodic medication reviews.
d) UTP will conduct root cause analysis of non-compliance, potential medication errors, or adverse drug events and develop/implement processes to address those causes.
e) UTP's quality improvement office will conduct QI for each of the clinics providing specialty care using methods such as rapid cycle improvement.

Milestones and Metrics:

For the Patient-Centered Medication Therapy Management Program, we have chosen the below milestones and metrics based upon the above project components and relationship to project goals and population needs. All baselines and goals will be determined during DY2.

Process Milestones and Metrics:

Milestone 1 [P-2.]: Develop criteria and identify targeted patient populations
Metric 1 [P-2.1.]: Establish evidence based criteria for medication management planning in target population based on assessment of population needs
Milestone 2 [P-2.]: Develop criteria and identify targeted patient populations
Metric 1 [P-2.2.]: Written medication management plan(s)

Improvement Milestones and Metrics:

Milestone 3 [I-9.]: Manage medications for targeted patients
Metric 1 [I-9.1.]: Increase the number of patients (meeting criteria for chronic condition) contacted or receiving medication management
Milestone 4 [I-16.]: Improvement in selected clinical measures in target population
Metric 1 [I-16.1.]: TBD by Performing Provider-Percent of patients who have shown improvement in selected clinical measures (e.g., blood pressure or LDLcholesterol) in targeted patient population

Unique community need identification numbers the project addresses:

This project addresses community needs CN.11 (High rates of chronic disease and inadequate access to treatment programs and services for illnesses associated with chronic disease).

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

This project represents a new initiative. UT Physicians have not previously had access to these types of tools and processes for ensuring the safety of their patients receiving medication therapy and for achieving patients goals.

Related Category 3 Outcome Measure(s):

OD-1 Primary Care and Chronic Disease Management

- IT-1.2 Annual monitoring for patients on persistent medications (NCQA-HEDIS 2012)219– angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARBs) (Non-standalone measure)
  Percentage of members 18 years of age and older who received at least 180 treatment days of ACE inhibitors or ARBs during the measurement year and had at least one serum potassium and either a serum creatinine or a blood urea nitrogen therapeutic monitoring test in the measurement year.

OD-1 Primary Care and Chronic Disease Management

- IT-1.3 Annual monitoring for patients on persistent medications (NCQA-HEDIS 2012)– digoxin (Non- standalone)
  Percentage of members 18 years of age and older who received at least 180 treatment days of digoxin during the measurement year and had at least one serum potassium and either a serum creatinine or a blood urea nitrogen therapeutic monitoring test in the measurement year.

OD-1 Primary Care and Chronic Disease Management

- IT-1.4 Annual monitoring for patients on persistent medications (NCQA-HEDIS 2012)– diuretic (Non- standalone measure)
  Percentage of members 18 years of age and older who received at least 180 treatment days of a diuretic during the measurement year and had at least one serum potassium and either a serum creatinine or a blood urea nitrogen therapeutic monitoring test in the measurement year.

Relationship to other Projects:

1.1 (C3) - The medication management program will be an integral part of the coordinated care provided by the primary care physicians.

1.2 (A2, SPH1) - Structured educational training for health care providers on quality and cost control will entail instruction in medication therapy management for minimizing medication errors.

1.3 (C12) - The disease management registries and the medication management project will complement each other to ensure patients with chronic diseases, especially those with multiple chronic conditions, get optimal care with minimal errors and sustained active follow up.

1.6 (C11) - The medication management program with its technological support will provide the nurses with useful information on patients to inform more efficient triaging.

1.7 (A1) - The medication management project will ensure that patient medications are managed in a coordinated manner even with inputs and prescriptions from specialists at different sites.

1.9 (C4) - The medication management project will serve as a useful resource to every provider involved in managing the enrolled patients, to ensure optimum outcomes.

2.1 (C1-2) - The medication management program will be an integral component of the provision of care within the medical home model.

2.2 (C5-9,CL3) - The medication management program will be an important resource for the provision of chronic disease care using Wagner's model as proposed in these projects.

2.10 (MS3) - The medication management program will be a useful resource for those providing palliative care to reduce the risk of medication errors and in acheiving patient goals for care.

2.15 (C13) - The medication management program will be a useful resource for the primary care physicians and the behavioral health physicians providing integrated care.

Relationship to Other Performing Providers' Projects in the RHP:

Primary Care/Ambulatory Care clinics are a top priority to Region 3 due to the acuity of the regional patient mix, population concentration, and lack of primary care access points for our patient base. The regional approach of collaboration as well as existing patient referral pattern relationships allowed our team to properly identify the community needs based on the necessity of population, uninsured, and medically underserved patient bases. This program is consistent with our region and similar to numerous initiatives in our RHP plan sharing both concepts as well as outcome measures focused to percent improvement over baseline of patient satisfaction scores, reduction of inappropriate ED utilization, and third next available appointment status. The Region 3 Initiative Grid attached as a RHP Plan addendum reflects a grid of relationship for all initiatives.

Plan for Learning Collaborative:

UTHealth will participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system.

Project Valuation:

The anchor, Harris Health, provided a spreadsheet which contained 6 criteria, which could be used to rate each project on a 10-point scale. The ratings for each criterion were weighted, summed for each project to arrive at a total score (value weight) for each project. The sum of all the project's total scores were then divided by the percent of total DSRIP funds to be secured for that year to arrive at a dollar value multiplier to be applied towards each project's total score (value weight), thereby allocating a greater proportion of the funds towards those projects valued highest based upon the 6 criteria. UTHealth used this approach, with one exception—we did not use two of the criteria. Following are the criteria, the considerations for awarding points for projects using that criteria, and the reasons two of the criteria were not used:

1. Transformational Impact (Weight = 20%): Points were awarded for projects that meet the community benefit criteria, such as: improving access; improving quality; improving costs (long-term cost-savings); transformative (Innovative), collaborative (partners with other organization(s)). This project's score for this criterion: **4**

2. Population Served/Project Size (Weight = 20%): Points were awarded based on the size of the population affected and whether the target population is uninsured or on Medicaid. This project's score for this criterion: **1**

3. Aligned with Community Needs (Weight = 20%): Points were awarded based on judgments in two categories: whether or not the CNA indicates a need in the area of the project and the severity of the health/healthcare need(s) the project addresses. This project's score for this criterion: 111810101.2.5 X 2 = **2**

4. Cost Avoidance (Weight = 15%): Points were awarded based on judgment of project's cost effectiveness relative to similar projects. This project's score for this criterion: **2**

5. Partnership/Collaboration (Weight = 10%): ***This was not rated***, because UTHealth planned to partner with Harris Health to perform many similar projects, so the rating would have been

the same for all projects. This would have diluted the scores, hiding the more significant variations in other value criteria.

6. Sustainability (Weight = 15%): ***This was also not rated***, because UTHealth does not consider any of the projects to be unsustainable, or at the very least do not consider one project less sustainable than another. Giving the projects the same, or very similar ratings on this criteria again would have had a diluting effect, hiding the more significant variations in other value criteria.

Total Valuation Score for this project: **1.7**

111810101.2.5	***2.11.1***	***A-D***	***C10 Patient-Centered Medication Therapy Management Program***
UTHealth, UTPhysicians			*111810101*
Related Category 3 Outcome Measure(s):	*111810101.3.20* *111810101.3.21* *111810101.3.22*	*IT-1.2* *IT-1.3* *IT-1.4*	*Annual monitoring for patients on persistent medications (NCQA -HEDIS 2012)219– angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARBs) (Non- standalone measure)* *Annual monitoring for patients on persistent medications (NCQA -HEDIS 2012)– digoxin (Non- standalone)* *Annual monitoring for patients on persistent medications (NCQA -HEDIS 2012)– diuretic (Non- standalone measure)*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-2.]: Develop criteria and identify targeted patient populations Metric 1 [P-2.1.]: Establish evidence based criteria for medication management planning in target population based on assessment of population needs Baseline/Goal: TBD Data Source: Written criterion for target population and program participation. Milestone 1 Estimated incentive payment: $ 1,628,337	**Milestone 2** [P-2.]: Develop criteria and identify targeted patient populations Metric 1 [P-2.2.]: Written medication management plan(s) Baseline/Goal: TBD Data Source: Paper or electronic medical record citing medication management counseling provided; medication reconciliation documented in paper or electronic medical record Milestone 2 Estimated incentive payment: $ 1,836,471	**Milestone 3** [I-9.]: Manage medications for targeted patients Metric 1 [I-9.1.]: Increase the number of patients (meeting criteria for chronic condition) contacted or receiving medication management Goal: TBD Data Source: Paper or electronic medical record Milestone 3 Estimated incentive payment: $ 1,909,930	**Milestone 4** [I-16.]: Improvement in selected clinical measures in target population Metric 1 [I-16.1.]: TBD by Performing Provider-Percent of patients who have shown improvement in selected clinical measures (e.g., blood pressure or LDLcholesterol) in targeted patient population Goal: TBD Data Source: EHR, palliative program records Milestone 4 Estimated incentive payment: $ 1,828,309
Year 2 Estimated Milestone Bundle Amount: $1,628,337	Year 3 Estimated Milestone Bundle Amount: $1,836,471	Year 4 Estimated Milestone Bundle Amount: $1,909,930	Year 5 Estimated Milestone Bundle Amount: $1,828,309
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*:* $7,203,047			

Project Option 2.12.2- 2.12 Implement/Expand Care Transitions Programs: UT Physicians Transitions of Care

Unique RHP Project ID: 111810101.2.6
Performing Provider Name/TPI: UTHealth, UTPhysicians / 111810101

Project Summary:

Provider:
UT Physicians is the clinical practice of The University of Texas Medical School at Houston. With more than 900 physicians certified in 80 medical specialties and subspecialties, 906 residents and fellows, and 283,920 patient visits in 2011, it is the fastest growing academic practice in the nation for the last five years. In addition to our flagship location in the Texas Medical Center, UT Physicians has 4 neighborhood locations throughout the Greater Houston area, and also offers specialty clinics at several Memorial Hermann Hospital locations.

Intervention(s):
This project will implement a comprehensive transitions of care program whcih will ensure that patients have an appointment for follow-up with an appropriate physician(s) prior to leaving the hospital, understand their discharge medications and other instructions, and are followed up post discharge, particularly those at risk of needing acute care services within 30-60 days. This will be implemented with UT Physicians' network of hospitalists with 24/7 management of inpatients with specific medical and surgical conditions.

Need for the project:
This project addresses several community including insufficient access to care coordination practice management and high rates of preventable hospital readmissions. When a patient is discharged without optimal follow-up, it could lead to hospital readmission and possibly death. Without sufficient information and an understanding of their diagnoses, medication, and self-care needs, patients cannot fully participate in their care during and after hospital stays.

Target Population:
The care transitions project will be for special populations, namely: cancer surgery patients, indigent patiets with type 1 diabetes, and children/adolescents with type 1 diabetes who are graduating to adult diabetes management.

Category 1 or 2 expected patient benefits:
Our goal in DY4 is to improve adherence to processes, and by DY5 to improve the percentage of patients in defined population receiving standardized care according to the approved clinical protocols and care transitions policies.
Category 3 outcomes:
IT-6.1 (1): Our goal is to increase by 3% in DY4 and 5% in DY5, the percent improvement over baseline of patient satisfaction scores on the adult CG-CAHPS survey module for are getting timely care, appointments, and information (for patients receiving the transitions of care intervention).

Project Option 2.12.2 – Implement/Expand Care Transitions Programs: A3,CL1,CL2,MS4 UT Physicians Transitions of Care

Unique RHP Project Identification Number: 111810101.2.6
Performing Provider Name/TPI: UTHealth, UTPhysicians/111810101

Project Description: 2.12 Implement/Expand Care Transitions Programs (Option 2.12.2)

There is evidence that care coordination and transitional care can reduce unplanned hospital readmissions, which are an indicator of quality of care and a source of significant wasted hospital resources and expenditures. Care coordination is defined by the Agency for Healthcare Research and Quality (AHRQ) as the "deliberate organization of patient care activities between two or more participants (including the patients) involved in a patient's care to facilitate the appropriate delivery of health care services."(McDonald KM, Sundaram V, Bravata DM, et al. Care Coordination. Vol 7 of: Shojania KG, McDonald KM, Wachter RM, Owens DK, editors. Closing the Quality Gap: A Critical Analysis of Quality Improvement Strategies. Technical Review 9 (Prepared by the Stanford University-UCSF Evidence-based Practice Center under contract 290-02-0017). AHRQ Publication No. 04-(07)-0051-7. In. Rockville, MD: Agency for Healthcare Research and Quality; June 2007.) Transitional care, which is complementary to care coordination, is "a broad range of time-limited services designed to ensure health care continuity, avoid preventable poor outcomes among at-risk populations, and promote the safe and timely transfer of patients from one level of care to another or from one type of setting to another." (Naylor MD, Aiken LH, Kurtzman ET, Olds DM, Hirschman KB. The care span: The importance of transitional care in achieving health reform. Health Aff (Millwood) 2011;30:746-54.)

UT Health proposes to implement a comprehensive transitions of care program. UT Physicians will implement a discharge planning program and post discharge support program that ensures that patients have an appointment for follow-up with an appropriate physician(s) prior to leaving the hospital, understand their discharge medications and other instructions, and are followed up post discharge, particularly those at risk of needing acute care services within 30-60 days. This will be implemented with UT Physicians' network of hospitalists with 24/7 management of inpatients with medical and surgical conditions. Additionally, we have planned specific transitions of care interventions for several special populations.

Successful care coordination and transitional care programs have traditionally been implemented for medical rather than surgical patients and in settings where patients have ready access to primary care providers. Cancer care and outcomes are worst among racial/ethnic minorities and uninsured patients and at safety-net hospitals serving a disproportionate percentage of these patients. Cancer surgery at safety-net hospitals has been associated with delays, or failures, in receiving treatment (both surgical and adjuvant) and an increased risk of death. In addition, major postoperative complications and readmissions occur commonly among cancer surgery patients, both of which are associated with increased risk of death; readmission rates after complex surgery have been reported to be as high as 59% in one year. Transitions to home after cancer surgery can be difficult because of pain, decreased function and mobility, and surgery-related symptoms or complications. These transitions may be even more difficult among patients with limited social support, reduced health literacy, and unclear expectations regarding post-operative recovery. Comprehensive care programs for high-risk neonates and chronically ill

children have been successfully implemented in resource-poor, inner-city settings (Dallas and Houston, Texas) by Dr. Jon Tyson (UT Health). Both of these programs resulted in significantly reduced healthcare utilization (intensive care unit admissions, hospitalizations, emergency room visits) and costs. The comprehensive care program for chronically ill children in Houston was associated with a difference in combined inpatient and outpatient costs per year of almost $20K (preliminary analyses). (Broyles RS, Tyson JE, Heyne ET, et al. Comprehensive follow-up care and life-threatening illnesses among high-risk infants: A randomized controlled trial. Jama 2000;284:2070-6.) Thus, there is good rationale and evidence to suggest that a comprehensive transitional care program would reduce readmissions and emergency room visits without increasing costs in high-risk surgical patients. The program could have other potential benefits such as: decreased patient anxiety and increased patient satisfaction; improved quality of care (and care coordination); improved access to specialty care; and reduced disparities in surgical and cancer-specific outcomes. A comprehensive care coordination and transitions program will be developed and implemented for cancer surgery patients, which will provide deliberate organization of patient care activities between all care givers and participants (including the patients) involved in a patient's care that facilitates the right care at the right time and ensures continuity of care, avoids preventable poor outcomes, and promotes the safe and timely transfer of patients from one level of care to another, or from one type of setting to another.

In addition to targeting cancer surgery patients, we will also provide transitions of care targeting patients admitted with DKA. Often the indigent patients keep cycling back and forth in the hospital with multiple DKA admissions. Without sufficient information and an understanding of their diagnoses, medication, and self-care needs, patients cannot fully participate in their care during and after hospital stays. Hence, intensive monitoring as part of this project is needed to improve treatment compliance and reduce readmission rates in these patients. This enhanced transitions of care project could improve diabetes-related health outcomes in indigent patients with type 1 diabetes, who are prone to occurrence of diabetic ketoacidosis (DKA). With the addition of critical personnel to Endocrine Services, practice providers will: 1. Survey daily hospital admissions for diagnosis of DKA, 2. Visit patients, explain the program, and schedule patients for outpatient follow-up in the DKA clinic within 2 weeks of discharge, 3. Maintain contact with the patient at home to facilitate home insulin treatment and ensure outpatient clinic visit on appointed day, 4. Work with Dr. Orlander (UT) to ensure appropriate outpatient testing and care for the patient, and 5. Maintain the existing DKA database to monitor cost-effectiveness and clinical outcomes over time.

Also, children and adolescents with type 1 diabetes or other forms of early onset diabetes need a well-structured transitional care program to move from (usually highly organized) pediatric diabetes management to (usually less structured, more self-managed) adult diabetes management at the age of 18 years. The first encounter of “graduating” pediatric diabetic patients with the adult health care system is often in the hospital ED in diabetic ketoacidosis due to a lack of insulin or an untreated acute illness. DKA is a highly preventable cause of medical admission and could result in death. Children with type 1 diabetes constitute a special needs population as there is currently no program that pays special attention to their peculiar needs when "graduating" to adult care. Advanced practice providers will identify all adolescent diabetic patients who will “graduate” from pediatric to adult diabetes specialist care in the following 6 months, work with the patients and their parents to arrange the first adult diabetes clinic visit, ensure continuing supply of insulin and other necessary medications during the transition, and

arrange for diabetes education in self-management as an adult diabetic patient, and maintain a database for outcomes of this project.

Goal and Relationship to Regional Goals:

Project Goal:

To implement improvements in care transitions and coordination of care from inpatient to outpatient, post-acute care, and home care settings in order to prevent increased health care costs and hospital readmissions.

This project addresses the following regional goal:

Care transitions project will make it easier for patients to access care in a coordinated manner, thereby attaining the regional goal to "transform health care delivery from a disease-focused model of episodic care to a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary or duplicative services..."

Challenges:

Need: 1) High rates of preventable hospital readmissions. 2) Insufficient access to care coordination practice management and integrated care treatment programs.

Implementation: 1) Ability to provide culturally appropriate discharge support. 2) Tackling barriers to compliance such as inability to afford care, transportation, and low literacy levels. 3) Identifying the main barriers and facilitators of implementing a comprehensive care program. 4) designing a feasible, effective, and self-sustainable program to address the problem of Unplanned readmissions. 5) Coordinating care across multiple services. 6) Determining which components of the multi-level program are most effective and efficient for which patients.

Dr. Jon Tyson's expertise in designing and implementing comprehensive care programs will assist us in addressing the implementation challenges.

5-Year Expected Outcome for Provider and Patients:

This transitional care project will provide "a broad range of time-limited services designed to ensure health care continuity, avoid preventable poor outcomes among at-risk populations, and promote the safe and timely transfer of patients from one level of care to another or from one type of setting to another." The at-risk populations will include the Medicaid and Medicaid-eligible patients of Memorial Hermann Hospital and UT Physicians. Patients receiving timely care, appointments and information, will have better outcomes and improved patient satisfaction.

Starting Point/Baseline:

To be determined during DY3.

Rationale:

When a patient is discharged without optimal follow-up, it could have terrible consequences such as hospital readmission and possibly death. Without sufficient information and an understanding of their diagnoses, medication, and self-care needs, patients cannot fully participate in their care during and after hospital stays. Additionally, poorly designed discharge processes create unnecessary stress for medical staff causing failed communications, rework, and frustrations. A comprehensive and reliable discharge plan, along with proactive post-discharge support, can reduce readmission rates and improve health outcomes.

Project Components:

Through the UT Physicians Transitions of Care Program, we propose to meet all required project components listed below.

1) UTP will recruit additional staff to manage the transitions of care program.
2) UTP will work with MHH to develop processes using best practices and evidence-based protocols for effectively communicating with patients and families during discharge to improve adherence to discharge and follow-up care instructions. These processes will include:
   a. Use of discharge checklists,
   b. Development of post-discharge medication planning,
   c. Arranging post-op clinic visit before discharge,
   d. Development of "Hand off" communication plans between providers, and
   e. Provision of patient and family post-operative recovery education and wellness education.
3) UTP will conduct follow-up contacts with discharged patients using automated flags and reminders.

Milestones and Metrics:

For the UT Physicians Transitions of Care Program, we have chosen the below milestones and metrics based upon the above project components and relationship to project goals and population needs. All baselines and goals will be determined during DY2.

Process Milestones and Metrics:

Milestone 1 [P-1.]: Develop best practices or evidence-based protocols for effectively communicating with patients and families during and post-discharge to improve adherence to discharge and follow-up care instructions.

Metric 1 [P-1.1.]: Care transitions protocols

Milestone 2 [P-2.]: Implement standardized care transition processes

Metric 1 [P-2.1.]: Care transitions policies and procedures

Improvement Milestones and Metrics:

Milestone 3 [I-14]: Milestone: Implement standard care transition processes in specified patient populations.

Metric 1 [I-14.1]: Measure adherence to processes.

Milestone 4 [I-11.]: Improve the percentage of patients in defined population receiving standardized care according to the approved clinical protocols and care transitions policies

Metric 1 [I-11.1]: Number over time of those patients in target population receiving standardized, evidence-based interventions per approved clinical protocols and guidelines

Unique community need identification numbers the project addresses:

This project addresses community needs CN.6 (Inadequate access to treatment and services designed for special needs populations, including disabled, homeless, children, elderly), CN.7 (Insufficient access to care coordination practice management and integrated care treatment programs), CN.9 (High rates of preventable hospital readmissions), and CN.10 (High rates of preventable hospital admissions).

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

The project represents a new initiative. UT Physicians does not currently have any of the transitions of care initiatives described in this project.

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

- IT-6.1 (1) Percent improvement over baseline of patient satisfaction scores: (1) are getting timely care, appointments, and information (Stand-alone measure)

Percent improvement over baseline of patient satisfaction scores (all questions within a survey need to be answered to be a stand-alone measure). Percent improvement over baseline of patient satisfaction scores for one or more of the patient satisfaction domains that the provider targets for improvement in a specific tool. Certain supplemental modules for the adult CG-CAHPS survey may be used to establish if patients: (1) are getting timely care, appointments, and information (for patients receiving the transitions of care intervention)

Relationship to other Projects:

1.1 (C3) - The expanded capacity to deliver primary care will ensure that patients are able to be assigned to a care team in the UT medical homes.
1.2 (A2, SPH1) - The innovative residency program and the training of community health workers will ensure availability of human resources to facilitate the transition of patients between care givers in a medical home.
1.3 (C12) - The disease management registry will be a useful resource for the care team in ensuring that continuity of care is maintained.
1.7 (A1) - Telemedicine capabilities within the UT Medical Homes will provide increased capacity to deliver both primary and specialty care services to patients when and where needed.
1.9 (C4) - The expansion of specialty care in the primary care setting will provide a greater availability of needed services for cancer patients with complex needs.
2.1 (C1-2) - The UT Health Multispecialty Physician Group will provide an extensive network of specialty support centers for primary care providers in advanced medical homes, better equiped to care for patients transitioning from acute care who have complex needs.
2.2 (C5-9,CL3) - The chronic care management models being implemented within the UT Medical Homes will provide improved care for cancer patients who must also manage a chronic disease.

Relationship to Other Performing Providers' Projects in the RHP:

Primary Care/Ambulatory Care clinics are a top priority to Region 3 due to the acuity of the regional patient mix, population concentration, and lack of primary care access points for our patient base. The regional approach of collaboration as well as existing patient referral pattern relationships allowed our team to properly identify the community needs based on the necessity of population, uninsured, and medically underserved patient bases. This program is consistent with our region and similar to numerous initiatives in our RHP plan sharing both concepts as well as outcome measures focused to percent improvement over baseline of patient satisfaction scores, reduction of inappropriate ED utilization, and third next available appointment status. The Region 3 Initiative Grid attached as a RHP Plan addendum reflects a grid of relationship for all initiatives.

Plan for Learning Collaborative:

UTHealth will participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system.

Project Valuation:

The anchor, Harris Health, provided a spreadsheet which contained 6 criteria, which could be used to rate each project on a 10-point scale. The ratings for each criterion were weighted, summed for each project to arrive at a total score (value weight) for each project. The sum of all the project's total scores were then divided by the percent of total DSRIP funds to be secured for that year to arrive at a dollar value multiplier to be applied towards each project's total score (value weight), thereby allocating a greater proportion of the funds towards those projects valued highest based upon the 6 criteria. UTHealth used this approach, with one exception—we did not use two of the criteria. Following are the criteria, the considerations for awarding points for projects using that criteria, and the reasons two of the criteria were not used:

1. Transformational Impact (Weight = 20%): Points were awarded for projects that meet the community benefit criteria, such as: improving access; improving quality; improving costs (long-term cost-savings); transformative (Innovative), collaborative (partners with other organization(s)). This project's score for this criterion: **6**

2. Population Served/Project Size (Weight = 20%): Points were awarded based on the size of the population affected and whether the target population is uninsured or on Medicaid. This project's score for this criterion: **2**

3. Aligned with Community Needs (Weight = 20%): Points were awarded based on judgments in two categories: whether or not the CNA indicates a need in the area of the project and the severity of the health/healthcare need(s) the project addresses. This project's score for this criterion: 111810101.2.6 X 2 = **3**

4. Cost Avoidance (Weight = 15%): Points were awarded based on judgment of project's cost effectiveness relative to similar projects. This project's score for this criterion: **4**

5. Partnership/Collaboration (Weight = 10%): ***This was not rated***, because UTHealth planned to partner with Harris Health to perform many similar projects, so the rating would have been the same for all projects. This would have diluted the scores, hiding the more significant variations in other value criteria.

6. Sustainability (Weight = 15%): ***This was also not rated***, because UTHealth does not consider any of the projects to be unsustainable, or at the very least do not consider one project less sustainable than another. Giving the projects the same, or very similar ratings on this criteria again would have had a diluting effect, hiding the more significant variations in other value criteria.

Total Valuation Score for this project: **2.8**

<table>
<tr><td>111810101.2.6</td><td>2.12.2</td><td>A-F</td><td colspan="2">A3,CL1,CL2,MS4 UT PHYSICIANS TRANSITIONS OF CARE</td></tr>
<tr><td colspan="4">UTHealth, UTPhysicians</td><td>111810101</td></tr>
<tr><td>Related Category 3 Outcome Measure(s):</td><td>111810101.3.23</td><td>IT-6.1 (1)</td><td colspan="2">Percent improvement over baseline of patient satisfaction scores: (1) are getting timely care, appointments, and information (Standalone measure)</td></tr>
<tr><th>Year 2
(10/1/2012 – 9/30/2013)</th><th colspan="2">Year 3
(10/1/2013 – 9/30/2014)</th><th>Year 4
(10/1/2014 – 9/30/2015)</th><th>Year 5
(10/1/2015 – 9/30/2016)</th></tr>
<tr><td>Milestone 1 [P-1.]: Develop best practices or evidence-based protocols for effectively communicating with patients and families during and post-discharge to improve adherence to discharge and follow-up care instructions.
Metric 1 [P-1.1.]: Care transitions protocols
Baseline/Goal: TBD
Data Source: Submission of protocols, Care transitions program materials

Milestone 1 Estimated incentive payment: $ 2,681,967</td><td colspan="2">Milestone 2 [P-2.]: Implement standardized care transition processes
Metric 1 [P-2.1.]: Care transitions policies and procedures
Baseline/Goal: TBD
Data Source: Policies and procedures of care transitions program materials

Milestone 2 Estimated incentive payment: $ 3,024,775</td><td>Milestone 3 [I-14]: Milestone: Implement standard care transition processes in specified patient populations.
Metric 1 [I-14.1]: Measure adherence to processes.
Goal: TBD
Data Source: Administrative data and EMR.

Milestone 3 Estimated incentive payment: $ 3,145,766</td><td>Milestone 4 [I-11.]: Improve the percentage of patients in defined population receiving standardized care according to the approved clinical protocols and care transitions policies
Metric 1 [I-11.1]: Number over time of those patients in target population receiving standardized, evidence-based interventions per approved clinical protocols and guidelines
Goal: TBD
Data Source: Registry or EMR report/analysis

Milestone 4 Estimated incentive payment: $ 3,011,332</td></tr>
<tr><td>Year 2 Estimated Milestone Bundle Amount: $2,681,967</td><td colspan="2">Year 3 Estimated Milestone Bundle Amount: $3,024,775</td><td>Year 4 Estimated Milestone Bundle Amount: $3,145,766</td><td>Year 5 Estimated Milestone Bundle Amount: $3,011,332</td></tr>
<tr><td colspan="5">TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $11,863,840</td></tr>
</table>

PProject Option 2.15.1- 2.15 Integrate Primary and Behavioral Health Care Services: Integrated Primary and Behavioral Health Care Services

Unique RHP Project ID: 111810101.2.7
Performing Provider Name/TPI: UTHealth, UTPhysicians / 111810101

Project Summary:

Provider:
UT Physicians is the clinical practice of The University of Texas Medical School at Houston. With more than 900 physicians certified in 80 medical specialties and subspecialties, 906 residents and fellows, and 283,920 patient visits in 2011, it is the fastest growing academic practice in the nation for the last five years. In addition to our flagship location in the Texas Medical Center, UT Physicians has 4 neighborhood locations throughout the Greater Houston area, and also offers specialty clinics at several Memorial Hermann Hospital locations.

Intervention(s):
UT Health will design, implement and evaluate a project that will integrate primary and behavioral healthcare services within UT Physicians' clinics to achieve a close collaboration in a partly integrated system of care (Level IV). A behavioral health provider will be placed in the primary care setting to provide patients with behavioral health services at their usual source of health care. This will facilitate care coordination between primary and behavioral healthcare.
Need for the project:
This project addresses several community needs including inadequate access to behavioral health care, and high rates of tobacco use and excessive alcohol use. The Health of Houston Survey, 2010, reported that 9% of residents did not see a behavioral health professional, even though they felt it was needed. Service integration will help to address the reasons care was not sought by the 31% that felt uncomfortable about it, the 22% that was concerned that someone would find out, the 17% that had trouble getting an appointment, and the 59% that had cost concerns.
Target Population:
The service areas of our 4 outlying clinics include health professional shortage areas, and medically underserved areas and populations. Using the Harris County rate (14.5%) of Medicaid clients, there are an estimated 1,423,176 Medicaid clients living within our service areas. In FY 2012, UTP provided 321,716 patient visits and expects to add another 80,000 (most, of which are expected to be Medicaid clients) primary and specialty patient visits (not counting behavioral health) by DY5 for over 400,000 patient visits.
Category 1 or 2 expected patient benefits:
Our goal in DY4 will be to increase the percentage of individuals receiving both physical and behavioral health care at the established locations, and by DY5 to increase the percent of individuals with a treatment plan developed and implemented with primary care and behavioral health expertise.
Category 3 outcomes:
IT-1.8: Our goal is to increase by 3% in DY4 and 5% in DY5, the percentage of UT Physicians patients who receive screening for clinical depression using a standardized tool, and for whom a follow-up plan is documented.

Project Option 2.15.1 – Integrate Primary and Behavioral Health Care Services: C13 Integrated Primary and Behavioral Health Care Services

Unique RHP Project Identification Number: 111810101.2.7
Performing Provider Name/TPI: UTHealth, UTPhysicians/111810101

Project Description: 2.15 Integrate Primary and Behavioral Health Care Services (Option 2.15.1)

UT Health will design, implement and evaluate a project that will integrate primary and behavioral health care services within UT Physicians clinics to achieve a close collaboration in a partly integrated system of care (Level IV). The project will recruit and place a behavioral health provider in the primary care setting to provide patients with behavioral health services at their usual source of health care and will facilitate the coordination of care involving both primary and behavioral health. The project will focus on low behavioral health – low physical health complexity/risk (Quadrant I) and low behavioral health – high physical health complexity/risk (Quadrant III) of the Four Quadrant Model, which are most amendable to the primary care settings. This project will be structured to achieve level 4 (close collaboration in a partly integrated system, where providers share the same facility and share scheduling systems and medical records, and have regular face-to-face communication, functioning as a team), or preferably level 5, levels of interaction (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 or vice versa). The need for any legal agreements that may be needed in a collaborative practice will be explored for this project, and in addition necessary arrangements will be made for facilities to achieve this service integration.

Along with the co-location of services, protocols, training, and team building will be implemented to improve communications and enhance coordination of care to deliver care that meets the needs of the whole person. Finally, through project MS1 (UT Health Regional Systems Engineering Center and UT Health Quality Improvement Dashboard Development Center), the systems engineering and QI teams at UT Health will identify QI targets and methods needed to achieve continuous quality improvement for this project, especially as it relates to identifying challenges for expansion, and building on lessons learned.

Goal and Relationship to Regional Goals:
Project Goal:
Integrate primary care and behavioral health care services in order to improve care and access to needed services.
This project addresses the following regional goal:
Provision of both physical and behavioral health services in one location will make care more accessible to patients in a convenient location, and this relates to one of the goals of the region which is to "develop a regional approach to health care delivery that leverages and

improves on existing programs and infrastructure, is responsive to patient needs throughout the entire region, and improves health care outcomes and patient satisfaction".

Challenges:

Need: 1) Insufficient access to integrated care programs for behavioral health and physical health conditions. 2) Inadequate access to behavioral health care. 3) High rates of tobacco use and excessive alcohol use.

Implementation: 1) Motivation and ability of primary care and behavioral health teams to work together. 2) Patient awareness about service availability.

Despite high indicators of need, patients experience barriers in accessing behavioral health servcices, such as the stigma attached to mental health facilities and the inconvenience of adding another visit to their health care regimen. The integration of behavioral and primary care in this project enables patients to access coordinated efficient care in a convenient and less-stigmatized setting. Primary care providers will be trained to consult with and direct patients that may need behavioral health care services to the behavioral health provider. The behavioral health provider will have access to the patients records and be trained to consult with and direct patients to the primary care provider that may warrant further primary care services, or screenings. Patients will be able to address both behavioral health needs and primary care needs in a single visit.

5-Year Expected Outcome for Provider and Patients:

Attainment of a level 4 or 5 integration level in primary care and behavioral health will help to achieve optimal patient outcomes. This will lead to increased screening and better management of depression in the population served by UT Physicians and better health overall. In addition to benefiting the current Medicaid (23% as of 2011, or 65,302 patient visits) and low-income client base of UTP clinics, the program will be available to an additional 1,423,176 Medicaid and Medicaid-eligible residents living within the service areas of the UT Physician Clinics. In FY 2012, UTP provided 321,716 patient visits and expects to add another 80,000 (most, of which are expected to be Medicaid clients) primary and specialty patient visits (not counting behavioral health) by DY5 for over 400,000 patient visits.

Starting Point/Baseline:

To be determined during DY3.

Rationale:

Patients will be able to receive care that is more convenient (located within their community and in a clinic offering extended hours), coordinated (ability to address both conditions in a single visit), and in a setting that reduces the stigma of receiving behavioral health services, since it is located within the primary care setting. The Health of Houston Survey, 2010, reported that 9% of residents did not see a behavioral health professional, even though they felt it was needed. The integration of behavioral health into the primary care setting will help to address the reasons care was not sought by the 31% that felt uncomfortable about it, the 22% that was concerned that someone would find out, the 17% that had trouble getting an appointment, and the 59% that were concerned about the cost. The primary care setting can provide increased continuity of care for behavioral health care problems, often occuring over extended periods of time, with symptoms that range from well-controlled to severe.

Project Components:

Through the Integrated Primary and Behavioral Health Care Services Program, we propose to meet all required project components listed below.

1. UTP will identify sites for integrated care projects, which would have the potential to benefit a significant number of patients in the community.
2. UTP will develop provider agreements whereby co-scheduling and information sharing between physical health and behavioral health providers could be facilitated. UTP will also develop any necessary legal agreements that may be needed in a collaborative practice.
3. Also, protocols and processes for communication, data sharing, and referral between behavioral and physical health providers will be established that will include:
    a. Regular consultative meetings between physical health and behavioral health practitioners,
    b. Case conferences on an individualized as-needed basis to discuss individuals served by both types of practitioners, and/or
    c. Shared treatment plans co-developed by both physical health and behavioral health practitioners.
4. UTP will recruit specialty providers (mental health and substance abuse) and support staff to provide mental health services in the primary care clinics.
5. UTP will train physical and behavioral health providers in protocols, effective communication and team approach.
6. UTP will acquire the necessary data reporting, communication and collection tools (equipment) to be used in the integrated setting.
7. UTP will develop and implement data collection and reporting mechanisms and standards to track the utilization of integrated services as well as the health care outcomes of individual treated in these integrated service settings.
8. UTP's quality improvement office will conduct QI for each of the clinics providing specialty care using methods such as rapid cycle improvement.

Milestones and Metrics:

For the Integrated Primary and Behavioral Health Care Services Program, we have chosen the below milestones and metrics based upon the above project components and relationship to project goals and population needs. All baselines and goals will be determined during DY2.

Process Milestones and Metrics:

Milestone 1 [P-2.]: Identify existing clinics or other community-based settings where integration could be supported. It is expected that physical health practitioners will share space in existing behavioral health settings, but it may also be possible to include both in new settings or for physicians to share their office space with behavioral health practitioners.

Metric 1 [P-2.1.]: Discussions/Interviews with community healthcare providers (physical and behavioral), city and county governments, charities, faith-based organizations and other community based helping organizations.

Milestone 3 [P-5.]: Develop integrated sites reflected in the number of locations and providers participating in the integration project:

Metric 1 [P-5.1.]: Number of agreements signed for the provision of integrated services

Metric 2 [P-5.2.]: Number of primary care providers newly located in behavioral health settings.

Metric 3 [P-5.3.]: Number of behavioral health providers newly located in primary care clinics.

Improvement Milestones and Metrics:

Milestone 4 [I-8.]: Integrated Services

Metric 1 [I-8.1.]: X% of Individuals receiving both physical and behavioral health care at the established locations.

Milestone 5 [I-9.]: Coordination of Care

Metric 1 [I-9.1.]: X% of Individuals with a treatment plan developed and implemented with primary care and behavioral health expertise

Unique community need identification numbers the project addresses:

This project addresses community needs CN.3 (Inadequate access to behavioral health care), CN.12 (High rates of tobacco use and excessive alcohol use), and CN.18 (Insufficient access to integrated care programs for behavioral health and physical health conditions).

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

This project represents a new initiative. UT Physicians does not currently provide behavioral health care at its 4 outlying (outside the TMC) clinics. UT Physicians will hire behavioral health providers to work with primary care providers to provide comprehensive and integrated care for patients in these 4 clinics, which serve areas that include large populations with economic, cultural, language, and transportation barriers to receiving care.

Related Category 3 Outcome Measure(s):

OD-1 Primary Care and Chronic Disease Management

- IT-1.8 Depression management: Screening and Treatment Plan for Clinical Depression (PQR 2011, #134) (Non- standalone measure)
  Numerator: Patient's screening for clinical depression using a standardized tool AND follow-up plan is documented.

OD-1 Primary Care and Chronic Disease Management

- IT-1.9 Depression management: Depression Remission at Twelve Months (NQF# 0710) (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.
  Exclusions: 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.

Relationship to other Projects:

1.1 (C3) - Expanded primary care services will ensure there is reserve capacity to handle the increased collaboration necessary for integration physical health care with behavioral health care in the primary care setting.

1.2 (A2, SPH1) - Structured educational training for health care providers on team-based models of care will equip physicians and CHWs with the knowledge and skills to deliver this integrated model of care.
1.3 (C12) - The disease management registries will be a useful tool for the integrated care team in providing appropriate care for patients managing chronic diseases.
1.6 (C11) - The nurse triage line will provide 24/7 access to care for patients receiving both behavioral and physical health care.
1.7 (A1) - The telemedicine program will provide greater access for patients to their care providers (behavioral, primary and specialty care) when needed, particularly when distance is a barrier.
1.9 (C4) - The expansion of specialty services in the primary care setting will help to ensure that patients receiving integrated care will also have access to other specialty care when necessary in the same care setting.
2.1 (C1-2) - Patients receiving the integrated model of behavioral and physical health care will be enrolled in the UT Health Medical Homes.
2.2 (C5-9,CL3) - Patients with chronic diseases receiving the integrated model of behavioral and physical health care, will also received evidence-based care for their chronic disease. UTHealth will be using Wagner's chronic disease management model to manage chronic disease.
2.11 (C10) - The medication management program will be an integral component in the provision of integrated behavioral and physical health care.

Relationship to Other Performing Providers' Projects in the RHP:

The cohabitation of primary care and behavioral health is an important focus of our region in order to treat the patient base with comprehensive physical and behavioral healthcare issues. There are multiple initiatives in our RHP plan that address this need and all can be found on the Region 3 Initiative Grid in the addendums. The outcome measures focused to screening measures and access of the patient base.

Plan for Learning Collaborative:

UTHealth will participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system.

Project Valuation:

The anchor, Harris Health, provided a spreadsheet which contained 6 criteria, which could be used to rate each project on a 10-point scale. The ratings for each criterion were weighted, summed for each project to arrive at a total score (value weight) for each project. The sum of all the project's total scores were then divided by the percent of total DSRIP funds to be secured for that year to arrive at a dollar value multiplier to be applied towards each project's total score (value weight), thereby allocating a greater proportion of the funds towards those projects valued highest based upon the 6 criteria. UTHealth used this approach, with one exception—we did not use two of the criteria. Following are the criteria, the considerations for awarding points for projects using that criteria, and the reasons two of the criteria were not used:

1. Transformational Impact (Weight = 20%): Points were awarded for projects that meet the community benefit criteria, such as: improving access; improving quality; improving costs (long-term cost-savings); transformative (Innovative), collaborative (partners with other organization(s)). This project's score for this criterion: **5**

2. Population Served/Project Size (Weight = 20%): Points were awarded based on the size of the population affected and whether the target population is uninsured or on Medicaid. This project's score for this criterion: **2**

3. Aligned with Community Needs (Weight = 20%): Points were awarded based on judgments in two categories: whether or not the CNA indicates a need in the area of the project and the severity of the health/healthcare need(s) the project addresses. This project's score for this criterion: 111810101.2.7 X 2 = **7**

4. Cost Avoidance (Weight = 15%): Points were awarded based on judgment of project's cost effectiveness relative to similar projects. This project's score for this criterion: **2**

5. Partnership/Collaboration (Weight = 10%): ***This was not rated***, because UTHealth planned to partner with Harris Health to perform many similar projects, so the rating would have been the same for all projects. This would have diluted the scores, hiding the more significant variations in other value criteria.

6. Sustainability (Weight = 15%): ***This was also not rated***, because UTHealth does not consider any of the projects to be unsustainable, or at the very least do not consider one project less sustainable than another. Giving the projects the same, or very similar ratings on this criteria again would have had a diluting effect, hiding the more significant variations in other value criteria.

Total Valuation Score for this project: **3.1**

111810101.2.7	*2.15.1*	*A-J*	*C13 INTEGRATED PRIMARY AND BEHAVIORAL HEALTH CARE SERVICES*
UTHealth, UTPhysicians			*111810101*
Related Category 3 Outcome Measure(s):	*111810101.3.24* *111810101.3.25*	*IT-1.8* *IT-1.9*	*Depression management: Screening and Treatment Plan for Clinical Depression (PQR 2011, #134) (Non- standalone measure)* *Depression management: Depression Remission at Twelve Months (NQF# 0710) (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.]: Identify existing clinics or other community-based settings where integration could be supported. It is expected that physical health practitioners will share space in existing behavioral health settings, but it may also be possible to include both in new settings or for physicians to share their office space with behavioral health practitioners. Metric 1 [P-2.1.]: Discussions/Interviews with community healthcare providers (physical and behavioral), city and county governments, charities, faith-based organizations and other community based helping organizations. Baseline/Goal: TBD Data Source: Information from persons interviewed Milestone 1 Estimated incentive payment: $ 2,969,321	**Milestone 3** [P-5.]: Develop integrated sites reflected in the number of locations and providers participating in the integration project Metric 1 [P-5.1.]: Number of agreements signed for the provision of integrated services Baseline/Goal: TBD Data Source: Project data Metric 2 [P-5.2.]: Number of primary care providers newly located in behavioral health settings. Baseline/Goal: TBD Data Source: Project data Metric 3 [P-5.3.]: Number of behavioral health providers newly located in primary care clinics. Baseline/Goal: TBD Data Source: Project data Milestone 3 Estimated incentive payment: $ 3,348,858	**Milestone 4** [I-8.]: Integrated Services Metric 1 [I-8.1.]: X% of Individuals receiving both physical and behavioral health care at the established locations. Goal: TBD Data Source: Project data; claims and encounter data; medical records Milestone 4 Estimated incentive payment: $ 3,482,813	**Milestone 5** [I-9.]: Coordination of Care Metric 1 [I-9.1.]: X% of Individuals with a treatment plan developed and implemented with primary care and behavioral health expertise Goal: TBD Data Source: Project data; claims and encounter data; medical records Milestone 5 Estimated incentive payment: $ 3,333,974

111810101.2.7	***2.15.1***	***A-J***	***C13 Integrated Primary and Behavioral Health Care Services***
UTHealth, UTPhysicians			*111810101*
Related Category 3 Outcome Measure(s):	*111810101.3.24* *111810101.3.25*	*IT-1.8* *IT-1.9*	*Depression management: Screening and Treatment Plan for Clinical Depression (PQR 2011, #134) (Non- standalone measure)* *Depression management: Depression Remission at Twelve Months (NQF# 0710) (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: $2,969,321	Year 3 Estimated Milestone Bundle Amount: $3,348,858	Year 4 Estimated Milestone Bundle Amount: $3,482,813	Year 5 Estimated Milestone Bundle Amount: $3,333,974
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*:* $13,134,966			

The University of Texas Health Science Center - Houston

Pass 3

Project Option 2.15.1- 2.15 Integrate Primary and Behavioral Health Care Services: Integrated Primary and Behavioral Health Care Services for Children and Adolescents

Unique RHP Project ID: 111810101.2.8
Performing Provider Name/TPI: UTHealth, UTPhysicians / 111810101

Project Summary:

Provider:
UT Physicians is the clinical practice of The University of Texas Medical School at Houston. With more than 900 physicians certified in 80 medical specialties and subspecialties, 906 residents and fellows, and 283,920 patient visits in 2011, it is the fastest growing academic practice in the nation for the last five years. In addition to our flagship location in the Texas Medical Center, UT Physicians has 4 neighborhood locations throughout the Greater Houston area, and also offers specialty clinics at several Memorial Hermann Hospital locations.

Intervention(s):
UT Health will design, implement and evaluate a project that will integrate primary and behavioral healthcare services for children and adolescents within UT Physicians' clinics to achieve a close collaboration in a partly integrated system of care (Level IV). A pediatric behavioral health provider will be placed in the primary care setting to children and adolescents with behavioral health services at their usual source of health care. This will facilitate care coordination between primary and behavioral healthcare.

Need for the project:
20% of children either have, or will have a debilitating mental disorder and about 13% of children ages 8 to 15 had a diagnosable mental disorder within the previous year, though only half received any treatment. This project addresses several community needs including inadequate access to behavioral health care.

Target Population:
The service areas of our 4 outlying clinics include health professional shortage areas, and medically underserved areas and populations. Using the Harris County rate (14.5%) of Medicaid clients, there are an estimated 1,423,176 Medicaid clients living within our service areas.

Category 1 or 2 expected patient benefits:
Our goal in DY4 will be to increase the percentage of children/adolescents receiving both physical and behavioral health care at the established locations, and by DY5 to increase the percent of children/adolescents with a treatment plan developed and implemented with primary care and behavioral health expertise.

Category 3 outcomes:
Our goal is the reduce the number of days to third next available appointment to two days for a pediatric behavioral health appointment (IT-1.1) and to increase by 5% in DY5 the number of patients ages 6-18 who complete at least 84 days of continuous treatment with an antidpressant medication during the 114-day acute phase treatment period folloing the IPSD and who complete at least 180 days of continuoust treatment with antidepressant medication during the 231-day continuation phase following the IPSD (IT-1.19).

Project Option 2.15.1 – Integrate Primary and Behavioral Health Care Services: Integrated Primary and Behavioral Health Care Services for Children and Adolescents

Unique RHP Project Identification Number: 111810101.2.8
Performing Provider Name/TPI: UTHealth, UTPhysicians/111810101

Project Description: 2.15 Integrate Primary and Behavioral Health Care Services (Option 2.15.1)

UT Health will design, implement and evaluate a project that will integrate primary and behavioral health care services for children and adolescents within UT Physicians 4 outlying clinics and the pediatric specialty clinic in the Texas Medical Center in order to achieve a close collaboration in a partly integrated system of care (Level IV). The project will recruit and place a pediatric behavioral health provider in the 4 primary care settings and the 1 pediatric specialty care clinic to provide children and adolescents with behavioral health services at their usual source of health care and will facilitate the coordination of care involving both primary and behavioral health. For the 4 outlying clinics, the project will focus on low behavioral health – low physical health complexity/risk (Quadrant I) and low behavioral health – high physical health complexity/risk (Quadrant III) of the Four Quadrant Model, which are most amendable to the primary care settings. Quadrants II and IV will be included with Quadrants I and III for the pediatric specialty care clinic in the Texas Medical Center. This project will be structured to achieve level 4 interaction (close collaboration in a partly integrated system, where providers share the same facility and share scheduling systems and medical records, and have regular face-to-face communication, functioning as a team), or preferably level 5 interaction (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 or vice versa). The need for any legal agreements that may be needed in a collaborative practice will be explored for this project, and in addition necessary arrangements will be made for facilities to achieve this service integration.

Along with the co-location of services, protocols, training, and team building will be implemented to improve communications and enhance coordination of care to deliver care that meets the needs of the whole person. Finally, through project MS1 (UT Health Regional Systems Engineering Center and UT Health Quality Improvement Dashboard Development Center), the systems engineering and QI teams at UT Health will identify QI targets and methods needed to achieve continuous quality improvement for this project, especially as it relates to identifying challenges for expansion, and building on lessons learned.

Goal and Relationship to Regional Goals:
Project Goal:
Integrate primary care and behavioral health care services in order to improve care and access to needed services.

<u>This project addresses the following regional goal:</u>

Provision of both physical and behavioral health services in one location will make care more accessible to patients in a convenient location, and this relates to one of the goals of the region which is to "develop a regional approach to health care delivery that leverages and improves on existing programs and infrastructure, is responsive to patient needs throughout the entire region, and improves health care outcomes and patient satisfaction".

Challenges:

Need: 1) Insufficient access to integrated care programs for behavioral health and physical health conditions. 2) Inadequate access to behavioral health care. 3) High rates of tobacco use and excessive alcohol use.

Implementation: 1) Motivation and ability of primary care and behavioral health teams to work together. 2) Patient awareness about service availability.

Despite high indicators of need, parents of pediatric patients experience barriers in accessing behavioral health services, such as the stigma attached to mental health facilities and the inconvenience of adding another visit to their child's health care regimen. The integration of pediatric behavioral and primary care in this project enables parents of pediatric patients to access coordinated efficient care in a convenient and less-stigmatized setting. Primary care providers will be trained to consult with and direct patients that may need behavioral health care services to the pediatric behavioral health provider. The pediatric behavioral health provider will have access to the patients records and be trained to consult with and direct patients to the primary care provider that may warrant further primary care services, or screenings. Parents of pediatric patients will be able to address both behavioral health needs and primary care needs in a single visit.

5-Year Expected Outcome for Provider and Patients:

Attainment of a level 4 or 5 integration level in primary care and behavioral health will help to achieve optimal patient outcomes. This will lead to increased screening and better management of depression in the population served by UT Physicians and better health overall. In addition to benefiting the current Medicaid (23% as of 2011, or 65,302 patient visits) and low-income client base of UTP clinics, the program will be available to the pediatric population proportion of an additional estimated 80,000 patient visits expected as a result of UTP's primary and specialty care expansion.

<u>Starting Point/Baseline:</u>

To be determined during DY3.

<u>Rationale:</u>

According to the National Institute of Mental Health, 1 in 5 children (20%), either have, or will have a seriously debilitating mental disorder and data from the CDC's National Health and Nutrition Examination Survey showed that about 13% of children ages 8 to 15 had a "diagnosable mental disorder within the previous year," yet in the preceeding year, only half had received treatment for their disorder. (Merikangas KR, He JP, Merikangas KR, He J, Burstein M, Swanson SA, Avenevoli S, Cui L, Benjet C, Georgiades K, Swendsen J. Lifetime prevalence of mental disorders in U.S. adolescents: Results from the National Comorbidity Study-Adolescent Supplement (NCS-A). J Am Acad Child Adolesc Psychiatry. 2010 Oct;49(10):980-

989. http://www.nimh.nih.gov/statistics/1ANYDIS_CHILD.shtml) (Merikangas KR, He JP, Brody D, Fisher PW, Bourdon K, Koretz DS. Prevalence and treatment of mental disorders among US children in the 2001-2004 NHANES. Pediatrics. 2010, 125(1):75-81. http://www.nimh.nih.gov/statistics/1NHANES.shtml) By providing pediatric behavioral health services in the primary care setting, children and adolescents will be able to receive care that is more convenient for their parents (located within their community and in a clinic offering extended hours), coordinated (ability to address both conditions in a single visit), and in a setting that reduces the stigma surrounding behavioral health services, since it is located within the primary care setting.

Project Components:

Through the Integrated Primary and Behavioral Health Care Services Program, we propose to meet all required project components listed below.

9. UTP will identify sites for integrated care projects, which would have the potential to benefit a significant number of children/adolescents in the community.
10. UTP will develop provider agreements whereby co-scheduling and information sharing between physical health and behavioral health providers could be facilitated. UTP will also develop any necessary legal agreements that may be needed in a collaborative practice.
11. Also, protocols and processes for communication, data sharing, and referral between behavioral and physical health providers will be established that will include:
    a. Regular consultative meetings between physical health and behavioral health practitioners,
    b. Case conferences on an individualized as-needed basis to discuss individuals served by both types of practitioners, and/or
    c. Shared treatment plans co-developed by both physical health and behavioral health practitioners.
12. UTP will recruit specialty providers (pediatric mental health providers) and support staff to provide mental health services in the primary care clinics and in the pediatric specialty clinic.
13. UTP will train physical and behavioral health providers in protocols, effective communication and team approach.
14. UTP will acquire the necessary data reporting, communication and collection tools (equipment) to be used in the integrated setting.
15. UTP will develop and implement data collection and reporting mechanisms and standards to track the utilization of integrated services as well as the health care outcomes of individuals treated in these integrated service settings.
16. UTP's quality improvement office will conduct QI for each of the clinics providing specialty care using methods such as rapid cycle improvement.

Milestones and Metrics:

For the Integrated Primary and Behavioral Health Care Services Program, we have chosen the below milestones and metrics based upon the above project components and relationship to project goals and population needs. All baselines and goals will be determined during DY2.

<u>Process Milestones and Metrics</u>:

Milestone 1 [P-2.]: Identify existing clinics or other community-based settings where integration could be supported. It is expected that physical health practitioners will share space in existing behavioral health settings, but it may also be possible to include both in new settings or for physicians to share their office space with behavioral health practitioners.
Metric 1 [P-2.1.]: Discussions/Interviews with community healthcare providers (physical and behavioral), city and county governments, charities, faith-based organizations and other community based helping organizations.
Milestone 3 [P-5.]: Develop integrated sites reflected in the number of locations and providers participating in the integration project:
Metric 1 [P-5.1.]: Number of agreements signed for the provision of integrated services
Metric 3 [P-5.3.]: Number of pediatric behavioral health providers newly located in primary care clinics.

Improvement Milestones and Metrics:

Milestone 4 [I-8.]: Integrated Services
Metric 1 [I-8.1.]: X% of Individuals (children/adolescents) receiving both physical and behavioral health care at the established locations.
Milestone 5 [I-9.]: Coordination of Care
Metric 1 [I-9.1.]: X% of Individuals (children/adolescents) with a treatment plan developed and implemented with primary care and behavioral health expertise

Unique community need identification numbers the project addresses:

This project addresses community needs CN.3 (Inadequate access to behavioral health care) and CN.18 (Insufficient access to integrated care programs for behavioral health and physical health conditions).

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

This project represents a new initiative. UT Physicians does not currently provide pediatric behavioral health care at its 4 outlying (outside the TMC) clinics. UT Physicians will hire behavioral health providers to work with primary care providers to provide comprehensive and integrated care for pediatric patients in these 4 clinics and in the pediatric specialty clinic, which serve areas that include large populations with economic, cultural, language, and transportation barriers to receiving care.

Related Category 3 Outcome Measure(s):

OD-1 Primary Care and Chronic Disease Management
IT-1.1 Third next available appointment (Non- standalone measure)
Reduce the average length of time in days between the day a patient makes a request for an appointment with a physician and the third available appointment for a new patient physical, routine exam, or return visit exam.

OD-1 Primary Care and Chronic Disease Management
IT-1.19 Antidepressant Medication Management - NQF 0105 (Standalone measure)
The management of antidepressant medication in children ages 6-18 who were discharged alive) from an acute inpatient setting (including acute care psychiatric facilities) with a

principal mental health diagnosis: A) the acute phase treatment period consisting at least 84 days (12 weeks) of continuous treatment with antidepressant medication during the 114-day period following the IPSD (inclusive), and B) the continuation phase treatment period consisting of at least 180 days (6 months) of continuous treatment with antidepressant medication (Table AMM-D) during the 231-day period following the IPSD (inclusive).

Relationship to other Projects:

1.1 (C3) - Expanded primary care services will ensure there is reserve capacity to handle the increased collaboration necessary for integration physical health care with behavioral health care in the primary care setting.

1.2 (A2, SPH1) - Structured educational training for health care providers on team-based models of care will equip physicians and CHWs with the knowledge and skills to deliver this integrated model of care.

1.3 (C12) - The disease management registries will be a useful tool for the integrated care team in providing appropriate care for patients managing chronic diseases.

1.6 (C11) - The nurse triage line will provide 24/7 access to care for patients receiving both behavioral and physical health care.

1.7 (A1) - The telemedicine program will provide greater access for patients to their care providers (behavioral, primary and specialty care) when needed, particularly when distance is a barrier.

1.9 (C4) - The expansion of specialty services in the primary care setting will help to ensure that patients receiving integrated care will also have access to other specialty care when necessary in the same care setting.

2.1 (C1-2) - Patients receiving the integrated model of behavioral and physical health care will be enrolled in the UT Health Medical Homes.

2.2 (C5-9,CL3) - Patients with chronic diseases receiving the integrated model of behavioral and physical health care, will also received evidence-based care for their chronic disease. UTHealth will be using Wagner's chronic disease management model to manage chronic disease.

2.11 (C10) - The medication management program will be an integral component in the provision of integrated behavioral and physical health care.

Relationship to Other Performing Providers' Projects in the RHP:

The cohabitation of primary care and behavioral health is an important focus of our region in order to treat the patient base with comprehensive physical and behavioral healthcare issues. There are multiple initiatives in our RHP plan that address this need and all can be found on the Region 3 Initiative Grid in the addendums. The outcome measures focused to screening measures and access of the patient base.

Plan for Learning Collaborative:

UTHealth will participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system.

Project Valuation:

The anchor, Harris Health, provided a spreadsheet which contained 6 criteria, which could be used to rate each project on a 10-point scale. The ratings for each criterion were weighted, summed for each project to arrive at a total score (value weight) for each project. The sum of all the project's total scores were then divided by the percent of total DSRIP funds to be secured for that year to arrive at a dollar value multiplier to be applied towards each project's total score (value weight), thereby allocating a greater proportion of the funds towards those projects valued highest based upon the 6 criteria. UTHealth used this approach, with one exception—we did not use two of the criteria. Following are the criteria, the considerations for awarding points for projects using that criteria, and the reasons two of the criteria were not used:

1. Transformational Impact (Weight = 20%): Points were awarded for projects that meet the community benefit criteria, such as: improving access; improving quality; improving costs (long-term cost-savings); transformative (Innovative), collaborative (partners with other organization(s)). This project's score for this criterion: **5**

2. Population Served/Project Size (Weight = 20%): Points were awarded based on the size of the population affected and whether the target population is uninsured or on Medicaid. This project's score for this criterion: **2**

3. Aligned with Community Needs (Weight = 20%): Points were awarded based on judgments in two categories: whether or not the CNA indicates a need in the area of the project and the severity of the health/healthcare need(s) the project addresses. This project's score for this criterion: 111810101.2.7 X 2 = **7**

4. Cost Avoidance (Weight = 15%): Points were awarded based on judgment of project's cost effectiveness relative to similar projects. This project's score for this criterion: **2**

5. Partnership/Collaboration (Weight = 10%): ***This was not rated***, because UTHealth planned to partner with Harris Health to perform many similar projects, so the rating would have been the same for all projects. This would have diluted the scores, hiding the more significant variations in other value criteria.

6. Sustainability (Weight = 15%): ***This was also not rated***, because UTHealth does not consider any of the projects to be unsustainable, or at the very least do not consider one project less sustainable than another. Giving the projects the same, or very similar ratings on this criteria again would have had a diluting effect, hiding the more significant variations in other value criteria.

Total Valuation Score for this project: **3.1**

111810101.2.8	***2.15.1***	***A-J***	***INTEGRATED PRIMARY AND BEHAVIORAL HEALTH CARE SERVICES***
UTHealth, UTPhysicians			*111810101*
Related Category 3 Outcome Measure(s):	*111810101.3.31* *111810101.3.32*	*IT-1.1* *IT-1.19*	*Third next available appointment (Non- standalone measure)* *Antidepressant Medication Management - NQF 0105 (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.]: Identify existing clinics or other community-based settings where integration could be supported. It is expected that physical health practitioners will share space in existing behavioral health settings, but it may also be possible to include both in new settings or for physicians to share their office space with behavioral health practitioners. Metric 1 [P-2.1.]: Discussions/Interviews with community healthcare providers (physical and behavioral), city and county governments, charities, faith-based organizations and other community based helping organizations. Baseline/Goal: TBD Data Source: Information from persons interviewed Milestone 1 Estimated incentive payment: $ 3,711,650	**Milestone 3** [P-5.]: Develop integrated sites reflected in the number of locations and providers participating in the integration project Metric 1 [P-5.1.]: Number of agreements signed for the provision of integrated services Baseline/Goal: TBD Data Source: Project data Metric 3 [P-5.3.]: Number of behavioral health providers newly located in primary care clinics. Baseline/Goal: TBD Data Source: Project data Milestone 3 Estimated incentive payment: $ 4,186,076	**Milestone 4** [I-8.]: Integrated Services Metric 1 [I-8.1.]: X% of Individuals receiving both physical and behavioral health care at the established locations. Goal: TBD Data Source: Project data; claims and encounter data; medical records Milestone 4 Estimated incentive payment: $ 4,353,516	**Milestone 5** [I-9.]: Coordination of Care Metric 1 [I-9.1.]: X% of Individuals with a treatment plan developed and implemented with primary care and behavioral health expertise Goal: TBD Data Source: Project data; claims and encounter data; medical records Milestone 5 Estimated incentive payment: $ 4,167,468
Year 2 Estimated Milestone Bundle Amount: $3,711,650	Year 3 Estimated Milestone Bundle Amount: $4,186,076	Year 4 Estimated Milestone Bundle Amount: $4,353,516	Year 5 Estimated Milestone Bundle Amount: $4,167,468
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*:* $16,418,710			

University of Texas M.D. Anderson Cancer Center

Pass 1

Project Option 2.7.1 – Implement innovative evidence-based strategies to increase appropriate use of technology and testing for targeted populations (e.g., mammography screens, colonoscopies, prenatal alcohol use, etc.): Colorectal cancer (CRC) screening program for low-income residents of RHP3.

Unique RHP Project ID: 112672402.2.1

Performing Provider Name/TPI: The University of Texas MD Anderson Cancer Center / 112672402

Project Summary:

Provider: The University of Texas MD Anderson Cancer Center is a comprehensive cancer center ranked first in cancer care by *U.S. News & World Report* and dedicated to patient care, education, research and prevention. MD Anderson is comprised of several Texas Medical Center campus locations, two research campuses in Bastrop County, Texas, four regional care centers and a number of national and international divisions and affiliates. More than 108,000 people—almost one-third of them new patients—were seen in FY2011. MD Anderson provided $215 million in uncompensated charity care to Texans in FY2011.

Intervention(s): This project will expand a two-year Colorectal Cancer (CRC) screening program in Federally Qualified Health Centers (FQHCs) in Harris County into other RHP3 counties. This project targets low-income and underinsured populations with the intent of increasing adherence by distributing Fecal Immunochemical Test (FIT) take-home tests at the time of annual flu innoculation. Patients will receive a FIT test with verbal and written instructions on how to complete the test, brief verbal messages reinforcing the importance of screening (e.g., "an annual FOBT (FIT) test is as important as an annual flu shot"), educational materials, and clinic phone numbers should questions arise.

Need for the project: **A)** This program relates to the identified Community Needs in RHP3: CN.2-Inadequate access to specialty care; CN.11-High rates of chronic disease and inadequate access to treatment programs and services for illnesses associated with cancer; CN.20-Lack of access to programs providing health promotion education, training and support, including screenings, nutrition counseling, patient education programs; CN.22-Insufficient access to services that are specifically designed to address racial, ethnic and cultural health care disparities; CN.23-Lack of patient navigation, patient and family education and information programs. **B)** There is a multi-county need as data from the 2010 Behavioral Risk Factor Surveillance indicates that in Public Health Administrative Region 6/5S, only 38.6% of adults 50 years and older reported having ever had a sigmoidoscopy or colonoscopy in the past 5 years, and 13.9% reported annual fecal occult blood testing. This is well below the ACS' 2015 goal of 75% of all adults over 50 having a recent CRC screening test.

Target Population: Indigent and Medicaid patients, aged 50 years and older, who, in accordance with the U.S. Preventive Services Task Force recommendations, qualify for CRC screening.

Category 1 or 2 expected patient benefits: The DY4 goal is to increase the number in the target population receiving FIT by 5% over DY3. The DY5 goal is to increase number of target population receiving FIT by 5% over DY4.

Category 3 outcomes: **IT-11.3**: Improve utilization rates of clinical preventive services (CRC screening) in target population with identified disparity – Number of individuals of target population reached by the FIT/Flu project. **IT-12.3**: Colorectal Cancer Screening (HEDIS 2012): Number of adults aged 50 -75 who have received one of the following screenings: Fecal occult blood test yearly, flexible sigmoidoscopy every five years, and colonoscopy every 10 years.

Project Option 2.7.1 – Implement innovative evidence-based strategies to increase appropriate use of technology and testing for targeted populations (e.g., mammography screens, colonoscopies, prenatal alcohol use, etc.): Colorectal cancer (CRC) screening program for low-income residents of RHP3

Unique RHP Project Identification Number: 112672402.2.1
Performing Provider Name/TPI: The University of Texas MD Anderson Cancer Center / 112672402

Project Description:
We propose to implement a FIT-Flu program in RHP3 targeting low-income and underinsured populations with the intent of increasing adherence with this screening method.

We selected the FIT test because it requires less patient preparation compared with FOBT. An evidence-based intervention developed by Dr. Michael Potter at the University of California at San Francisco (UCSF), the FIT/Flu combines the distribution of either FOBT or FIT tests with annual flu inoculations. The FIT test analyzes specific antibodies to human blood components, and thus does not require patients to follow any dietary or medication restrictions. The FIT-Flu intervention involves offering patients who undergo annual flu inoculations a stool test to take home and return via mail in a postage-paid envelope.

This intervention has demonstrated significant increases in screening adherence across diverse patient populations and settings. Study settings included community clinics that served multiethnic and low income populations with low baseline CRC screening rates, as well as retail chain pharmacies where flu shots are typically offered. In a study involving annual flu shot clinics, there was a significant increase in FIT adherence over baseline in the FIT-Flu intervention group (from 54.4% to 84.3%) versus a control group that received only CRC screening education (from 52.9% to 57.3%).[1] More modest increases in adherence were achieved in a study involving primary care clinics, with the intervention group increasing from 32.5% to 45.5% versus the control group which rose from 31.3% to 35.6%.[2]

The success of this intervention may be attributed to even this brief interaction between clinician and patient at the time of flu inoculation, as it offers a "teachable moment" to reinforce the need for regular screening. Studies provide consistent evidence that a FIT-Flu intervention is a practical strategy with high potential to increase CRC screening adherence in community clinic settings. Furthermore, evidence generated by these studies indicates a strong likelihood of successful replication in real world, non-controlled settings.

This project expands a currently ongoing two year FIT/Flu initiative in Federally Qualified Health Centers (FQHCs) in Harris County in other RHP3 counties. We will reach indigent and Medicaid patients, age 50 years and older, who, in accordance with the U.S. Preventive Services Task Force (USPSTF) recommendations, qualify for CRC screening.[3] Our exclusion criteria include the following:

- Allergic to flu vaccine or refusal to receive a flu inoculation
- Active inflammatory bowel disease (Crohn's, ulcerative colitis)
- Visible rectal bleeding
- Hematuria

- Menstruation at the time of obtaining a stool specimen
- A positive FOBT or FIT test in the past 12 months
- A colonoscopy or sigmoidoscopy within the past 5 years
- A medical condition that would preclude any benefit from OC (cancer or any terminal illness)
- Inability to prepare a stool specimen
- Patient with an ileostomy or colostomy
- Symptomatic acute colitis or acute diarrhea
- Recent acute diverticulitis
- Recent colorectal surgery

Patients in our project will receive a FIT with verbal and written instructions on how to complete the test, brief verbal messages reinforcing the importance of screening (e.g., "an annual FOBT (FIT) test is as important as an annual flu shot"), educational materials, and clinic phone numbers should questions arise. We anticipate receiving 50% return of stool specimens for processing, of which approximately 15% (published ranges of 8-14%) may be positive.[4-5] Patients with positive FIT tests will be referred for optical colonoscopy. Endoscopy providers will be contracted to provide these services. Uninsured individuals diagnosed with cancer will be navigated to Harris Health Systems or other providers.

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

The goal of this project is utilize an evidence based approach in RHP3 FQHC clinics and other primary care offices to increase CRC screening by distributing the take-home FIT test at the time of flu inoculation. Patient Navigators will follow-up those patients who do not return the FIT to encourage them to do so and will navigate those patients with positive FIT results to screening colonoscopy. Culturally sensitive educational and instructional materials will be distributed to increase patient knowledge about CRC and the importance of early screening. We will partner with the American Cancer Society (ACS) to offer professional education and support material to assist primary care physicians in providing appropriate CRC screening recommendations to their patient population.

Project Goals:

- Reduce the incidence and mortality of colorectal cancer in the indigent and Medicaid population through the increased use of a low-cost stool test for the early detection of adenomas and cancers.
- Increase target population's knowledge about the risk factors and screening guidelines for CRC.
- Increase the use of appropriate CRC screening in the primary care setting.
- This project meets the following Region 3 goals:
- Increase access to primary and specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their condition, regardless of where they live or their ability to pay.

The FIT-Flu program aims to reduce the incidence and mortality of colorectal cancer by offering a process to dispense CRC screening in the primary care setting. This project will be implemented in FQHCs in RHP3 and is an extension of an existing program in Harris County FQHCs.

Challenges:

According to the Agency for Healthcare Research and Quality (AHRQ), only about half of all adults aged 50-75 have ever received age-appropriate colorectal cancer (CRC) screening, and the proportion of minority populations who have ever been screened is reported to be approximately 30%.[6] The Texas Cancer Registry indicates that 44.5% of adults reported having sigmoidoscopy or colonoscopy in the past 5 years, and 14.1% reported annual FOBT. [7] Various public education campaigns and strategies have been attempted to increase CRC screening rates in the underserved and underinsured populations, but poor adherence with stool tests, especially in the uninsured, remains a significant barrier to effective CRC screening.

Barriers to CRC screening reported by patients include practical issues such as being too busy, a lack of access to providers, the cost of the exam, being asymptomatic, embarrassment, and fear of finding polyps or cancer.[8] Other important barriers to implementing CRC screening in primary care practice settings include patients' lack of awareness of their risk for developing CRC and/or a lack of knowledge of screening options, particularly among poor and underserved populations.[9-13] Incomplete follow-up of positive FOBT results is another issue, as primary care physicians often fail to recommend optical colonoscopy to patients with positive FOBT results.[14-18]

The challenge of improving CRC screening adherence is even greater in large primary care practices, where time and resource limitations reduce the likelihood that physicians are able to adequately discuss CRC screening with their patients.[19] In a study by Wolf, only 9% of age-eligible patients at thirty-one Federally Qualified Health Centers (FQHCs) received a CRC screening recommendation from their physician and only 7% were adherent to screening, primarily through FOBT.[19] Difficulties cited include prioritization, time, resources, complexity of referral, and perceived acceptance of screening tests.[21] This project will include a culturally sensitive educational program on CRC for patients, as well as professional training on the importance and appropriate use of CRC screening in a primary care setting.

5-Year Expected Outcome for Provider and Patients:

It is expected that this project in DY2 – DY5 would:

- Increase the use of FIT as first-line CRC screening in the primary care setting.
- Increase patient knowledge regarding colorectal cancer incidence and available screening tools.
- Increase appropriate use of CRC screening modalities in primary care practice.

Starting Point/Baseline:

There is a multi-county need as data from the 2010 Behavioral Risk Factor Surveillance indicates that in Public Health Administrative Region 6/5S, only 38.6% of adults 50 years and older reported having ever had a sigmoidoscopy or colonoscopy in the past 5 years, and 13.9% reported annual fecal occult blood testing.[22] This is well below the ACS' 2015 goal of 75% of all adults over 50 having a recent CRC screening test.[39] The baseline for all milestones and metrics will be set at 0 as currently there are no programs to distribute FIT tests at the time of flu vaccination in the RHP3 counties beyond Harris County.

Rationale/Reason for selecting the program option:

CRC screening has been shown to save lives.[23] Screening prevalence is lower among people aged 50 to 64 compared to those 65 years and older, and is especially low among those who are non-white, who have fewer years of education, who lack health insurance coverage, and who are recent immigrants. [24] The 2010 National Healthcare Quality and Disparities Report indicates that Hispanics/Latinos undergo CRC screening at rates lower than African Americans and Whites, and thus are at great risk for presenting with late-stage disease at diagnosis.[25] Improving CRC screening in clinics serving indigent and Medicaid patients is a priority need, as these clinics are the primary source of care for a disproportionately high number of African American and Hispanic/Latino patients.[25] Low levels of knowledge about this topic have been linked with inaccurate CRC risk perceptions and low utilization of screening services. [26-33] The primary reason patients do not return FOBTs is that they do not believe they need screening if they have no symptoms of CRC. [12 -15, 34-35] These data underscore the need to implement innovative screening strategies.

Project Components:

Through the FIT-Flu Program, we propose to meet all required project components listed below and believe that the selected milestones and metrics relate to the project components:

a) Increase recommended CRC screening by means of an evidence based process to reach eligible patients unscreened for CRC and by offering professional education to assist primary care physicians in providing appropriate CRC screening recommendations to their patient population.
b) Establish collaborative partnerships with community organizations to ensure culturally competent patient education materials are disseminated and evidence based health professional training is utilized.
c) Educate patients on the risk factors and screening recommendations for CRC.
d) Increase access to CRC screening.
e) Conduct quality improvement using methods evaluate the ongoing effectiveness of the program.

Milestones & Metrics:

The following milestones and metrics have been chosen for the FIT-Flu Project based on the needs of the target population.

- Process Milestones and Metrics: P-1 [P-1.1]; P-2 [P-2.1]; P-4 [P-4.1]; P-X [P-X.1]; P-7[P-7.1]
- Improvement Milestones and Metrics: l-7 [l-7.1] [l-7.2] [l-7.3]

Customizable Process Milestones and Metrics were chosen to specifically tailor their intent to the project process.

Unique community need identification number the project addresses:

The project addresses the following unique community needs, as identified in the community needs assessment:

- CN.2 Inadequate access to specialty care.
- CN.11 High rates of chronic disease and inadequate access to treatment programs and services for illnesses associated with chronic disease, including cancer, diabetes obesity, cardiovascular disease, asthma, and AIDS/HIV.
- CN.20 Lack of access to programs providing health promotion education, training and support, including screenings, nutrition counseling, patient education programs.
- CN.22 Insufficient access to services that are specifically designed to address racial, ethnic and cultural health disparities.

- CN.23 Lack of patient navigation, patient and family education and information programs.

How the project represents a new initiative for the Performing Provider or significantly enhances an existing delivery system reform initiative:
This project will expand an existing FIT/Flu initiative in Federally Qualified Health Centers (FQHCs) in Harris County, extending this project into other RHP3 counties not currently served by this initiative. Additionally, the existing Harris County project would be included in DY4 and DY5, extending this project an additional two years.

Related Category 3 Outcome Measure(s):
OD-11 Addressing Health Disparities in Minority Populations
IT-11.3 Improve utilization rates of clinical preventive services (CRC screening) in target population with identified disparity. (Non-standalone measure)
a. Numerator: Number of individuals of target population reached by the FIT/Flu project
b. Denominator: Number of individuals in the target population
c. Data Source: Documentation of target population reached, as designated in the project plan
d. Rationale/Evidence: FIT-Flu intervention is a practical strategy with high potential to increase CRC screening adherence in community clinic settings. Individuals with low SES and minorities are more likely to die from colon cancer than those at higher SES levels
OD-12 Primary Care and Primary Prevention
IT-12.3 Colorectal Cancer Screening (HEDIS 2012)

a. Numerator: Number of adults aged 50 to 75 who have received one of the following screenings: Fecal occult blood test yearly, Flexible sigmoidoscopy every five years, and colonoscopy every 10 years
b. Denominator: Number of adults aged 50 to 75 in the patient or target population. Adults with colorectal cancer or total colectomy are excluded.
c. Data Source: Data Source: Clinic EMR Rationale/Evidence: CRC is often curable if detected in its early stages but often fatal when diagnosed later. According to the Surveillance, Epidemiology and End Results (SEER) Program, patients diagnosed with Stage 1 disease (localized to the bowel wall) have a 90.1% 5-year survival rate compared to those with Stage 4 disease (distant metastases) who have an 11.7% 5-year survival rate.[36] Similar data are found in Texas with localized CRC showing an 88.1% 5-year survival and distant disease yielding a 13.2% 5-year survival. 37 CRC screening has been shown to save lives.[23] The United States Preventive Services Task Force (USPSTF) recommends the following CRC screening options for persons age 50-75 who are at average risk for the disease: (1) annual fecal occult blood testing (FOBT) using high-sensitivity stool guaiac tests or fecal immunochemical tests (FIT), (2) flexible sigmoidoscopy every 5 years plus FOBT or FIT every three years, or (3) optical colonoscopy every 10 years.

Reasons/Rationale for selecting the outcome measure(s):
One major goal outlined in NCI's Strategic Plan is to overcome disparities across the cancer control continuum from disease prevention to end-of-life care by studying and identifying factors contributing to disparities, developing culturally appropriate intervention approaches, and disseminating interventions.[38] Improving CRC screening in clinics serving low-income and underinsured patients is a priority need, as these clinics are the primary source of care for a disproportionately high number of African American and Hispanic/Latino patients.[25] With

decreasing rates of CRC screening in the uninsured Hispanic population and lower rates of screening and early detection among African Americans as compared to Whites, the FIT-Flu CRC screening initiative will increase adherence to USPSTF CRC screening guidelines through the use low-cost FOBT screening in the primary care setting. Moreover, this initiative offers a teachable moment for clinicians to create awareness of CRC risk factors and screening guidelines for an uninformed or misinformed population. Additionally, clinicians will be educated on the appropriate guidelines for CRC screening in their patient population.

Relationship to other Projects:
This project reinforces and extends an existing colorectal screening project of the Colorectal Cancer Workgroup, which is one of eight focus areas in the Comprehensive Cancer Control initiative in the Houston MSA.

Relationship to Other Performing Providers' Projects in the RHP:
The increase of primary care and specialty care will naturally result in additional ambulatory care encounters for our region patient base. The ambulatory initiatives cover items such as laboratory, PT/OT, social work, etc. and are a necessity of our patients to ensure a comprehensive treatment for access as well as cost avoidance. The Region 3 initiative grid in the addendum reflects all ambulatory operations initiatives.

Plan for Learning Collaborative:
We will participate in face-to-face learning such as meetings or seminars with other providers and the RHP, at least twice per year to promote collaborative learning around shared or similar projects. At each face-to-face meeting, we will collaborate to identify performance improvements and will ensure that these suggested improvements will be incorporated into our project processes.

Project Valuation: We have based our project valuation on California's 1115 Medicaid Waiver model. As such, we have valued our projects at 2.5 times that of the estimated costs. Basing our valuations on California's calculations we know we are well within the potential range of future cost savings when looking at the following from Prevention Institute and Trust for America's Health Issue Report entitled *Prevention for a Healthier America: Investments in Disease Prevention Yield Significant Savings, Stronger Communities (July 2008)*:

- Prevention can reduce end-of-life costs by increasing health during the lifespan, what researchers call the *compression of morbidity*.
- There is a substantial return-on-investment in prevention – For every $1 invested in community-based prevention, the return amounts to $5.60.

UNIQUE IDENTIFIER: **112672402.2.1**	*RHP PP REFERENCE NUMBER:* *2.7.1*	PROJECT COMPONENTS *2.7.1*	**PROJECT TITLE: IMPLEMENT INNOVATIVE EVIDENCE-BASED STRATEGIES TO INCREASE APPROPRIATE USE OF TECHNOLOGY AND TESTING FOR TARGETED POPULATIONS (E.G., MAMMOGRAPHY SCREENS, COLONOSCOPIES, PRENATAL ALCOHOL USE, ETC.): COLORECTAL CANCER SCREENING PROGRAM FOR LOW-INCOME RESIDENTS OF RHP3**
Performing Provider Name: The University of Texas MD Anderson Cancer Center			*TPI – 112672402*
Related Category 3 Outcome Measure(s):	*112672402.3.1* *112672402.3.2*	IT-11.1 IT-12.3	*Improvement in Clinical Indicator in identified disparity group.* *Colorectal Cancer Screening (HEDIS 2012)*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-1]: Development of innovative evidence-based FIT/Flu CRC screening initiative for low-income and minority populations. Metric 1 [P-1.1]: Provide report identifying the following: Resources and potential partnerships Intervention plan (including implementation, evaluation, and sustainability) Characteristics of patient population Staff requirements IT requirements Available site, state, county and clinical data, including target population by race and ethnicity, number of FOBT distributed and return rate a. Data Source: Clinic EMR, program documentation, State and county data sources, memoranda of understanding b. Rationale/Evidence: FIT-Flu intervention is a practical strategy with high potential to increase CRC screening adherence in community clinic settings. Milestone 1 Estimated Incentive Payment (*maximum amount*):	**Milestone 6 [P-2]:** Implement innovational FIT/Flu CRC screening project for low-income and minority populations. Metric 1[P-2.1]:Document implementation strategy, develop database and track testing outcomes Baseline/Goal: N/A. a. Data Source: Performing Provider contract(s), clinic EMR or other documentation of implementation TBD by Performing Provider. b. Rationale/Evidence: FIT-Flu CRC screening intervention is a practical strategy with high potential to increase CRC screening adherence in community clinic settings. Milestone 6 Estimated Incentive Payment (*maximum amount*): $807,076.20 **Milestone 7 [P-7]:** 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	**Milestone 9 [I-7.]:** Increase access to CRC screening using innovative FIT/Flu project. Metric 1 [I-7.1]: Increase number of target population receiving FIT by 5% over DY3 by extending project into additional RHP3 area FQHCs Baseline/Goal: DY 3 baseline/Increase by 5%. a. Numerator: Total number of individuals of target population who are clinic clients who receive FIT test and educational material. b. Denominator: Number of individuals in the target population who are clients of the contracted clinics. c. Data Source: Documentation of target population reached, as designated in the project plan. d. Rationale/Evidence: FIT-Flu intervention is a practical strategy with high potential to increase CRC screening adherence in community clinic settings. Increase access to CRC screening using the innovative, evidence-based FIT Flu project. Metric 2 [I-7.2.]: Increase number of FIT CRC screening tests returned to laboratory.	**Milestone 11** [I-7]: Increase access to CRC screening using innovative FIT/Flu project. Baseline/Goal: DY 4 baseline/Increase number receiving FIT by 5% over baseline. Metric 1 [I-7.1]: Increase number of target population receiving FIT by 5% DY4 by extending project into additional RHP3 area FQHCs. a. Numerator: Total number of individuals of target population who are clinic clients who receive FIT test and educational material. b. Denominator: Number of individuals in the target population who are clients of the contracted clinics. c. Data Source: Documentation of target population reached, as designated in the project plan. d. Rationale/Evidence: FIT-Flu intervention is a practical strategy with high potential to increase CRC screening adherence in community clinic settings. Increase access to CRC screening using the innovative, evidence-based FIT Flu project. Metric 2 [I-7.2.]: Increased number of FIT CRC screening tests returned to

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UNIQUE IDENTIFIER: **112672402.2.1**	***RHP PP REFERENCE NUMBER:*** *2.7.1*	**PROJECT COMPONENTS** *2.7.1*	**PROJECT TITLE: IMPLEMENT INNOVATIVE EVIDENCE-BASED STRATEGIES TO INCREASE APPROPRIATE USE OF TECHNOLOGY AND TESTING FOR TARGETED POPULATIONS (E.G., MAMMOGRAPHY SCREENS, COLONOSCOPIES, PRENATAL ALCOHOL USE, ETC.): COLORECTAL CANCER SCREENING PROGRAM FOR LOW-INCOME RESIDENTS OF RHP3**
Performing Provider Name: The University of Texas MD Anderson Cancer Center			*TPI – 112672402*
Related Category 3 Outcome Measure(s):	*112672402.3.1* *112672402.3.2*	IT-11.1 IT-12.3	*Improvement in Clinical Indicator in identified disparity group.* *Colorectal Cancer Screening (HEDIS 2012)*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
$274,907.43 **Milestone 2 [P-4]:** Hire and train staff to operate and manage FIT/Flu CRC screening project. Metric 1 [P 4.1]: Number of staff secured and trained; Baseline/Goal: TBD a. Data Source: Project records; Training curricula Milestone 2 Estimated Incentive Payment (*maximum amount*): $274,907.43 **Milestone 3 [P-X]**: To measure improvement over self, in DY2 establish a baseline of patients currently receiving FIT or FOBT for CRC screening. Metric 1 [P-X.1]: Number of eligible patients in the target population. a. Baseline/Goal: TBD/Number of eligible patients in the target population who have received appropriate USPSTF defined CRC screening modality. b. Data Source: Individual clinic EMR Milestone 3 Estimated Incentive Payment (*maximum amount*):	initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements. Metric 1 [P-7.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Baseline/Goal: N/A a. Data Source: Documentation of semiannual meetings including meeting agendas and slides from presentations, and/or meeting notes. b. Rationale/Evidence: Investment in learning and sharing of ideas is central to improvement. The highest quality health care systems promote continuous learning and exchange between providers and decide collectively how to "raise the floor" for performance across all providers. Milestone 7 Estimated Incentive Payment (*maximum amount*): $807,076.20 **Milestone 8 [I-7.]:** Increase access to CRC screening using innovative FIT/Flu project. Metric 1 [I-7.1]: Increase number of target population receiving FIT CRC	Baseline/Goal: DY 3 baseline/Increase number of returned tests by 5% a. Numerator: Total number of FIT tests distributed to clinic target population and returned to laboratory. b. Denominator: Total number of clinic clients in target population. b Data Source: Laboratory requisition tracking, c. Rationale/Evidence: This measures the increased number of returned FIT for laboratory analysis. Metric 3 [1-7.3]: Increase in number of referrals for CRC screening in target population (50 years and over) by primary care physicians and healthcare providers. Data Source: Survey of participating primary care physicians and healthcare providers. Rationale/Evidence: Even a brief contact with a provider to reinforce the need for regular screening, such as during flu inoculation, provides a "teachable moment" for raising awareness of CRC screening. Milestone 9 Estimated Incentive Payment (*maximum amount*): $1,161,253.80	laboratory. a. Numerator: Total number of FIT tests distributed to clinic target population and returned to laboratory. b. Denominator: Total number of clinic clients in target population. b Data Source: Laboratory requisition tracking, c. Rationale/Evidence: This measures the increased number of returned FIT for laboratory analysis. Metric 3 [1-7.3]: Increase in number of referrals for CRC screening in target population (50 years and over) by primary care physicians and healthcare providers. Baseline/Goal: DY 4 referrals/Increase number of referrals by 5%. Data Source: Survey of participating primary care physicians and healthcare providers. Rationale/Evidence: Even a brief contact with a provider to reinforce the need for regular screening, such as during flu inoculation, provides a "teachable moment" for raising awareness of CRC screening. Milestone 11 Estimated Incentive Payment (*maximum amount*):

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UNIQUE IDENTIFIER: **112672402.2.1**	***RHP PP REFERENCE NUMBER:*** *2.7.1*	**PROJECT COMPONENTS** *2.7.1*	**PROJECT TITLE: IMPLEMENT INNOVATIVE EVIDENCE-BASED STRATEGIES TO INCREASE APPROPRIATE USE OF TECHNOLOGY AND TESTING FOR TARGETED POPULATIONS (E.G., MAMMOGRAPHY SCREENS, COLONOSCOPIES, PRENATAL ALCOHOL USE, ETC.): COLORECTAL CANCER SCREENING PROGRAM FOR LOW-INCOME RESIDENTS OF RHP3**
Performing Provider Name: The University of Texas MD Anderson Cancer Center			*TPI – 112672402*
Related Category 3 Outcome Measure(s):	*112672402.3.1* *112672402.3.2*	IT-11.1 IT-12.3	*Improvement in Clinical Indicator in identified disparity group.* *Colorectal Cancer Screening (HEDIS 2012)*
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
$274,907.43 **Milestone 4 [P-X]** Develop culturally sensitive promotional and educational materials. Metric 2: [P-1.2] Production of fliers, posters and brochures in English, Spanish, Chinese and Vietnamese. Baseline/Goal: N/A a. Data Source: Project procedural manual, National Cancer Institute, American Cancer Society, MD Anderson Cancer Institute CRC educational materials. b. Rationale/Evidence: The Community Preventive Services Task Force recommends interventions that use small media based on strong evidence of their effectiveness in increasing colorectal cancer screening by fecal occult blood test (FOBT). Milestone 4 Estimated Incentive Payment (*maximum amount*): $274,907.43 **Milestone 5 [P-7]:** 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	screening by 5% over baseline established in DY2 by extending project into additional RHP3 area FQHCs. Baseline/Goal: DY 2 screenings/Increase by 5% a. Numerator: Total number of individuals of target population who are clinic clients who receive FIT test and educational material. b. Denominator: Number of individuals in the target population who are clients of the contracted clinics. c. Data Source: Documentation of target population reached, as designated in the project plan. d. Rationale/Evidence: FIT-Flu intervention is a practical strategy with high potential to increase CRC screening adherence in community clinic settings. Metric 2 [I-7.2.]: Increase number of FIT CRC screening tests returned to laboratory. Baseline/Goal: TBD/TBD a. Numerator: Total number of FIT tests distributed to clinic target population and returned to laboratory. b. Denominator: Total number of	**Milestone 10** [P-7]: Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements. Metric 1 [P-7.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Baseline/Goal: N/A a. Data Source: Documentation of semiannual meetings including meeting agendas and slides from presentations, and/or meeting notes. b. Rationale/Evidence: Investment in learning and sharing of ideas is central to improvement. The highest quality health care systems promote continuous learning and exchange between providers and decide collectively how to "raise the floor"	$1,327,824.23 **Milestone 12 [P-7]:** Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements. Metric 1 [P-7.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Baseline/Goal: N/A. a. Data Source: Documentation of semiannual meetings including meeting agendas and slides from presentations, and/or meeting notes. b. Rationale/Evidence: Investment in learning and sharing of ideas is central to improvement. The highest quality health care systems promote continuous learning and exchange between providers and decide

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UNIQUE IDENTIFIER: 112672402.2.1	RHP PP REFERENCE NUMBER: 2.7.1	PROJECT COMPONENTS 2.7.1	PROJECT TITLE: IMPLEMENT INNOVATIVE EVIDENCE-BASED STRATEGIES TO INCREASE APPROPRIATE USE OF TECHNOLOGY AND TESTING FOR TARGETED POPULATIONS (E.G., MAMMOGRAPHY SCREENS, COLONOSCOPIES, PRENATAL ALCOHOL USE, ETC.): COLORECTAL CANCER SCREENING PROGRAM FOR LOW-INCOME RESIDENTS OF RHP3
Performing Provider Name: The University of Texas MD Anderson Cancer Center			*TPI – 112672402*
Related Category 3 Outcome Measure(s):	*112672402.3.1* *112672402.3.2*	IT-11.1 IT-12.3	*Improvement in Clinical Indicator in identified disparity group.* *Colorectal Cancer Screening (HEDIS 2012)*

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance). Each participating provider should publicly commit to implementing these improvements. Metric 1 [P-7.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Baseline/Goal: N/A a. Data Source: Documentation of semiannual meetings including meeting agendas and slides from presentations, and/or meeting notes. b. Rationale/Evidence: Investment in learning and sharing of ideas is central to improvement. The highest quality health care systems promote continuous learning and exchange between providers and decide collectively how to "raise the floor" for performance across all providers. Milestone 5 Estimated Incentive Payment (*maximum amount)*: $274,907.43	clinic clients in target population. b Data Source: Laboratory requisition tracking, c. Rationale/Evidence: This measures the increased number of returned FIT for laboratory analysis. Metric 3 [1-7.3]: Increase in number of referrals for CRC screening in target population (50 years and over) by primary care physicians and healthcare providers. Data Source: Survey of participating primary care physicians and healthcare providers. Rationale/Evidence: Even a brief contact with a provider to reinforce the need for regular screening, such as during flu inoculation, provides a "teachable moment" for raising awareness of CRC screening. Milestone 8 Estimated Incentive Payment (*maximum amount)*: $807,076.20	for performance across all providers. Milestone 10 Estimated Incentive Payment (*maximum amount)*: $1,161,253.80	collectively how to "raise the floor" for performance across all providers. Milestone 12 Estimated Incentive Payment (*maximum amount)*: $1,327,824.23

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UNIQUE IDENTIFIER: **112672402.2.1**	***RHP PP REFERENCE NUMBER:*** *2.7.1*	**PROJECT COMPONENTS** *2.7.1*	**PROJECT TITLE: IMPLEMENT INNOVATIVE EVIDENCE-BASED STRATEGIES TO INCREASE APPROPRIATE USE OF TECHNOLOGY AND TESTING FOR TARGETED POPULATIONS (E.G., MAMMOGRAPHY SCREENS, COLONOSCOPIES, PRENATAL ALCOHOL USE, ETC.): COLORECTAL CANCER SCREENING PROGRAM FOR LOW-INCOME RESIDENTS OF RHP3**
Performing Provider Name: The University of Texas MD Anderson Cancer Center			*TPI – 112672402*
Related Category 3 Outcome Measure(s):	*112672402.3.1* *112672402.3.2*	IT-11.1 IT-12.3	*Improvement in Clinical Indicator in identified disparity group.* *Colorectal Cancer Screening (HEDIS 2012)*
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone): $1,374,537.15	Year 3 Estimated Milestone Bundle Amount: $2,421,228.60	Year 4 Estimated Milestone Bundle Amount: $2,322,507.60	Year 5 Estimated Milestone Bundle Amount: $2,655,648.45
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over DYs 2-5)***:** $8,773,921.80			

Project Option 2.7.2 – Implement innovative evidence-based strategies to reduce tobacco use – Evidence-Based Smoking Cessation Program for Underserved Persons Living with HIV/AIDS

Unique RHP Project ID: 112672402.2.2

Performing Provider Name/TPI: The University of Texas MD Anderson Cancer Center / 112672402

Project Summary:

Provider: The University of Texas MD Anderson Cancer Center is a comprehensive cancer center ranked first in cancer care by *U.S. News & World Report* and dedicated to patient care, education, research and prevention. MD Anderson is comprised of several Texas Medical Center campus locations, two research campuses in Bastrop County, Texas, four regional care centers and a number of national and international divisions and affiliates. More than 108,000 people—almost one-third of them new patients—were seen in FY2011. MD Anderson provided $215 million in uncompensated charity care to Texans in FY2011.

Intervention(s): This project will implement an evidence-based smoking cessation program for persons living with HIV/AIDS at the Legacy Community Health Services sites. Legacy provides care to approximately 40,000 underserved individuals (including 4,000 individuals living with HIV/AIDS) per year at five clinic sites in the greater Houston area. Legacy is also a nationally recognized leader in HIV/AIDS care.

Need for the project:

- This project addresses Community Needs: CN.6: Inadequate access to treatment and services designed for special needs populations, including disabled, homeless, children, elderly; CN.11: High rates of chronic disease and inadequate access to treatment programs and services for illnesses associated with chronic disease including: cancer, diabetes, obesity, cardiovascular disease, asthma, and AIDS/HIV; CN.12 – High rates of tobacco use and excessive alcohol use.
- A wide range of studies have documented dramatically elevated rates of current smoking in HIV-positive populations, generally two to three times higher than the prevalence of smoking in the general population. Recent evidence indicates that smoking cessation among person with HIV could reduce the risk of overall mortality by almost 16%; reduce the risk of a major cardiovascular disease event by 20%; and reduce the risk of non-AIDS malignancies by 34%.

Target Population: One thousand patients living with HIV/AIDS will be enrolled in the smoking cessation program. While current smoking prevalence data are not available for the Legacy patient population, the estimated prevalence is 50%. This estimate is based on extensive existing literature documenting high smoking rates in this population. (Estimates range from 50 to 70%).

Category 1 or 2 expected patient benefits: The DY4 goal is enroll 50% of program eligible smokers into smoking cessation services. The DY5 goal is to disseminate the cell phone smoking cessation intervention to HIV care centers located throughout the RHP.

Category 3 outcomes:

IT-11.6: Other Outcome Improvement Target (Quit Attempts) – 75% of enrollees (n=750) will make a successful quit attempt

IT-11.6: Other Outcome Improvement Target (Smoking Cessation/Staying Quit) – 25% of smokers (n=250) will be abstinent at the time of follow-up

Project Option 2.7.2 – Implement innovative evidence-based strategies to reduce tobacco use - Evidence-Based Smoking Cessation Program for Underserved Persons Living with HIV/AIDS

<u>Unique RHP Project Identification Number</u>: 112672402.2.2
<u>Performing Provider Name/TPI</u>: The University of Texas MD Anderson Cancer Center / 112672402

<u>Project Description</u>:
The goal of the current proposal is to adapt, implement, and evaluate an evidence-based, cell phone-delivered smoking cessation treatment program targeted to low-income and underinsured individuals living with HIV/AIDS. The proposed smoking cessation project will involve a partnership with Legacy Community Health Services – a large, Federally Qualified Health Center (FQHC).

<u>Program overview</u>. In the first phase of our project, we will train Legacy staff to: 1) screen for current smoking, 2) identify eligible HIV+ smokers 3) offer smoking cessation treatment to eligible participants, and 4) administer the cessation intervention. Active recruitment will begin in phase 2. Participants who enroll in the program will meet with their HIV Case Manager and treatment materials (call calendar and nicotine replacement patches) will be dispersed. The final phase of the project will consist of follow-up assessment and dissemination to other HIV care centers in the RHP.

<u>Treatment overview</u>. Enrollees will be given brief advice to quit smoking and offered nicotine replacement therapy (NRT) in the form of nicotine patches. Enrollees will then receive a series of proactive telephone counseling sessions that will be conducted over a six month time period. This evidence-based treatment approach is based on the United States Public Health Service (USPHS) Guidelines and our previous work with HIV+ smokers.[1-3] Extensive evidence supports the efficacy of NRT. We have chosen to use nicotine patches due to their ease of use and low risk of side effects. When combined with provider advice to quit smoking, NRT effectively doubles the odds of successfully quitting.[2] For the phone counseling component, we have chosen to use the approach developed in our earlier clinical trial. Counseling session content is primarily drawn from cognitive-behavioral and motivational interviewing techniques. Importantly, content is tailored to the individual's HIV status, and addresses HIV-specific issues.

Assessments, which will include smoking status measures, psychosocial measures, and process variables, will be conducted in the Legacy clinics at the time of program enrollment, and at 3- and 6-months post enrollment. After all program participants have completed the 6-month follow-up, a detailed program evaluation will be conducted.

<u>Community Partner</u>. For this project, we will partner with Legacy Community Health Services. Legacy provides care to approximately 40,000 underserved individuals (including 4,000 individuals living with HIV/AIDS) per year at five clinic sites in the greater Houston area. Legacy is also a nationally recognized leader in HIV/AIDS care. Providers (intake nurses and case managers/social workers) at the clinic sites will assist with screening and smoking cessation intervention delivery. We have a strong record of this type of collaboration as evidenced by our previous research initiatives at Thomas Street Health Center of the Harris Health System.

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

Aim 1: Adapt a previously developed smoking cessation treatment approach for use with Legacy Community Health Service's HIV+patient population.

Our goal is to work with Legacy staff to adapt our proactive cell phone counseling intervention so that program implementation will minimize clinic flow disruption, while appealing to a majority of the target population. If successful, our program will be readily implemented, maintained, and administered by the Legacy clinic sites and, ultimately, disseminable to other HIV-care centers across the RHP.

Aim 2: Implement an evidence-based smoking cessation program for persons living with HIV/AIDS at the Legacy clinic sites.

Our goal is to screen, enroll, and provide smoking cessation treatment (consisting of brief provider advice to quit, nicotine replacement therapy, and proactive phone counseling) to 1000 smokers receiving HIV care at the 5 Legacy clinic sites.

Aim 3: Evaluate the effectiveness of the smoking cessation program implemented at Legacy.

Our goal is to evaluate the following:

- ***Reach** of the smoking cessation program - defined as the proportion of identified HIV-positive smokers who enroll in the program.*
- ***Efficacy** of the program - defined as the proportion of smokers who successfully quit smoking.*
- ***Implementation** of the program – defined as: 1) proportion of Legacy patients screened for program eligibility; 2) proportion of scheduled counseling calls completed by Case Managers; 3) dose of counseling treatment per participant (proportion of scheduled calls);and 4) dose of nicotine replacement therapy (NRT) per participant (proportion of NRT patches used).*
- ***Costs** – cost analysis, cost-effectiveness analysis, and cost utility analysis of the treatment program will be performed.*

Regional Goal. This proposed project is responsive to the first regional goal, "Develop a regional approach to health care delivery that leverages and improves on existing programs and infrastructure, is responsive to patient needs throughout the entire region, and improves health outcomes and patient satisfaction." At the present time, Legacy Community Health Services (an FQHC providing care to the underserved population in the greater Houston area) does not systematically screen smoking status, or offer smoking cessation services. Thus, the proposed project will fill an important gap. An existing evidence-based treatment will be offered to HIV+ smokers, while non-HIV+ positive smokers will be referred to the Texas Quitline. Moreover, the treatment provided to the HIV+ smokers will be administered through the HIV Case Management service already in place at Legacy.

Challenges:

Major challenges of the project include the following: 1) obtaining buy-in from staff at Legacy, 2) overcoming barriers to smoking cessation treatment, and 3) offering a sustainable program. We have carefully considered each of these challenges in the design of the project. First, buy-in will be facilitated by the support we have already received from Legacy Leadership. Specifically, Dr. Richard Beech, Chief Medical Officer, strongly supports this program and is fully committed to our initiative. Also, a key collaborator on this project, Dr. Leonard Zwelling, Professor, Experimental Therapeutics at MD Anderson Cancer Center serves on the Board of Directors at Legacy. Thus, he will be able to facilitate communications between project investigators and Legacy leadership. Second, the design of the project itself overcomes many barriers to treatment

commonly experienced by underserved HIV+ smokers. Key program elements, such as use of cell phones for treatment delivery, use of NRT (vs. other medications), and eliminating extra clinic visits, are each designed to minimize barriers, potential hazards, and overall participant burden. Third, a crucial component of the project is the training of case managers to deliver and administer the cessation program. Thus, the personnel resources will remain after the funding for the program ends. In addition, the program will ultimately be appropriate for a large number of HIV care centers.

5-Year Expected Outcome for Provider and Patients:
We believe our program will result in: 1) enhanced screening for smoking, 2) promote the delivery of evidence-based smoking cessation treatment, 3) promote quit attempts among participants receiving treatment, 4) reduce the prevalence of current smoking, and ultimately 5) reduce morbidity and mortality of smoking-related malignancies in the HIV-positive population.

Starting Point/Baseline: Patients will be recruited from the population of individuals receiving care at the Legacy Community Health Services, a Federally Qualified Health Center with a national reputation as a leader in HIV/AIDS prevention and treatment. Legacy provides care to approximately 40,000 patients, including more than 4,000 persons living with HIV/AIDS. Currently, smoking status is not systematically assessed, nor is cessation treatment offered. The HIV+ patient population is racially/ethnically diverse (33% Black/African American; 33% White; and 26% Hispanic). Approximately 70% of the patients are male, and 78% are between the ages of 25 and 54 years. Finally, 47% of the population is gay or bisexual and 44% are heterosexual.

We plan to enroll 1000 patients in the smoking cessation program. While current smoking prevalence data are not available for the Legacy patient population, we estimate a prevalence of 50%. This estimate is based on the extensive existing literature documenting high smoking rates in this population (estimates ranging from 50 to 70%),[4-8] as well as anecdotal reports from Legacy clinic staff ("at least 50% of the patients smoke"). We estimate, conservatively, that 50% of the HIV/AIDS patients screened at the Legacy clinics will be current smokers (that is 2000 of the 4000 HIV+ patients treated at Legacy). We would, therefore, need to enroll approximately 50% of these patients to reach our target of 1000. Given our ability to consistently enroll approximately 66% of smokers in our previous and ongoing studies with HIV+ smokers, a goal of 50% in the proposed program is readily achievable. In addition, non-HIV positive smokers will be referred to the Texas Quitline.

Rationale:

Cigarette smoking among persons living with HIV/AIDS represents a significant public health problem. A wide range of studies have documented dramatically elevated rates of current smoking in HIV-positive populations, generally two to three times higher than the prevalence of smoking in the general population.[4,6-8] Recent evidence indicates that smoking cessation among persons with HIV could reduce the risk of overall mortality by almost 16%; reduce the risk of a major cardiovascular disease event by 20%; and reduce the risk of non-AIDS malignancy by 34%.[9] Despite the high prevalence of current smoking and the substantial health benefits offered by smoking cessation treatment, surprisingly few efforts to deliver cessation treatment to this population appear in the literature.[10]

In previous efforts, Dr. Vidrine and colleagues have developed and performed efficacy assessments of behavioral interventions consisting of proactive cell phone-delivered smoking cessation counseling for HIV+ smokers. Findings from these efforts indicate that this treatment approach significantly increases abstinence rates over usual care (see preliminary evidence section) in the HIV-positive population. Despite the positive findings, much room for program dissemination and treatment improvement exists.

Several key factors were considered in the design of the proposed smoking cessation program. First, the proposed intervention (brief advice to quit, proactive cell phone counseling + NRT) builds on a solid, evidence-based foundation. This intervention has yielded positive results in earlier studies targeting underserved persons with HIV. Moreover, the efficacy of proactive phone counseling interventions and NRT have been extensively established in the general population. Second, the proposed intervention successfully overcomes many barriers to other interventions. For example, barriers such as limited transportation, housing instability, treatment costs, lack of landline/internet access, and limited literacy will not prevent participation in the proposed program. Finally, we have chosen to offer NRT as a component of the treatment. NRT is effective and offers several advantages over other potential pharmacotherapies (i.e., bupropion and varenicline), including fewer potential interactions with antiretroviral medications and less risk of psychiatric side effects. NRT is also available at no (or greatly reduced) cost to Legacy patients.

Project Components:
We believe our program will result in: 1) enhanced screening for smoking [P-X], 2) promote the delivery of evidence-based smoking cessation treatment [P-2], 3) promote quit attempts among participants receiving treatment [P-X], 4) reduce the prevalence of current smoking [IT-11.1], and ultimately 5) reduce morbidity and mortality of smoking-related malignancies in the HIV-positive population [IT-11.6].

Milestones & Metrics:
The following milestones and metrics have been chosen for the Smoking Cessation Program for Underserved Persons Living with HIV/AIDS:

- Process Milestones and Metrics: P-X (P-X.1); P-1 (P-1.1); P-2 (P-2.1); P-7 (P-7.1., P-7.2)
- Improvement Milestones and Metrics: I-5 (1-5.1); OD-11 (IT-11.1, IT-11.6)

Unique community need identification number the project addresses:
The project addresses the following unique community needs as identified in the community needs assessment:

- CN.6 – Inadequate access to treatment and services designed for special needs populations, including disabled, homeless, children, elderly
- CN.11 – High rates of chronic disease and inadequate access to treatment programs and services for illnesses associated with chronic disease including: cancer, diabetes, obesity, cardiovascular disease, asthma, and AIDS/HIV
- CN.12 – High rates of tobacco use and excessive alcohol use

How the project represents a new initiative for the Performing Provider or significantly enhances an existing delivery system reform initiative:
An innovative component of our program is the use of case managers as program stakeholders. HIV case management is a client-focused process that delivers, expands, and coordinates services to clients. Generally stated, the ultimate goal of HIV case management is to help

patients achieve better levels of physical, emotional, and social functioning.[11] The literature indicates that HIV case management can result in a number of improved health outcomes, particularly for individuals with complex health care needs, including improved quality of life.[12] Therefore, offering smoking cessation counseling fits well within the mission of the case management discipline. In addition, input from clinical staff at Legacy indicated that an intervention that utilizes the already established case management service would be ideal. Finally, because case management is available in most HIV clinics, our approach may have higher dissemination potential than alternative approaches. For example, The Ryan White Care Act currently provides funding to more than 2500 organizations, and case management services to more than 500,000 HIV-positive individuals.

Related Category 3 Outcome Measure(s):

IT-11.6 Other Outcome Improvement Target: Quit attempt

- 75% of enrollees (n=750) will make a successful quit attempt.

IT-11.6 Other Outcome Improvement Target: Smoking cessation/Staying Quit

- 25% of smokers (n=250) will be abstinent at the time of follow-up

Reasons/rationale for selecting the outcome measure(s):

Several important factors support our choice of OD-11 as our category 3 outcome domain. First, HIV/AIDS is among the conditions with the greatest disparities in health services and quality.[13] Education, income, and employment status, along with race/ethnicity have been identified as important independent predictors of HIV/AIDS status.[14,15] For instance, AIDS incidence and mortality are disproportionately high among African American and Hispanic individuals. African Americans and Hispanics account for approximately one quarter of the total U.S. population; however, these same two groups account for more than two thirds of the reported cases of AIDS.[16] This translates to a rate among African Americans that is more than 8 times higher than the rate for whites, and the rate for Hispanics is 3 times higher compared to whites.[16] Therefore, reducing the disproportionate impact of HIV/AIDS among traditionally underserved populations and improving health outcomes for people living with HIV/AIDS are national priorities.[17,18]

A second important consideration is high prevalence of current smoking among people living with HIV/AIDS. Numerous reports describing dramatically elevated rates of smoking (40-70%) in this special population appear in the scientific literature. [e.g.,6-8] There are several characteristics that are known to be associated with both smoking status and HIV serostatus. Education level, income, and employment status have been identified as important independent predictors of both HIV/AIDS and smoking status.[14,15] Certain behavioral and psychosocial variables (e.g., sexual orientation, heavy alcohol consumption, illicit drug use, and depressive symptoms) are also associated with both smoking status and HIV/AIDS.[19-22] While smoking is a hazardous behavior for all populations, HIV+ individuals appear to be particularly susceptible to the adverse health effects of tobacco use.[23] In addition to increasing the risk of various pulmonary conditions and oral infections, [24-32] smoking significantly elevates the risk of cancer among individuals with HIV.[33-37] For example, anal, cervical, and lung cancers are observed significantly more often among HIV+ smokers compared to nonsmokers.[33,37-39]

Despite the high prevalence of smoking and the increased risk of numerous adverse health outcomes, efforts to deliver cessation treatment to persons living with HIV/AIDS are rare.[10] In fact, our community partner for the proposed project serves one of the largest HIV+ patient populations in the state, yet currently has no smoking cessation program available to these patients. Therefore, offering an evidence-based cessation program presents the potential to

reduce smoking prevalence in the Legacy patient population, resulting in fewer smoking-related diseases and poor health outcomes.

Relationship to other Projects: By delivering an evidenced based smoking cessation program to the underserved population of HIV+ smokers at Legacy Community Health Services, this program is in line with the RHP. This project also supports our other projects in that they all support one of the eight goals of the Comprehensive Cancer Control Program at The University of Texas MD Anderson Cancer Center.

Relationship to Other Performing Providers' Projects in the RHP:
Innovation is key to the transformation of healthcare in our community. The consistency of innovation in our region allows for increased improvements based on research trends, patient need, and provider availability. The waiver funding allows for innovation in specific areas and all innovative projects included in the plan are similar in the fact of program redesigns for historic treatments, and focus to chronic condition outcome measures such as central line infections. The Region 3 initiative grid in the addendum can provide a side by side comparison of all projects that directly relate to innovation.

Plan for Learning Collaborative: We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for RHP3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system.

Project Valuation: We have based our project valuation on California's 1115 Medicaid Waiver model. As such, we have valued our projects at 2.5 times that of the estimated costs. Basing our valuations on California's calculations we know we are well within the potential range of future cost savings when looking at the following from Prevention Institute and Trust for America's Health Issue Report entitled *Prevention for a Healthier America: Investments in Disease Prevention Yield Significant Savings, Stronger Communities (July 2008)*:

- Prevention saves money – an investment of $10 per person per year in programs to increase physical activity, improve nutrition, and prevent tobacco use could save the country more than $16 billion in annual health care costs within five years.
- Prevention can reduce end-of-life costs by increasing health during the lifespan, what researchers call the *compression of morbidity*.

There is a substantial return-on-investment in prevention – For every $1 invested in community-based prevention, the return amounts to $5.60.

Unique Identifier: 112672402.2.2	**RHP PP Reference Number:** 2.7.2	**Project Components:** 2.7.2	***Project Title:*** *Implement innovative evidence-based strategies to reduce tobacco use - Evidence-Based Smoking Cessation Program for Underserved Persons Living with HIV/AIDS*
Performing Provider Name: *The University of Texas MD Anderson Cancer Center*			***TPI -*** *112672402*
Related Category 3 Outcome Measure(s):	*112672402.3.3* *112672402.3.4*	***IT-11.6*** ***IT-11.6***	• *Other Outcome Improvement Target: (Quit Attempts)* • *Other Outcome Improvement Target: (Staying Quit)*
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-X] **Identify baseline prevalence of current smoking among HIV+ individuals receiving services at the Legacy Community Health Center sites.** Metric [P-X.1]: Document a baseline **Baseline/Goal:** At present, smoking cessation is not documented systematically. Our goal is to train staff and implement procedures to screen for, and document smoking status among all patients. **Data Source:** Medical record data and primary data collection. **Milestone 1 Estimated Incentive Payment:** $307,370.70 **Milestone 2 [P-1]: Development of innovative evidence-based project for targeted population** Metric [P-1.1] Document innovational strategy and plan; Finalize treatment components (e.g., HIV-related text messages and delivery system components). **Baseline/Goal:** Our previously developed cell phone delivered cessation treatment will serve as the baseline. Our goal is to adapt and further develop this program for use with Legacy patients.	**Milestone 5 [P-2]: Implement evidence-based innovational project for targeted population** Metric [P-2.1]: Document implementation strategy and testing outcomes; Enroll and deliver treatment to 50% of eligible HIV+ smokers screened at Legacy. **Baseline/Goal: TBD/**Presently, Legacy does not offer a smoking cessation program. Our goal is to enroll 50% of the eligible smokers we identify. **Data Source:** Primary data collection to be recorded in medical records and program databases. **Milestone 5 Estimated Incentive Payment:** $609,636.83 **Milestone 6 [P-7]: 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**	**Milestone 7 [P-2]: Implement evidence-based innovational project for targeted population** Metric [P-2.1]: Document Implementation strategy and testing outcomes; Enroll and deliver treatment to 50% of eligible HIV+ smokers screened at Legacy. **Baseline/Goal: TBD/**Presently, Legacy does not offer a smoking cessation program. Our goal is to enroll 50% of the eligible smokers we identify. **Data Source:** Primary data collection to be recorded in medical records and program databases. **Milestone 7 Estimated Incentive Payment:** $318,950.10 **Milestone 8 [P-7]: 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**	**Milestone 9 [P-X]: Improvement in Clinical Indicator in identified disparity group** Metric [P-X.1]: Document the dissemination of cell phone smoking cessation intervention; Disseminate the cell phone smoking cessation intervention to HIV care centers located throughout the RHP. **Baseline/Goal: TBD/**Presently, few if any, HIV care centers in the region systematically screen for smoking and offer treatment. Our goal is to reach out to other HIV care centers providing medical care to underserved populations across the region. We will offer training and assistance with the cessation program implementation. **Data Source:** previous developed training materials, procedures, treatment materials, and program databases. **Milestone 9 Estimated Incentive Payment:** $147,592.20 **Milestone 10 [P-7]: 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.**

UNIQUE IDENTIFIER: 112672402.2.2	RHP PP REFERENCE NUMBER: 2.7.2	PROJECT COMPONENTS: 2.7.2	*Project Title: Implement innovative evidence-based strategies to reduce tobacco use - Evidence-Based Smoking Cessation Program for Underserved Persons Living with HIV/AIDS*
Performing Provider Name: *The University of Texas MD Anderson Cancer Center*			***TPI -*** *112672402*
Related Category 3 Outcome Measure(s):	*112672402.3.3* *112672402.3.4*	***IT-11.6*** ***IT-11.6***	• *Other Outcome Improvement Target: (Quit Attempts)* • *Other Outcome Improvement Target: (Staying Quit)*
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Data Source: Input from Legacy staff, project investigators, and the scientific literature. **Milestone 2 Estimated Incentive Payment:** $307,370.70 **Milestone 3 [P-X]:** Conduct training sessions with Legacy staff (case managers and other providers). Metric [P-X.1]: Document training sessions **Baseline/Goal:** Our goal is to train staff on the proper delivery of brief advice to quit smoking, and on the conduct of the proactive telephone sessions, which includes both CBT and MI components. Staff will also be trained on the appropriate use of NRT. **Data Source:** Previously developed training materials, as well as input from Legacy staff, project investigators, and the scientific literature. **Milestone 3 Estimated Incentive Payment:** $307,370.70 **Milestone 4 [P-2]: Implement evidence-based innovational project for targeted population** Metric [P-2.1] Document implementation strategy and testing	**provider should publicly commit to implementing these improvements.** Metric (P-7.1) Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Baseline/Goal: N/A **Data Source:** Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Metric (P-7.2) Implement the "raise the floor" improvement initiatives established at the semiannual meeting. Baseline/Goal: TBD **Data Source:** Documentation of "raise the floor" improvement initiatives agreed upon at each semiannual meeting and documentation that the participating provider implemented the "raise the floor" improvement initiative after the semiannual meeting. **Milestone 6 Estimated Incentive Payment:** $$609,636.83	**implementing these improvements.** Metric (P-7.1) Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Baseline/Goal: N/A **Data Source:** Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Metric (P-7.2) 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. **Milestone 8 Estimated Incentive Payment:** $318,950.10	**At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to "raise the floor" for performance.) Each participating provider should publicly commit to implementing these improvements.** Metric (P-7.1) Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Baseline/Goal: N/A. **Data Source:** Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Metric (P-7.2) Implement the "raise the floor" improvement initiatives established at the semiannual meeting. Baseline/Goal: TBD **Data Source:** Documentation of "raise the floor" improvement initiatives agreed upon at each semiannual meeting and documentation that the participating provider implemented the "raise the floor" improvement initiative after the semiannual meeting. **Milestone 10 Estimated Incentive Payment:** $147,592.20

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<table>
<tr><td>Unique Identifier:
112672402.2.2</td><td>RHP PP Reference Number:
2.7.2</td><td>Project Components:
2.7.2</td><td colspan="2">Project Title: Implement innovative evidence-based strategies to reduce tobacco use - Evidence-Based Smoking Cessation Program for Underserved Persons Living with HIV/AIDS</td></tr>
<tr><td colspan="4">Performing Provider Name: The University of Texas MD Anderson Cancer Center</td><td>TPI - 112672402</td></tr>
<tr><td>Related Category 3 Outcome Measure(s):</td><td>112672402.3.3
112672402.3.4</td><td>IT-11.6
IT-11.6</td><td colspan="2">• Other Outcome Improvement Target: (Quit Attempts)
• Other Outcome Improvement Target: (Staying Quit)</td></tr>
<tr><th>Year 2
(10/1/2012 – 9/30/2013)</th><th>Year 3
(10/1/2013 – 9/30/2014)</th><th>Year 4
(10/1/2014 – 9/30/2015)</th><th colspan="2">Year 5
(10/1/2015 – 9/30/2016)</th></tr>
<tr><td>outcomes; Implement procedures to systematically assess smoking status and offer smoking cessation treatment to all HIV+ positive smokers.
Baseline/Goal: Presently, Legacy does not offer a smoking cessation program. Our goal is to identify current smokers and offer then evidence based treatment.
Data Source: Primary data collection and program databases.
Milestone 4 Estimated Incentive Payment: $307,370.70</td><td></td><td></td><td colspan="2">Milestone 11: [I-5] Identify X number of patients in defined population receiving innovative intervention consistent with evidence-based model.
Metric [I-5.1]: TBD by Performing Provider.
Baseline/Goal: TBD.
Date Source: Documentation of target population reached.
Milestone 11 Estimated Incentive Payment: $147,592.20</td></tr>
<tr><td>Year 2 Estimated Milestone Bundle Amount: $1,229,482.80</td><td>Year 3 Estimated Milestone Bundle Amount: $1,219,273.65</td><td>Year 4 Estimated Milestone Bundle Amount: $637,900.20</td><td colspan="2">Year 5 Estimated Milestone Bundle Amount: $442,776.60</td></tr>
<tr><td colspan="5">TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $3,529,433.25</td></tr>
</table>

Project Option 2.7.2 – Implement innovative evidence-based strategies to reduce tobacco use – Multimedia Tools and Community Engagement for Youth Early Tobacco Prevention and Cessation

Unique RHP Project ID: 112672402.2.3

Performing Provider Name/TPI: The University of Texas MD Anderson Cancer Center / 112672402

Project Summary:

Provider: The University of Texas MD Anderson Cancer Center is a comprehensive cancer center ranked first in cancer care by *U.S. News & World Report* and dedicated to patient care, education, research and prevention. MD Anderson is comprised of several Texas Medical Center campus locations, two research campuses in Bastrop County, Texas, four regional care centers and a number of national and international divisions and affiliates. More than 108,000 people—almost one-third of them new patients—were seen in FY2011. MD Anderson provided $215 million in uncompensated charity care to Texans in FY2011.

Intervention(s): A Smoking Prevention Interactive Experience (ASPIRE) will be utilized to reach underserved, at-risk youth at various access points in RHP3 counties. Youth will be exposed to multilingual, culturally relevant anti-tobacco messages using electronic, digital and print media. Youth tobacco users and nonusers will join in the initiative and be exposed to five modules of tobacco prevention and cessation education.

Need for the project:

- This project addresses Community Needs in RHP3: CN.11-High rates of chronic disease and inadequate access to treatment programs and services for illnesses associated with chronic disease including: cancer, diabetes, obesity, cardiovascular disease, asthma, and AIDS/HIV; CN.12 – High rates of tobacco use and excessive alcohol use; CN.20 – Lack of access to programs providing health promotion education, training and support, including screenings, nutrition counseling, patient education programs; CN.22-Insufficient access to services that are specifically designed to address racial, ethnic and cultural health care disparities; CN.23-Lack of patient navigation, patient and family education and information programs.
- In the state of Texas, over one third of students use tobacco products and at least two thirds of middle and high school students reported they were not exposed to anti-smoking messages.

Target Population: Ten percent of Medicaid-eligible youth (11-18 years old) will be enrolled in up to three counties per year within the RHP3. The facilities targeted for provider training will be school-based student health clinics, as well as schools, community centers, faith organizations, and juvenile detention facilities.

Category 1 or 2 expected patient benefits:

- The DY4 goal is to implement evidence-based innovative ASPIRE program among adolescents in Chambers and Matagorda counties – 10% Improvement over DY3.
- The DY5 goal is to implement evidence-based innovative ASPIRE program among adolescents in Waller and Wharton counties – 20% over DY3.

Category 3 outcomes:

IT-11.6: Other Outcome Improvement Target – Improve utilization rates of the tobacco prevention and cessation program (ASPIRE) in adolescents aged 11 to 18 years of age.

Project Option 2.7.2 - Implement innovative evidence-based strategies to reduce tobacco use - Multimedia Tools and Community Engagement for Youth Early Tobacco Prevention and Cessation

Unique Project ID: 112672402.2.3
Performing Provider Name/TPI: The University of Texas MD Anderson Cancer Center / 112672402

Project Description:
Tobacco is the number one preventable cause of death from cancer and other diseases. Nearly all tobacco use begins during the teenage years. Low-income, underserved youth are at highest risk for becoming tobacco users. For these reasons, we will target individuals aged 11 to 18 years and propose a tobacco prevention and cessation initiative utilizing multimedia resources as well as an extensive community network.

The program would prevent smoking initiation and facilitate early cessation among those accessible in middle- and high-schools as well as for those inaccessible in schools (e.g., school dropouts, absentees, and transfers). Our evidence-based online tobacco program ASPIRE (A Smoking Prevention Interactive Experience) is free to the public and sustainable. It will serve as the primary resource for this project. ASPIRE will be utilized to reach underserved, at-risk youth at various access points in Regional Health Partnership (RHP) 3 counties. Youth will be exposed to multilingual, culturally relevant anti-tobacco messages using electronic, digital and print media. By the end of year 5 we anticipate enrolling more than 60,000 adolescents in RHP3 counties into the ASPIRE program.

Goal(s) and Relationship to Regional Goal(s):
This project will influence knowledge, attitudes, and perceptions of young people about tobacco products. Receipt of ASPIRE's health education, in turn will lead to reduced consumption of tobacco products and incidence of tobacco-related disease among participants, thereby increasing the future health and wellbeing of Region 3 adolescents.

This initiative will employ a range of activities and services to include: youth engagement through school-based events, Facebook/online advertising, and other group activities; community outreach with incentives/contests around national anti-tobacco events, youth education and counseling (including expectant teen mothers), parental /family and community involvement and provider/educator training. Furthermore, our concept will require the involvement of the following facilities: middle and high schools, clinics (e.g., WIC, family planning, STD), community centers, faith organizations, congregation spaces and juvenile detention facilities. Examples of providers include: administrative and educational personnel in schools, community leaders, congregation leaders, counselors, social workers and nurses.

This project meets the following regional goals:

- Develop a culture of ongoing transformation and innovation that maximizes the use of technology and best-practices, facilitates regional collaboration and sharing, and engages patients, providers, and other stakeholders in the planning, implementation, and evaluation processes.

- Develop a regional approach to health care delivery that leverages and improves on existing programs and infrastructure, is responsive to patient needs throughout the entire region, and improves health care outcomes and patient satisfaction.

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Challenges:
A main challenge will be the recruitment and retention of youth (i.e., maintaining their interest, motivation and commitment to the program). Secondarily, technology can pose its own challenges (e.g. glitches, bandwidth, software compatibility, etc.). Another challenge is related to the consistency of ASPIRE implementation among our partners. These obstacles can be successfully addressed by the implementation team. They have considerable experience in working with young, disadvantaged populations and intervention delivery. The director of this initiative, Dr. Alex Prokhorov has 30 years of experience in preventing youth tobacco use among underserved populations. We plan to also leverage the expertise of the following collaborators: Dr. Ellen Gritz (international leader in tobacco control), Dr. Damon Vidrine (expertise in mHealth/eHealth), Dr. Karen Calabro (education/smoking in young populations), Salma Marani (biostatistician for various tobacco and youth studies), and Lauren McCoy (health marketing/communications professional). Another strategic advantage for this initiative is the provision of resources that can compensate both individual participants and member partners (i.e., furnishing computer resources to facilitate youth viewing of ASPIRE within partner facilities).

5-Year Expected Outcome for Provider and Patients:
Our intent is to disseminate ASPIRE on a per-county basis. We plan to enroll 10% of Medicaid-eligible youth in up to three counties per year. Youth tobacco users and nonusers will join the initiative and be exposed to five modules of tobacco prevention and cessation education. In the past, ASPIRE participants nationwide have indicated that: (1) 92% learned new facts about the risks associated with tobacco, (2) 84% reported that ASPIRE influenced them not to use tobacco in the future, and (2) 92% have reported a greater understanding of how tobacco affects their health, the health of their family and friends. We expect the same level of engagement and receptivity to ASPIRE in Region 3.

Starting Point/Baseline:
The ASPIRE initiative is an existing program with widespread reach. Within the Houston area, 4,100 adolescents are engaged in ASPIRE or have been exposed to ASPIRE (year-to-date from 2008 to August 2012).

Rationale:
Project option 2.7.2 was selected because ASPIRE is an evidence-based program proven to reduce the uptake of tobacco use among underserved teenagers at highest risk for smoking initiation.

In the state of Texas, over one third of students use tobacco products and at least two thirds of middle and high school students reported they were not exposed to anti-smoking messages. Concurrently, youth are known to be heavy users of technology. For these reasons we will specifically focus on reaching underserved youth within Region 3 counties using a technology-based program that is evidence-based for high-risk adolescents. ASPIRE was tested among inner-city youth in urban Houston high schools and proved to be effective in preventing

smoking initiation. The program is used by adolescents in counties within Texas, is easily accessible with Internet access and is available at no cost to users. Additional funding will allow us to enhance the sustainability of ASPIRE and to offer better incentives for broader program participation. Additionally, the ASPIRE program can be easily implemented as it is self-directed for the students.

Project Components:
The activities of this initiative include efforts to train providers and community partners to consistently refer adolescents to tobacco prevention and tobacco cessation, which can lead to widespread delivery of tobacco prevention services in the RHP3 counties [P-6; IT-11.6]. The facilities targeted for provider training will be school-based student health clinics, as well as schools, community centers, faith organizations, and juvenile detention facilities.

Milestones & Metrics:
The following milestones and metrics were selected for the ASPIRE youth tobacco use prevention and cessation project based on the needs of the target population:

- Process Milestones and Metrics: P-2 (P-2.1); P-7 (P-7.1)
- Improvement Milestone and Metric: I-5 (I-5.1)

Unique community need identification number the project addresses: The project addresses the following unique community needs as identified in the Region 3 community needs assessment:

- CN.11- High rates of chronic disease and inadequate access to treatment programs and services for illnesses associated with chronic disease, including
  - Cancer
  - Diabetes
  - Obesity
  - Cardiovascular disease
  - Asthma
  - AIDS/HIV
- CN.12 - High rates of tobacco use and excessive alcohol use
- CN.20 - Lack of access to programs providing health promotion education, training and support, including screenings, nutrition counseling, patient education programs
- CN.22 - Insufficient access to services that are specifically designed to address racial, ethnic and cultural health care disparities
- CN.23 - Lack of patient navigation, patient and family education and information programs.

How the project represents a new initiative for the Performing Provider or significantly enhances an existing deliver system reform initiative:
Currently, there is no evidence-based tobacco prevention and cessation program that is available to teens in RHP3 counties at no cost to participants. This initiative will not only introduce this culturally-tailored resource to adolescents, but also provide access to tobacco education in support of positive health outcomes. During this initiative, we also plan to have bi-annual meetings with other RHP providers to contribute to the sharing of ideas and identifying best practices for the region.

Related Category 3 Outcome Measure(s):

OD-11 Addressing Health Disparities in Minority Populations:

- IT-11.6: Improve utilization rates of the tobacco prevention and cessation program (ASPIRE) in adolescents aged 11 to 18 years.
  - Numerator: Number of adolescents to enroll in program
  - Denominator: Number of adolescents
  - Data Source: ASPIRE administrative data system (numerator) and TBD (denominator)

Reasons/rationale for selecting the outcome measure(s):

Based on the options available, we believe the ASPIRE initiative is compatible with this Category 3 outcome measure because ASPIRE provides access to preventive services virtually non-existent in these communities. The ASPIRE program was tested with an 18-month randomized controlled study among 1160 ethnically diverse students from 16 inner-city high schools in Houston. About 6% of control group participants initiated smoking whereas < 2% of the intervention group initiated smoking ($p < .05$).[256] According to the 2010 U.S. Bureau of the Census, there are approximately 1.4 million adolescents residing in RHP3 counties. Within this figure, we conservatively estimate that nearly 350,000 young within this group (i.e., 25%) are covered by Medicaid.

Relationship to Other Projects:

By delivering a tobacco use prevention and cessation program to youth, this project, like our other projects, supports one of the eight goals of the Comprehensive Cancer Control Program at MD Anderson Cancer Center.

Relationship to Other Performing Providers' Projects in the RHP:

Healthcare treatment cannot focus to only the acute or chronic encounter and properly treat the patient. It is critical that our region focuses to patient education and community education to ensure a proactive and responsive approach to healthcare needs. The education models represented in the Region 3 RHP plan can be identified in the Initiative Grid (addendum) and all focus to outcome measures such as appropriate utilization, patient satisfaction scores, and standalone chronic condition scores such as diabetes and asthma.

Plan for Learning Collaborative: We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for RHP 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system.

Project Valuation: We have based our project valuation on California's 1115 Medicaid Waiver model. As such, we have valued our projects at 2.5 times that of the estimated costs. Basing our valuations on California's calculations we know we are well within the potential range of future cost savings when looking at the following from Prevention Institute and Trust for America's

[1.] Prokhorov, A. V., Kelder, S. H., Shegog, R., Murray, N., Peters, R., Jr., Agurcia-Parker, C., Hudmon, K. S. (2008). Impact of A Smoking Prevention Interactive Experience (ASPIRE), an interactive, multimedia smoking prevention and cessation curriculum for culturally diverse high-school students. *Nicotine Tob Res, 10*(9), 1477-1485

Health Issue Report entitled *Prevention for a Healthier America: Investments in Disease Prevention Yield Significant Savings, Stronger Communities (July 2008)*:

- Prevention saves money – an investment of $10 per person per year in programs to increase physical activity, improve nutrition, and prevent tobacco use could save the country more than $16 billion in annual health care costs within five years.
- Prevention can reduce end-of-life costs by increasing health during the lifespan, what researchers call the *compression of morbidity*.

There is a substantial return-on-investment in prevention – For every $1 invested in community-based prevention, the return amounts to $5.60.

Unique Identifier: 112672402.2.3	***RHP PP Reference Number:** 2.7.2*	***Project Components:** 2.7.2*	***Project Title:** Implement innovative evidence-based strategies to reduce tobacco use - Multimedia Tools and Community Engagement for Youth Early Tobacco Prevention and Cessation*
The University of Texas MD Anderson Cancer Center			*112672402*
Related Category 3 Outcome Measure(s):	112672402.3.5	*IT-11.6*	*Other Outcome Improvement Target (Improve utilization rates of the tobacco prevention and cessation program [ASPIRE] in adolescents aged 11 to 18 years)*

Year 2 (10/1/2012 – 9/30/2013)	**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]: Implement evidence-based innovative ASPIRE program among adolescents in Harris and Austin counties. Metric 1[P-2.1]: Enroll 10% of counties' adolescents in ASPIRE program. Baseline/Goal: *Baseline of nearly 4,100 enrolled ASPIRE participants in the Houston area* Data Source: ASPIRE data system Milestone 1: Estimated Incentive Payment: $4,725,000.00	**Milestone 2** [P-2]: Implement evidence-based innovative ASPIRE program among adolescents in Calhoun, Colorado, and Fort Bend counties. Metric 1[P-2.1]: Enroll 10% of counties' adolescents in ASPIRE program. Baseline/Goal: TBD Data Source: ASPIRE data system **Milestone 2: Estimated Incentive Payment:** $2,264,075.00 **Quality Improvement Milestone 3** [P-7] : Participate in bi-annual meetings with other RHP providers and identify areas for improvement Metric [P-7.1]: Attendance in at least 2 semi-annual face-to-face meetings organized by the RHP **Milestone 3: Estimated Incentive Payment:** $2,264,075.00	**Milestone 4** [P-2]: Implement evidence-based innovative ASPIRE program among adolescents in Chambers and Matagorda counties. Metric 1[P-2.1]: Enroll 10% of counties' adolescents in ASPIRE program. Baseline/Goal: DY 3 baseline/10% enrollment improvement over DY 3 baseline Data Source: ASPIRE data system **Milestone 4: Estimated Incentive Payment:** $2,264,075.00 **Quality Improvement Milestone 5** [P-7] : Participate in bi-annual meetings with other RHP providers and identify areas for improvement Metric [P-7.1]: Attendance in at least 2 semi-annual face-to-face meetings organized by the RHP Baseline/Goal: N/A. **Milestone 5: Estimated Incentive Payment:** $2,264,075.00	**Milestone 6** [P-2]: Implement evidence-based innovative ASPIRE program among adolescents in Waller and Wharton counties. Metric 1[P-2.1]: Enroll 10% of counties' adolescents in ASPIRE program. Baseline/Goal: DY 3 baseline/20% enrollment improvement over DY 3. Data Source: ASPIRE data system **Milestone 6: Estimated Incentive Payment:** $1,576,050.00 **Quality Improvement Milestone 7** [P-7] : Participate in bi-annual meetings with other RHP providers and identify areas for improvement Metric [P-7.1]: Attendance in at least 2 semi-annual face-to-face meetings organized by the RHP Baseline/Goal: N/A. **Milestone 7: Estimated Incentive Payment:** $1,576,050.00 **Milestone 8** [I-5] Identify X number or percent of patients in defined population receiving innovative intervention consistent with evidence-based model.

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<tr><td colspan="2">Unique Identifier: 112672402.2.3</td><td colspan="2">RHP PP Reference Number: 2.7.2</td><td colspan="2">Project Components: 2.7.2</td><td colspan="2">Project Title: Implement innovative evidence-based strategies to reduce tobacco use - Multimedia Tools and Community Engagement for Youth Early Tobacco Prevention and Cessation</td></tr>
<tr><td colspan="7">The University of Texas MD Anderson Cancer Center</td><td>112672402</td></tr>
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(10/1/2013 – 9/30/2014)</td><td colspan="2">Year 4
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(10/1/2015 – 9/30/2016)</td></tr>
<tr><td colspan="2"></td><td colspan="2"></td><td colspan="2"></td><td colspan="2">Baseline/Goal: TBD
Metric: TBD

Milestone 8: Estimated incentive payment: $1,576,050.00</td></tr>
<tr><td colspan="2">Year 2 Estimated Milestone Bundle Amount:$4,725,000.00</td><td colspan="2">Year 3 Estimated Milestone Bundle Amount: $4,728,150.00</td><td colspan="2">Year 4 Estimated Milestone Bundle Amount: $4,728,150.00</td><td colspan="2">Year 5 Estimated Milestone Bundle Amount: $4,728,150.00</td></tr>
<tr><td colspan="8">TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over DYs 2-5): $18,909,450.00</td></tr>
</table>

Project Option 2.7.1 – Implement innovative evidence-based strategies to increase appropriate use of technology and testing for targeted populations (e.g., mammography screens, colonoscopies, prenatal alcohol use, etc.): Expand Project VALET
Unique RHP Project ID: 112672402.2.4
Performing Provider Name/TPI: The University of Texas MD Anderson Cancer Center / 112672402 **Project Summary:**
Provider: The University of Texas MD Anderson Cancer Center is a comprehensive cancer center ranked first in cancer care by *U.S. News & World Report* and dedicated to patient care, education, research and prevention. MD Anderson is comprised of several Texas Medical Center campus locations, two research campuses in Bastrop County, Texas, four regional care centers and a number of national and international divisions and affiliates. More than 108,000 people—almost one-third of them new patients—were seen in FY2011. MD Anderson provided $215 million in uncompensated charity care to Texans in FY2011.
Intervention(s): This project will expand Project VALET (Providing Valuable Area Life-Saving Exams in Town), a breast cancer screening mammography service for uninsured women, ages 40 and older in Houston, to the RHP3's coverage area.
Need for the project: **A)** This project addresses the following unique community needs in the RHP3: CN.2-Inadequate access to specialty care; CN.11-High rates of chronic disease and inadequate access to treatment programs and services for illnesses associated with cancer; CN.20-Lack of access to programs providing health promotion education, training and support, including screenings, nutrition counseling, patient education programs; CN.21-Inadequate transportation options for individuals in rural areas and for indigent/low-income populations; CN.22-Insufficient access to services that are specifically designed to address racial, ethnic, and culturally health disparities. **B)** This program has consistently increased the numbers of uninsured and low-income women – especially racial/ethnic minorities, such as Hispanic and African American – getting screened for breast cancer. Since its inception, Project VALET has demonstrated that despite Houston's vast medical services, the percentage of women in need of breast cancer screening is still high (36%). Barriers to care, such as lack of transportation, partially explain low screening rates in this population. Currently, the number of screening appointments needed exceeds the available screening capacity.
Target Population: Women within the RHP3 counties eligible to participate in Project VALET are those 40 years of age or older, asymptomatic and without medical insurance. Women must also receive a clinical breast exam at one of the participating clinics before scheduling with MD Anderson Mobile Mammography Appointment Line.
Category 1 or 2 expected patient benefits: The DY4 goal is to increase number of target population receiving breast cancer screening by 50% over DY3 (Screen 1,200 women for breast cancer). The DY5 goal is to increase number of target population receiving screening by 25% over DY4 by extending project in two additional RHP area clinics (Screen 1,600 women for breast cancer).
Category 3 outcomes: **IT-11.1**: Improvement in Clinical Indicator in identified disparity group. Clinical indicator to be improved and disparity group to be determined by provider (Standalone Measure). Number of women who are assessed for eligibility for a screening mammogram, during the clinic intake and number of women seen in the participating clinics who receive a well-woman exam. **IT-12.1**: Breast Cancer Screening (HEDIS 2012) Number of women, ages 40 to 70, who have received an annual mammogram during the reporting period and number of women ages 40 to 70 in service area who meet Project VALET's eligibility criteria.

~~**Project Option 1.1.3 – Expand Mobile Clinics – Expansion of Project VALET of Screening Mammograms**~~

Project Option 2.7.1 Implement innovative evidence-based strategies to increase appropriate use of technology and testing for targeted populations (e.g., mammography screens, colonoscopies, prenatal alcohol use, etc.) – Expansion of Project VALET of Screening Mammograms

Unique Project ID: 112672402.2.4
Performing Provider Name/TPI: The University of Texas MD Anderson Cancer Center / 112672402
Project Description:

The University of Texas MD Anderson Cancer Center (MD Anderson), in partnership with The Rose, a non-profit breast organization, and the Houston Department of Human and Health Services (HDHHS), will expand Project VALET (Providing Valuable Area Life-Saving Exams in Town), a breast cancer screening mammography service for uninsured women, ages 40 and older in Houston, to the RHP3's coverage area.

For the past four years, Project VALET has relied on the MD Anderson Breast Clinic's availability to provide screening dates with their sole digital mobile mammography van. Since the majority of the Breast Clinic's screening dates are reserved for long-standing corporate clients and clinics, the acquisition of a new mobile van would enable Project VALET to increase its screening capacity, thus reaching a broader base of at-risk populations and expanding its geographic coverage to include neighboring clinics within the RHP3 area.

Project VALET's overall goals align with the regional goals since they will leverage existing programs which offer well-woman exams and enhance them by providing free screening mammograms to underserved populations that might not otherwise have access to this specialty care or the ability to pay for it. Doing so will increase the number of underserved and uninsured women in the RHP3 who receive a clinical breast exam and screening mammogram, especially those who have not been compliant with the recommended American Cancer Society (ACS) screening guidelines for the early detection of breast cancer. (The ACS guidelines used for breast cancer are an annual clinical breast exam for asymptomatic women age 40 and older as a part of a periodic health examination as well as annual mammography) (1). This implements best-practices and maximizes the use of technology. This will reinforce patients to adopt preventive health care measures and in the process, positively impact breast cancer outcomes.

Target Population and Eligibility: To be eligible to participate in Project VALET, a woman must be 40 years of age or older, asymptomatic and without medical insurance. (Citizenship or legal residency status will not be requested.) After receiving a clinical breast exam at one of the participating clinics, women meeting the eligibility criteria will be given the phone number to the MD Anderson Mobile Mammography Appointment Line and information on what to expect on the day of the screening event. (The information will be available in English and Spanish.) It is the woman's responsibility to schedule her screening mammogram. MD Anderson Mobile Appointment Line staff members will make a reminder call to the patient 24-hours in advance of her appointment. On the screening day, the patient will complete her registration forms and receive an educational packet with breast health information and a list of organizations that can provide diagnostic tests and/or treatment if needed. Two to three weeks after the screening event,

both the patient and her referring clinic will receive a copy of the screening result. If the result is negative, the woman is encouraged to return for an annual screening mammogram. If positive, the community health worker (CHW) will navigate the woman to the appropriate service(s).

Goal(s) and Relationship to Regional Goal(s):
The goal of this project is to utilize an evidence-based approach in RHP 3 clinics to increase breast cancer screening to women, ages 40-70, who qualify for a free, breast screening mammogram. Culturally appropriate material will be distributed to all women who go in for a well-woman exam.

To ensure the success of this project, the program manager will train clinic staff and CHWs on the process of how to obtain a screening mammogram; ensure that proper data and documentation is being collected; attend screening events to help register patients and answer any questions that might arise.
Project Goals:

- Assess the number of women who have previously received a screening mammogram
- Increase the number of uninsured, underserved women who have received a screening mammogram in RHP3
- Establish base-line mammograms for traditionally non-compliant populations
- Increase the frequency and geographical range of screening mammogram events in the RHP3

This project meets the following Region 3 goals:

- Increase access to primary and specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their condition, regardless of where they live or their ability to pay.

The Project VALET Expansion program aims to reduce the incidence and mortality of breast cancer by offering free screening mammograms to women who qualify, in a participating neighborhood clinic. This project will be implemented in three counties within the RHP3 geographic area. Clinics targeted are: Houston Department of Health and Human Services, Federally Qualified Health Centers (FQHCs), and other clinics that provide well-woman exams.

Challenges:
Internal challenges: First and foremost, all program planning and implementation hinges on purchasing a new, digital mobile mammography van, without which, it is impossible to add more screening dates and/or clinics. This will also enable us to add screening dates since we have reached the maximum amount of days available with the current van. In addition, a new van will provide back-up van when mechanical issues arise with the primary van. (Historically, Project VALET cancels an average of four to five screenings per year due to this problem.) A secondary challenge is identifying clinics in neighboring RHP3 regions that offer well-woman services while meeting the MD Anderson Mobile Mammography van's primary criteria that screening sites must be within a 45-mile radius from the hospital. Though this will limit the number of clinics we can partner with in the RHP3 geographical area, for those clinics that meet the site criteria, we will be able to provide screening services in neighborhoods that have traditionally been without such services.

External challenges: Working with different clinics might impact the ability to collect complete clinical breast exam and screening data on an ongoing basis, especially when clinics

have staff transitions and/or reductions (we have faced both situations in our partnership with HDHHS). Furthermore, the clinics might not have the technical capability to do this. The program will offer to pay for technical upgrades to facilitate data collection.

Another challenge is recruiting women who are unaccustomed to seeking preventive care because of financial barriers or the fear of getting screened without resources for diagnostic testing and/or treatment, should they need them. The CHWs will create educational folders with breast cancer information and help navigate the patient in finding resources for low-cost or free services that might be needed. The CHWS and the program manager will be available for additional questions or issues that might arise.

Environmental challenges: Inclement weather (e.g., heavy rainfall) typically increases the no-show rate because some of the patients take public transportation or walk to the screening events.

Five-year Expected Outcome for Provider and Patients:

- Increase the number of uninsured, underserved women adhering to ACS' breast cancer screening guidelines
- Establish base-line mammograms for traditionally non-compliant populations
- Increase the frequency of screening mammogram events in RHP3

Starting Point/Baseline:

From June 2008 to August 2012, Project VALET has provided 1,205 screening mammograms from approximately 1,500 encounters with potential participants. Ninety percent of the providers affiliated with this program have received training on how to implement Project VALET. Since this is an expansion project, the baseline will be determined after an initial period of operation.

Rationale:

Project VALET was selected because it has been successfully implemented on a smaller scale in the City of Houston. Furthermore, this program has consistently increased the numbers of uninsured and low-income women – especially racial/ethnic minorities, such as Hispanic and African American – getting screened for breast cancer. Since its inception, Project VALET has demonstrated that despite Houston's vast medical services, the percentage of women in need of breast cancer screening is still high (36%) (2). Barriers to care such as lack of transportation partially explain low screening rates in this population (3). Currently, the number of screening appointments needed exceeds the available screening capacity.

More than 2,800 women are expected to die this year in Texas as a result of breast cancer (4) and many of the women who die will present with late stage disease because they did not participate in breast cancer screenings (5). Breast cancer death rates are highest for Black women (6). Indigent/low-income women and Hispanic women (7) are less likely to get annual breast screenings. Lack of insurance has been associated with significantly worse outcomes for several other cancer sites, specifically breast cancer (8). Moreover, malignant neoplasms exceed heart disease as a cause of death for Hispanics and the burden of cancer is more prominent in counties with larger numbers of Hispanics such as those in RHP 3 (9). The insurance barrier impacts indigent/low income women disproportionately. This population has a higher rate of non-compliance with recommended mammography screening. Overall, lower income, lack of

insurance and Hispanic ethnicity have been identified as factors associated with decreased participation in routine cancer screening.

Because this a mobile mammography program that offers screening at low or no cost to participants the barriers based on cost of services and lack of transportation to screening locations are eliminated. Furthermore, the project will addresses health care disparities due to language and cultural barriers because services and educational materials will be provided in Spanish using a culturally-tailored program for those in need of this approach.

Project Components:

Through Project VALET's Expansion Program, we propose to meet all required project components listed below and believe that the selected milestones and metrics relate to project components.

a) So that patients have enhanced access to breast cancer screening services, this project will expand the use of a mobile mammography screening program to additional clinics and counties in RHP 3. ~~Implement/expand a mobile health clinic program~~. ~~(P-3)~~ Implement evidence-based innovational project for target population (Expand Project VALET mobile mammography program) (P-2)
b) Designate/hire personnel or teams to support and/or manage the project. (P-X)
c) Develop process steps and marketing materials for the project. (P-X)
d) Conduct bi-annual trainings with clinic staff and make necessary technical upgrades to ensure compliance with patient reporting; market project through community outreach. (P-X)
e) Increase access to breast cancer screening through Project VALET. (P-X)
f) 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-X)
g) Hire an evaluator to assess the project. Review program project implementation with collaborators and address issues that have arisen. Tailor and redesign the project to increase participant rates using feedback from the clinics and the evaluator.

Milestones & Metrics:

The following milestones and metrics have been chosen for the Expansion of Project VALET based on the core components and the needs of the target population:

- Process Milestone and Metrics: P-2 (P-2.1); ~~P-3 (P-3.1);~~ P-X (P-X.1);
- Improvement Milestones and Metrics: I-X (I-X.1, I-X.2) ~~I-12 (I-12.1), (I-12.2); I-15 (I-15.3)~~

Customizable Process Milestones and Metrics were chosen to specifically tailor their intent to the project process.

Unique community needs identification number the project addresses:

The project addresses the following unique community needs as identified in the community needs assessment:

- CN.2 – Inadequate access to specialty care

- CN.11 – High rates of chronic disease and inadequate access to treatment programs and services for illnesses associated with cancer
- CN.20 – Lack of access to programs providing health promotion education, training and support, including screenings, nutrition counseling, patient education programs
- CN.21 – Inadequate transportation options for individuals in rural areas and for indigent/low-income populations
- CN.22 – Insufficient access to services that are specifically designed to address racial, ethnic and cultural health care disparities

How the project represents a new initiative for the Performing Provider or significantly enhances an existing delivery system reform initiative: The expansion of Project VALET represents a significant enhancement of current breast cancer screening programs by further reducing barriers to care such as access to screening services at low or no cost, language barriers, and lack of transportation.

Related Category 3 Outcome Measure(s):

OD-11 Addressing Health Disparities in Minority Populations

IT-11.1 Improvement in Clinical Indicator in identified disparity group. Clinical indicator to be improved and disparity group to be determined by provider (Standalone measure)

- Number of women that are assessed for eligibility for a screening mammogram, during the clinic intake. (TBD)
- Number of women who have been seen in the participating clinics who receive a well-woman exam

OD-12 Primary Care and Primary Prevention

IT-12.1 Breast Cancer Screening (HEDIS 2012)

- Number of women, ages 40 to 70, who have received an annual mammogram during the reporting period. (TBD)
- Number of women ages 40 to 70 in area, who meet Project VALET's eligibility criteria

Reasons/Rationale for selecting the outcome measure(s):

Providing free screening mammograms to uninsured and Medicaid women, who meet the screening criteria is a prevention strategy which removes the financial and transportation barriers that typically prevent these women from getting screened.

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 test(s) 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.

Screening completion rates for low-income/indigent and minority women in RHP 3 continue to fall below guidelines of the CDC initiative *Healthy People 2020* of 81.1 percent (10).

According to 2010 Texas Behavioral Risk Factor Surveillance System for PHR6/5S (which includes all the counties in RHP 3 except for Calhoun), 74.9% of Black women, 72.5% of Hispanic women, and only 69.3% of white women ages 40 and over have had a mammogram within the past two years (11). For women in household earning less than $25,000 per year, 64.3% have had a mammogram within the past two years. *Healthy People 2020*'s target for the breast cancer death rate is 20.6 deaths per 100,000 females and it seeks to reduce late-stage diagnosis of breast cancer to 41.0 new cases per 100,000 females by 2020 (12). None of the counties in RHP 3 has met this goal with the exception of Fort Bend County with 20.1 deaths per 100,000 for 2005-2009 (13).

Relationship to other Projects:
The project will support Goal 5, "Reducing the mortality of breast cancer in the Houston MSA," one of the eight goals of the Comprehensive Cancer Control Program at The University of Texas MD Anderson Cancer Center.

Relationship to Other Performing Providers' Projects in the RHP:
The increase of primary care and specialty care will naturally result in additional ambulatory care encounters for our region patient base. The ambulatory initiatives cover items such as laboratory, PT/OT, social work, etc. and are a necessity of our patients to ensure a comprehensive treatment for access as well as cost avoidance. The Region 3 initiative grid in the addendum reflects all ambulatory operations initiatives.

Plan for Learning Collaborative:
We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for the Region 3, Harris Health System. Our participation in this collaborative with other performing providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our region's health care system.

Project Valuation: We have based our project valuation on California's 1115 Medicaid Waiver model. As such, we have valued our projects at 2.5 times that of the estimated costs. Basing our valuations on California's calculations we know we are well within the potential range of future cost savings when looking at the following from Prevention Institute and Trust for America's Health Issue Report entitled *Prevention for a Healthier America: Investments in Disease Prevention Yield Significant Savings, Stronger Communities (July 2008)*:

- Prevention can reduce end-of-life costs by increasing health during the lifespan, what researchers call the *compression of morbidity*.
- There is a substantial return-on-investment in prevention – For every $1 invested in community-based prevention, the return amounts to $5.60.

112672402.1.1	*1.1.3*	*1.1.3*	*~~Expand Mobile Clinics~~ Implement innovative evidence-based strategies to increase appropriate use of technology and testing for targeted populations (e.g., mammography screens, colonoscopies, prenatal alcohol use, etc.) – Expansion of Project VALET of Screening Mammograms*
Performing Provider Name: The University of Texas MD Anderson Cancer Center			*TPI - 112672402*
Related Category 3 Outcome Measure(s):	*112672402.3.6* *112672402.3.7*	• *IT-11.1* • *IT.12.1*	• *Improvement in Clinical Indicator in identified disparity group. Clinical indicator to be improved and disparity group to be determined by provider.* • *Breast Cancer Screening (HEDIS 2012)*
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Milestone 1 ~~[P-3]~~: [P-2] ~~Implement/expand a mobile health clinic program.~~ Implement evidence-based innovational project for target population (Expand Project VALET mobile mammography) Metric 1 ~~[P-3.1]~~: [P-2.1] ~~Number of additional clinics or expanded hours or space.~~ Document implementation strategy and testing outcomes a. Documentation of detailed expansion plan: ~~b. Baseline/Goal: N/A~~ c. Data Source: New ~~primary care~~ mobile mammography schedule or other Performing Provider documents. d. Rationale/Evidence: Many RHP plans cover very large counties, including hundreds of miles. In some areas, it may take patients hours to drive to Performing Provider facilities. Therefore, a mobile clinic offers the benefits of taking the services to the patients, which will help keep them healthy proactively. **Milestone 1 Estimated Incentive Payment:** $929,082.00	**Milestone 4** [P-X]: Increase access to breast cancer screening through Project VALET. Metric 1 [P-X.2]: Implement project in four new clinics in the RHP3 area. a. Baseline/Goal: TBD/Goal is to screen 800 women for breast cancer. b. Data Source: Documented results of screened women **Milestone 4 Estimated Incentive Payment:** $415,206.75 **Milestone 5** [P-X]: Conduct bi-annual trainings with clinic staff and make necessary technical upgrades to ensure compliance with patient reporting; market project through community outreach. Metric 1 [P-X.1]: Community or population outreach and marketing, staff training, implement intervention. a. Baseline/Goal: TBD/Goal is to train staff at four additional clinics in the RHP3, twice yearly. b. Data Source: Training records and curricula	**Milestone 7** [P-X]: Increase access to breast cancer screening through Project VALET. Metric 1 [P-X.2]: Implement project in two new clinics in the RHP3 area. a. Baseline/Goal: DY 3 baseline/Increase number of target population receiving breast cancer screening by 50% over DY3 (Screen 1,200 women for breast cancer.) b. Data Source: Documented results of screened women **Milestone 7 Estimated Incentive Payment**: $345,901.50 **Milestone 8** [P-X]: Conduct bi-annual trainings with clinic staff and market project through community outreach. Metric 1 [P-X.1]: Community or population outreach and marketing, staff training, implement intervention. a. Baseline/Goal: Trained staff at four clinics/Goal is to train staff at two additional clinics (six clinics total) in the RHP3, twice yearly. b. Data Source: Training records and	**Milestone 11** [P-X]: Increase access to breast cancer screening through Project VALET. Metric 1 [P-X.2]: Implement project in two new clinics in the RHP3 area. a. Baseline/Goal: DY 4 screenings/Increase number of target population receiving breast cancer screening by 25% over DY4 by extending project in two additional RHP area clinics. (Screen 1,600 women for breast cancer.) b. Data Source: Documented results of screened women **Milestone 11 Estimated Incentive Payment:** $384,322.68 **Milestone 12** [P-X]: Conduct bi-annual trainings with clinic staff and market project through community outreach. Metric 1 [P-X.1]: Community or population outreach and marketing, staff training, implement intervention. a. Baseline/Goal: DY 4 trainings/ Goal is to train staff at two additional clinics (eight clinics total) in the

112672402.1.1	1.1.3	1.1.3	~~Expand Mobile Clinics~~ *Implement innovative evidence-based strategies to increase appropriate use of technology and testing for targeted populations (e.g., mammography screens, colonoscopies, prenatal alcohol use, etc.) – Expansion of Project VALET of Screening Mammograms*
Performing Provider Name: The University of Texas MD Anderson Cancer Center			*TPI - 112672402*
Related Category 3 Outcome Measure(s):	*112672402.3.6* *112672402.3.7*	• *IT-11.1* • *IT.12.1*	• *Improvement in Clinical Indicator in identified disparity group. Clinical indicator to be improved and disparity group to be determined by provider.* • *Breast Cancer Screening (HEDIS 2012)*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
<u>**Milestone 2**</u> <u>[P-X]:</u> Designate/hire personnel or teams to support and/or manage the project. <u>Metric 1 [P-X.1]:</u> Number of staff hired and trained. <u>a. Baseline/goal:</u> Hire and train one program manager and two part-time Community Health Workers (CHWs) to implement and manage program. <u>b. Data Source:</u> Project records; training curricula **Milestone 2 Estimated Incentive Payment:** $929,082.00 <u>**Milestone 3**</u> <u>[P-X]:</u> Develop process steps and marketing materials for the project. <u>Metric 1 [P-X.1]:</u> Create process steps, training manual and marketing materials. <u>a. Baseline/goal:</u> Develop print and online material. <u>b. Data Source:</u> Process steps for project, training curricula and marketing material.	**Milestone 5 Estimated Incentive Payment:** $415,206.75 <u>**Milestone 6**</u> <u>[P-X]:</u> Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to “raise the floor” for performance). Each participating provider should publicly commit to implementing these improvements. <u>Metric 1 [P-X.1]</u>: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Baseline/Goal: N/A <u>a. Data Source:</u> Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. <u>b. Rationale/Evidence:</u> Investment in learning and sharing of ideas is	curricula Milestone 8 Estimated Incentive Payment: $345,901.50 <u>**Milestone 9**</u> <u>[P-X]:</u> Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to “raise the floor” for performance). Each participating provider should publicly commit to implementing these improvements. <u>Metric 1 [P-X.1]</u>: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Baseline/Goal: N/A <u>a. Data Source:</u> Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. <u>b. Rationale/Evidence:</u> Investment in	RHP3, twice yearly. <u>b. Data Source:</u> Training records and curricula **Milestone 12 Estimated Incentive Payment:** $384,322.68 <u>**Milestone 13**</u> <u>[P-X]:</u> Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. At each face-to-face meeting, all providers should identify and agree upon several improvements (simple initiatives that all providers can do to “raise the floor” for performance). Each participating provider should publicly commit to implementing these improvements. <u>Metric 1 [P-X.1]</u>: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Baseline/Goal: N/A <u>a. Data Source:</u> Documentation of semiannual meetings including meeting agendas, slides from

112672402.1.1	1.1.3	1.1.3	~~Expand Mobile Clinics~~ *Implement innovative evidence-based strategies to increase appropriate use of technology and testing for targeted populations (e.g., mammography screens, colonoscopies, prenatal alcohol use, etc.) – Expansion of Project VALET of Screening Mammograms*
Performing Provider Name: The University of Texas MD Anderson Cancer Center			*TPI - 112672402*
Related Category 3 Outcome Measure(s):	*112672402.3.6* *112672402.3.7*	• *IT-11.1* • *IT.12.1*	• *Improvement in Clinical Indicator in identified disparity group. Clinical indicator to be improved and disparity group to be determined by provider.* • *Breast Cancer Screening (HEDIS 2012)*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 3 Estimated Incentive Payment: $929,082.00	central to improvement. The highest quality health care systems promote continuous learning and exchange between providers and decide collectively how to "raise the floor" for performance across all providers. **Milestone 6 Estimated Incentive Payment:** $415,206.75	learning and sharing of ideas is central to improvement. The highest quality health care systems promote continuous learning and exchange between providers and decide collectively how to "raise the floor" for performance across all providers. **Milestone 9 Estimated Incentive Payment:** $345,901.50 ~~**Milestone 10** [I-15] Increase access to primary care capacity~~ ~~Metric [I-15.3]: Documentation of increased number of unique patients, or size of patient panels.~~ ~~Baseline/Goal: TBD/TBD~~ ~~Data Source: Claims~~ **Milestone 10 [I-X]** Increase adoption of Project VALET protocol by participating clinic providers. Metric 1 [I-X.1] Short term: Increased adoption of Project VALET protocol by providers	presentations, and/or meeting notes. <u>b. Rationale/Evidence:</u> Investment in learning and sharing of ideas is central to improvement. The highest quality health care systems promote continuous learning and exchange between providers and decide collectively how to "raise the floor" for performance across all providers. **Milestone 13 Estimated Incentive Payment:** $384,322.68 <u>**Milestone 14** [P-X]:</u> Hire an evaluator to assess the project. Review program project implementation with collaborators and address issues that have arisen. Tailor and redesign the project to increase participant rates using feedback from the clinics and the evaluator. <u>Metric 1</u> [P-X.1]: Conduct needs assessment, literature review for evidence-based practices and tailor intervention to local context. <u>a. Baseline/Goal:</u> N/A/Make any recommended modifications to increase the project's efficiency.

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112672402.1.1	1.1.3	1.1.3	~~Expand Mobile Clinics~~ *Implement innovative evidence-based strategies to increase appropriate use of technology and testing for targeted populations (e.g., mammography screens, colonoscopies, prenatal alcohol use, etc.) – Expansion of Project VALET of Screening Mammograms*
Performing Provider Name: The University of Texas MD Anderson Cancer Center			*TPI - 112672402*
Related Category 3 Outcome Measure(s):	*112672402.3.6* *112672402.3.7*	• *IT-11.1* • *IT.12.1*	• *Improvement in Clinical Indicator in identified disparity group. Clinical indicator to be improved and disparity group to be determined by provider.* • *Breast Cancer Screening (HEDIS 2012)*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
		Data Source: Medical record data and primary data collection **Milestone 10 Estimated Incentive Payment:** $345,901.50	b. Data Source: Document the number of new participants and return participants **Milestone 14 Estimated Incentive Payment:** $384,322.68 ~~**Milestone 15** [I-15] Increase access to primary care capacity~~ ~~Metric [I-15.3]: Documentation of increased number of unique patients, or size of patient panels.~~ ~~Baseline/Goal: TBD/10% increase in unique patients compared with DY 4.~~ ~~Data Source: Claims~~ **Milestone 15 [I-X]** Increase adoption of Project VALET protocol by participating clinic providers. Metric 1 [I-X.2] Intermediate: Increased adherence of Project VALET protocol by providers Data Source: Medical record data and primary data collection

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112672402.1.1	*1.1.3*	*1.1.3*	~~*Expand Mobile Clinics*~~ *Implement innovative evidence-based strategies to increase appropriate use of technology and testing for targeted populations (e.g., mammography screens, colonoscopies, prenatal alcohol use, etc.) – Expansion of Project VALET of Screening Mammograms*
Performing Provider Name: The University of Texas MD Anderson Cancer Center			*TPI - 112672402*
Related Category 3 Outcome Measure(s):	*112672402.3.6* *112672402.3.7*	• *IT-11.1* • *IT.12.1*	• *Improvement in Clinical Indicator in identified disparity group. Clinical indicator to be improved and disparity group to be determined by provider.* • *Breast Cancer Screening (HEDIS 2012)*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
			Milestone 15 Estimated Incentive Payment: $384,322.68
Year 2 Estimated Milestone Bundle Amount: $2,787,246.00	Year 3 Estimated Milestone Bundle Amount: $1,247,620.25	Year 4 Estimated Milestone Bundle Amount: $1,383,606.00	Year 5 Estimated Milestone Bundle Amount: $1,921,613.40
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:** ~~$7,338,085.65~~ $7,340,085.65			

University of Texas M.D. Anderson Cancer Center

Pass 2

Project Option 2.7.2 – Implement innovative evidence-based strategies to reduce tobacco use – Replicating Ask Advise Connect (AAC) in Federally-Qualified Health Centers
Unique RHP Project ID: 112672402.2.5
Performing Provider Name/TPI: The University of Texas MD Anderson Cancer Center / 112672402
Project Summary:
Provider: The University of Texas MD Anderson Cancer Center is a comprehensive cancer center ranked first in cancer care by *U.S. News & World Report* and dedicated to patient care, education, research and prevention. MD Anderson is comprised of several Texas Medical Center campus locations, two research campuses in Bastrop County, Texas, four regional care centers and a number of national and international divisions and affiliates. More than 108,000 people—almost one-third of them new patients—were seen in FY2011. MD Anderson provided $215 million in uncompensated charity care to Texans in FY2011.
Intervention(s): Ask Advise Connect (AAC) will be delivered in Federally Qualified Health Centers (FQHCs) in Harris County by implementing clinical practice guidelines and promoting health system supports in electronic health records. In AAC, licensed vocational nurses and medical assistants are trained to ask all adult patients at every visit about their smoking status at the time that vital signs are assessed, provide brief advice to all smokers to quit, offer cessation assistance via the Quitline, and directly connect patients willing to accept assistance with the Quitline. Connections to the Quitline are made by clicking an automated link in the electronic health record (EHR) that sends smokers' names and phone numbers to the Quitline within 24 hours. Patients are contacted by the Quitline within 48 hours of receipt of their contact information.
Need for the project: **A)** This project addresses Community Needs in RHP3: CN.11-High rates of chronic disease and inadequate access to treatment programs and services for illnesses associated with chronic disease including: cancer, diabetes, obesity, cardiovascular disease, asthma, and AIDS/HIV; CN.12 – High rates of tobacco use and excessive alcohol use. **B)** An important component of the Patient Protection and Affordable Care Act (i.e., health care reform; ACA) is that information regarding tobacco use assessment and treatment be systematically tracked and recorded through electronic health records (EHR). Meaningful use criteria require clinicians to screen the smoking status of more than 50% of all unique patients who are 13 years old or older. Additionally, the percentage of patients 18 and older who are current tobacco users and who receive advice, cessation treatments, or recommendations to use cessation medications and/or other strategies from a practitioner during the year, must also be tracked.
Target Population: Adult tobacco users within the nine FQHCs in Harris County. This represents a total of 25 primary care clinic sites. FQHCs provide care to approximately 80,160 medically-underserved individuals in the greater Houston area.
Category 1 or 2 expected patient benefits: The DY3 & 4 goals are to screen 75% of the adult patients receiving services at selected FQHCs and to connect 15% of eligible smokers to the Quitline.
Category 3 outcomes: **IT-11.1** Improvement in clinical indicator in disparity population (Smoking Cessation – Staying Quit) – DY4, 28% of smokers enrolled in Quitline treatment will be abstinent at the time of follow-up; **IT-11.6** Other Outcome Improvement Target (Smoking Cessation – Quit Attempts) – DY 4, 50% of smokers enrolled in Quitline treatment will make a quit attempt

Project Option 2.7.2 Implement innovative evidence-based strategies to reduce tobacco use – Replicating Ask Advise Connect in Federally-Qualified Health Centers

Unique RHP Project Identification Number: 112672402.2.5 / Pass 2
Performing Provider Name/TPI: The University of Texas MD Anderson Cancer Center / 112672402
Project Description: Smoking is the leading cause of preventable disease, disability, and death in the United States. Smoking cessation decreases the risk of lung cancer, other cancers, heart attack, stroke, and chronic lung disease.[1] Although the health benefits of quitting smoking are substantial, quit rates are low. Furthermore, smokers with lower socioeconomic status tend to be less successful at quitting. Therefore, connecting underserved smokers with evidence-based cessation treatment such as treatment delivered by Quitlines is crucial for disease prevention and the elimination of tobacco-related health disparities.

The overarching goal of the proposed project, Replicating Ask Advise Connect (AAC), is to deliver evidence-based smoking cessation treatment to smokers seeking care in Federally-Qualified Health Centers (FQHC) in Harris County, Texas, and to ultimately reduce tobacco-related morbidity and mortality, particularly among individuals who are disproportionately burdened with the disease.

Associations Between Socioeconomic Status and Smoking. Smoking is becoming increasingly concentrated among individuals with the lowest levels of education, income, and occupational status.[2-5] These smokers tend to have greater difficulty quitting. [6,7] Further, low SES smokers are less likely to use effective resources for quitting and this phenomenon may partially explain why these smokers are less successful at quitting.[8] Smoking is the single largest behavioral contributor to cancer and other diseases, and heavily accounts for a significant proportion of socioeconomic disparities in the incidence and mortality of cancer and other diseases.[9,10] Thus, it is crucial that these smokers be provided with effective and accessible treatment.
Program overview . AAC is delivered through implementing clinical practice guidelines and promoting health system supports in electronic health records. In AAC, licensed vocational nurses and medical assistants are trained to ask all adult patients at every visit about their smoking status at the time that vital signs are assessed, provide brief advice to all smokers to quit, offer cessation assistance via the Quitline, and directly connect patients willing to accept assistance with the Quitline. Connections to the Quitline are made by clicking an automated link in the electronic health record (EHR) that sends smokers' names and phone numbers to the Quitline within 24 hours. Patients are contacted by the Quitline within 48 hours of receipt of their contact information.

Quitline-Delivered Treatment. The Quitline is supported by the State of Texas Department of State Health Services and operated by Alere Wellbeing, Inc. It is staffed with trained cessation counselors available 24 hours a day, seven days a week. Counseling is available in English and Spanish, and can be provided in at least 15 additional languages through a third party. All smokers who enroll in cessation treatment receive the standard *Guideline*-based protocol along with access to nicotine replacement therapy. [11,12] This includes up to five proactive counseling calls, each designed to help develop problem-solving and coping skills, secure social support, and plan for long-term abstinence. Follow up calls are timed to address smoking relapse. The call timing is flexible and adjusted as needed.

Community Partners. For this project, we will partner with the Harris County Healthcare Alliance (the Alliance), which coordinates efforts of safety-net clinics in Harris County. The Alliance will coordinate communication, EHR support, and data collection with participating FQHCs. There are nine Federally Qualified Health Centers in Harris County, with a total of 25 primary care clinic sites. FQHCs provide care to approximately 80,160 medically-underserved individuals in the greater Houston area.

The proposed program builds upon a strong and established partnership with Harris Health, The Texas Quitline, and Alere Wellbeing, and all partners will play substantial and integral roles in the program. Currently, AAC is being implemented in one FQHC, Good Neighbor Healthcare Center. Replication of the project to additional FQHCs will allow us to dramatically increase the number of smokers that are connected with evidence-based cessation treatment through implementing systems-level changes that will address both clinic- and patient-level barriers to connection with treatment through the use of an automated connection system. El Centro de Corazon is the first clinic that has agreed to implement AAC through the expansion effort.
Goal(s) and Relationship to Regional Goals(s): Aim 1: Disseminate a previously developed, evidence-based approach to linking smokers with cessation treatment in Federally-Qualified Health Centers.

Our goal is to work with up to four Federally Qualified Health Centers to disseminate Ask Advise Connect, a tested tobacco treatment program that utilizes systems level change and EHR to connect smokers to tobacco cessation treatment. If successful, our program will be readily implemented, maintained, and administered by the clinic sites and ultimately, disseminable to centers across the RHP.

Aim 2: Implement an evidence-based approach to linking smokers with cessation treatment among underserved persons receiving care at Federally-Qualified Health Centers.

Our goal is to screen, enroll, and connect smokers to smoking cessation treatment (standard Guideline-based treatment provided by the State Quitline) to smokers receiving care at FQHCs.

Aim 3: Evaluate the effectiveness of the smoking cessation treatment connection program implemented at FQHCs.

Our goal is to evaluate the following:

- ***Reach** of the program - defined as the proportion of smokers who enroll in smoking cessation treatment through the program.*
- ***Efficacy** of the program - defined as the proportion of smokers who successfully quit smoking, assessed at 6 month follow-up.*
- ***Implementation** of the program – defined as: 1) proportion of patients screened for program eligibility; 2) proportion of patients contacted by Quitline; 3) proportion of patients enrolled in treatment, and 4) proportion of patients who successfully quit smoking.*

Regional Goal. This proposed project is responsive to the first regional goal, "Develop a regional approach to health care delivery that leverages and improves on existing programs and infrastructure, is responsive to patient needs throughout the entire region, and improves health outcomes and patient satisfaction." At the present time, most FQHCs providing care to the underserved population in the greater Houston area do not systematically screen smoking status

or record status in the EHR. However, smoking status and tobacco cessation are new healthcare clinical measures that will be required for FQHCs to collect. Thus, the proposed project will fill an important gap by providing a systematic way to assess all patients' smoking status, provide advice to quit, and connect patients to tobacco cessation treatment.

Challenges: Major challenges of the project include the following: 1) enrolling FQHCs to accept the intervention, 2) overcoming barriers to implement the intervention, and 3) offering a sustainable program. We have carefully considered each of these challenges in the design of the project. First, buy-in will be facilitated by our partnerships with the Alliance and with Good Neighbor Health Care Center. Specifically, the executive director at Good Neighbor, strongly supports this program and is committed to disseminating Ask Advise Connect to other FQHCs. Also, key collaborators at the Alliance will coordinate communication, data collection, and systems (EHR) improvements with FQHCs. Second, the approach itself has been tested in 10 Harris Health community clinics, 10 Kelsey Seybold Clinics, and one FQHC and can be tailored to the EHR systems and staffing plans of each clinic. The clinical staff provided critical input to the planning and implementation of the program. The program is intended to work within the existing vital signs and patient assessment procedures of each clinic and adds minimal time to existing practices. Also, MD Anderson program staff will provide on-site training and technical support needed to implement the intervention. Third, a crucial component of the project is the training of LVNs and medical assistants to screen for smoking status, provide advice to quit, connect patients to treatment, and log process in the EHR. This intervention provides a clinical systems change to consistently screen for smoking status and connect smokers to cessation treatment. The personnel resources and EHR changes will remain after the funding for the program ends. The program will ultimately meet the needs of the clinics to address tobacco cessation, a new healthcare clinical measure requirement of FQHCs.

Five Year Expected Outcome for Provider and Patients: We believe our program will: 1) enhance screening for smoking, 2) promote the delivery of evidence-based smoking cessation treatment, 3) reduce the prevalence of current smoking, and ultimately 4) reduce morbidity and mortality of smoking-related malignancies among FQHC patients.

Starting Point/Baseline: Patients will be recruited from the population of individuals receiving care at up to four Federally Qualified Health Centers. The first clinic to agree to disseminate AAC is El Centro de Corazon. El Centro provides care to approximately 5,000 adult patients per year. The patient population is predominantly Hispanic (94%). Currently, smoking status is not systematically assessed, nor is cessation treatment offered.

El Centro: Based on our group randomized trial conducted in 10 Harris Health Community Health Centers, 16.2% of patients (810) are expected to be current smokers. Although our goal is to have the smoking status of all patients seeking care at the clinics assessed and recorded in the EHR, we believe that it is more realistic to estimate that 75% of patients will have their smoking status assessed and recorded in the EHR. Therefore, we anticipate that 3,750 patients will have their smoking status assessed and recorded in the EHR and that 607 (16.2%) of these individuals will be current smokers. All smokers will receive advice to quit smoking and will be offered connection with the Texas Quitline.

Based on the results of our previous studies, it is anticipated that 12.8% of the 607 patients identified and documented in the EHR as current smokers (77) will enroll in Quitline-delivered

treatment. Based on data from the Quitline, 85% of individuals who enroll in treatment will complete their first counseling call (65). Therefore, we anticipate that 65 smokers at El Centro will receive treatment annually.

The Alliance will work with us to identify and coordinate dissemination of AAC in up to three additional FQHCs of similar size. Therefore, reach will be multiplied based on number of clinics replicating AAC. With four clinics enrolled, we anticipate connecting 250 smokers to treatment.

Rationale: Reasons for selection the project option: The Role of Healthcare Reform in Supporting the Sustainability of AAC. Recent policy initiatives have created a unique and historic opportunity to integrate and sustain the delivery of evidence-based tobacco treatments into healthcare settings. Specifically, the Patient Protection and Affordable Care Act (i.e., health care reform; ACA) has created payment incentives that address tobacco. A critically important component of this legislation is that information regarding tobacco use assessment and treatment be systematically tracked and recorded through electronic health records (EHR). Meaningful use criteria require clinicians to screen the smoking status of more than 50% of all unique patients who are 13 years old or older, as well as track the percentage of patients 18 and older who are current tobacco users, seen by a practitioner during the year, and receive advice, cessation treatments, or recommendations to use cessation medications and/or other strategies.[13] As healthcare systems in Texas begin to implement systems to comply with meaningful use criteria regarding tobacco, referrals to the Texas Quitline are likely to increase dramatically. Unfortunately, without adequate infrastructure and financial support to treat these additional smokers, the Quitline is likely to become quickly overwhelmed and be unable to meet this increased demand for services.

Enhancing Widespread Adoption of Evidence-Based Smoking Cessation Treatment Delivered via the Texas Quitline. The past three decades have generated a tremendous amount of research and knowledge regarding how best to help smokers quit. These data indicate that the use of evidence-based cessation treatments can increase smoking abstinence rates as much as fourfold [14]. However, far more attention and research dollars have been directed toward expansion of this knowledge base than to the dissemination and utilization of this knowledge. This lack of dissemination will ultimately diminish progress toward achieving critically important public health goals [15,16]. Thus, the focus of this proposal is on increasing utilization of the Texas Quitline among smokers with the greatest need for assistance. Ask, Advise, Refer (AAR) is the recommended standard of care for linking smokers in healthcare settings with evidence-based cessation treatment. **Although AAR is an improvement over previous strategies, we have developed, implemented, and maintained an even more effective strategy for providing a seamless linkage between health care systems and the Texas Quitline. Ask Advise Connect (AAC) utilizes the electronic health record (EHR) to systematically prompt clinicians to assess the smoking status of every patient at every visit, advise him/her to quit smoking, and directly and electronically link interested smokers with the Quitline.** In a recently completed group randomized controlled trial among 10 Harris Health System community health clinics and over 113,000 patients, Quitline treatment uptake is 0.5% of all smokers seeking care at AAR clinics, vs. 14.7% among patients seeking care at AAC clinics, a 30-fold difference. To the best of our knowledge, this is the highest population level cessation treatment uptake reported to date. Similarly impressive results (0.6% in AAR clinics vs. 7.8% in AAC clinics)

were found in a second recently completed group randomized controlled trial among 10 Kelsey Seybold clinics (a Houston based health care system that does not focus on the underserved).

Project Components: We believe our program will result in: 1) dissemination of an evidence-based smoking cessation program [P-X], 2) enhanced screening for smoking [P-X], 3) promote the delivery of evidence-based smoking cessation treatment [P-2], 4) reduce the prevalence of current smoking [IT-11.1], and ultimately 5) reduce morbidity and mortality of smoking-related malignancies in the FQHC patient population [IT-11.6].

Milestones and Metrics: The following milestones and metrics have been chosen for the Smoking Cessation Program for Underserved Persons receiving care at FQHCs:

- Process Milestones and Metrics: P-X (P-X.1, P-X.2); P-2 (P-2.1, P-2.2); P-7 (P-7.1, P-7.2)
- Improvement Milestones and Metrics: I-X (I-X.1, I-X.2); OD-11 (IT-11.1, IT-11.6)

Unique community need identification number the project addresses: The project addresses the following unique community needs as identified in the community needs assessment:

- CN.11 – High rates of chronic disease and inadequate access to treatment programs and services for illnesses associated with chronic disease including: cancer, diabetes, obesity, cardiovascular disease, asthma, and AIDS/HIV
- CN.12 – High rates of tobacco use and excessive alcohol use

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

MD Anderson tested AAC in 10 Harris Health System community health centers, 10 Kelsey Seybold clinics, and is currently implementing the program in Good Neighbor Healthcare Center. AAC was found to have from a 13- (Kelsey) to 30-fold (Harris Health) increase in smoking cessation treatment enrollment compared to AAR, the standard treatment. To the best of our knowledge, this is the highest population level cessation treatment uptake reported to date. This new initiative is to support widespread adoption of AAC to Federally-Qualified Health Centers, where it will have broad reach to medically-underserved smokers.

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

IT-11.1 Improvement in clinical indicator in disparity population (Smoking Cessation – Staying Quit)

- DY 4, 28% of smokers enrolled in Quitline treatment will be abstinent at the time of follow-up

IT-11.6 Other Outcome Improvement Target (Smoking Cessation – Quit Attempts)

- DY 4, 50% of smokers enrolled in Quitline treatment will make a quit attempt

Reasons/rationale for selecting the outcome measure(s): The selected Category 3 Outcome Measure directly addresses the Regional Health Plan Community Needs CN.12 – High rates of tobacco use, and would capture reduction in tobacco use among smokers in participating FQHCs. Aim 3 of the program is to evaluate the effectiveness of the smoking cessation program implemented at FQHCs. The reach, efficacy, and impact of AAC will be evaluated using the RE-AIM conceptual framework.[17] RE-AIM provides a systematic way to evaluate the impact of

the dissemination and implementation of public health interventions and includes five criteria: reach, efficacy, adoption, implementation, and maintenance. **Reach** is defined as the number of smokers visiting the clinics that talked with the Quitline / total number of smokers that visited the clinics. **Efficacy** is defined as the total number of smokers visiting the clinics that enrolled in treatment with the Quitline / total number of smokers visiting the clinics that talked with the Quitline. **Impact** is defined as Reach x Efficacy.

Replication. A major consideration that guided the conceptualization and development of the Ask Advise Connect model was that it has the potential to make a significant public health impact. Because we are delivering the approach in community clinics that provide care to underserved, primarily racial/ethnic minority patients with low socioeconomic status, our dissemination setting is representative of real-world population-based tobacco control settings and has broad reach. In addition, the dissemination approach is intended to be delivered by clinical providers using the EHR. Third, the approach has been designed to greatly streamline the process of connecting smokers interested in quitting with the Quitline in order to shift the burden of counseling from clinical providers to the Quitline. In contrast to providing counseling in the clinic setting, connecting smokers with proactive telephone counseling via the Quitline is convenient, eliminates transportation time and costs, entails no childcare costs, is more acceptable to patients than face-to-face counseling, reduces the burden on physicians and other members of the health care team, and has demonstrated strong efficacy [11,18-22]. Importantly, our approach could be feasibly and cost-effectively implemented in numerous population-based settings for tobacco control (e.g., clinics, hospitals, dentist offices), the environments where quitlines would be most likely to be disseminated and implemented. Taken together, each of these factors is important and all are intended to ensure that the dissemination approach could be easily adopted in other public health settings.

Relationship to other Projects: By delivering an evidenced based smoking cessation program to the underserved population of smokers in FQHCs, this program is in line with the RHP. Unique RHP Project ID Number 112672402.2.2 provides a similar smoking cessation project in one FQHC, tailored to persons living with HIV/AIDS. Unique RHP Project ID Number 112672402.1.1 Expand Mobile Clinics will work in partnership with FQHCs to provide mammography screening. Also, all RHP project teams work in collaboration with the Comprehensive Cancer Control Program at MD Anderson.

Relationship to Other Performing Providers' Projects in the RHP: Innovation is key to the transformation of healthcare in our community. The consistency of innovation in our region allows for increased improvements based on research trends, patient need, and provider availability. The waiver funding allows for innovation in specific areas and all innovative projects included in the plan are similar in the fact of program redesigns for historic treatments, and focus to chronic condition outcome measures such as central line infections. The Region 3 initiative grid in the addendum can provide a side by side comparison of all projects that directly relate to innovation.

Plan for Learning Collaborative: We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for RHP3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system.

Project Valuation: We have based our project valuation on California's 1115 Medicaid Waiver model. As such, we have valued our projects at 2.5 times that of the estimated costs. Basing our valuations on California's calculations we know we are well within the potential range of future cost savings when looking at the following from Prevention Institute and Trust for America's Health Issue Report entitled *Prevention for a Healthier America: Investments in Disease Prevention Yield Significant Savings, Stronger Communities (July 2008)*:

- Prevention saves money – an investment of $10 per person per year in programs to increase physical activity, improve nutrition, and prevent tobacco use could save the country more than $16 billion in annual health care costs within five years.
- Prevention can reduce end-of-life costs by increasing health during the lifespan, what researchers call the *compression of morbidity*.

There is a substantial return-on-investment in prevention – For every $1 invested in community-based prevention, the return amounts to $5.60.

<table>
<tr><td>UNIQUE IDENTIFIER: 112672402.2.5</td><td>RHP PP REFERENCE NUMBER: 2.7.2</td><td>PROJECT COMPONENTS: N/A</td><td colspan="2">Project Title: Implement innovative evidence-based strategies to reduce tobacco use - Replicating Ask Advise Connect in Federally-Qualified Health Centers</td></tr>
<tr><td colspan="4">Performing Provider Name: The University of Texas MD Anderson Cancer Center</td><td>TPI - 112672402</td></tr>
<tr><td>Related Category 3 Outcome Measure(s):</td><td>112672402.3.8
112672402.3.9</td><td>IT-11.1
IT-11.6</td><td colspan="2">Improvement in Clinical Indicator in identified disparity group (Smoking Cessation);Medical Assistance With Smoking and Tobacco Use Cessation (HEDIS 2012)
Other Outcome Improvement Target (Smoking Cessation – Quit Attempts)</td></tr>
</table>

Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Milestone 1 [P-X.1]: Enroll up to four FQHCs to disseminate AAC. Metric 1 [P-X.1]: Document subcontracts/agreements; Number of FQHCs enrolled. Baseline/Goal: At present, primary care FQHCS do not systematically offer a proactive, evidence-based smoking cessation intervention. Currently we are implementing AAC in only one clinic. Our goal is to partner with up to four additional FQHCs to deliver AAC. Data Source: Subcontracts/agreements with FQHCs Milestone 1 Estimated Incentive Payment: $394,531.20	**Milestone 4** [P-X.2]: Identify prevalence of current smoking among adult patients receiving services at selected FQHCs. Metric 1 [P-X.2]: Screen 75% of adult patients Baseline/Goal: At present, smoking status is not documented systematically. Our goal is to document smoking status among 75% of adult patients. Data Source: EHR data and primary data collection. Milestone 4 Estimated Incentive Payment: $401,747.14 **Milestone 5** [P-2]: Implement evidence-based, innovative project for	**Milestone 7** [P-X.2]: Identify prevalence of current smoking among adult patients receiving services at selected FQHCs. Metric 1 [P-X.2]: Screen 75% of adult patients Baseline/Goal: At present, smoking status is not documented systematically. Our goal is to document smoking status among 75% of adult patients. Data Source: EHR data and primary data collection. Milestone 7 Estimated Incentive Payment: $411,437.05 **Milestone 8** [P-2]: Implement	**Milestone 11** [P-7]: Participate in face-to-face learning (i.e. meetings or seminars) at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects. Metric 1 [P-7.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Metric 2 [P-7.2]: Implement the “raise the floor” improvement initiatives established at the semiannual meeting. Data Source: Documentation of

UNIQUE IDENTIFIER: *112672402.2.5*	**RHP PP REFERENCE NUMBER:** *2.7.2*	**PROJECT COMPONENTS:** *N/A*	**Project Title:** *Implement innovative evidence-based strategies to reduce tobacco use - Replicating Ask Advise Connect in Federally-Qualified Health Centers*
Performing Provider Name: *The University of Texas MD Anderson Cancer Center*			**TPI -** *112672402*
Related Category 3 Outcome Measure(s):	***112672402.3.8*** ***112672402.3.9***	***IT-11.1*** ***IT-11.6***	*Improvement in Clinical Indicator in identified disparity group (Smoking Cessation);Medical Assistance With Smoking and Tobacco Use Cessation (HEDIS 2012)* *Other Outcome Improvement Target (Smoking Cessation – Quit Attempts)*

Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Milestone 2 [P-2]: Implement evidence-based, innovative project for target population Metric 1 [P-2.1]: Document implementation strategy; Program EHR systems for data collection and reporting. Baseline/Goal: Presently, FQHCs do not have tobacco screening, education, and treatment systematically documented in EHR. Our goal is to program EHR systems to document screening for smoking status and data collection for education and treatment offered. Data Source: Documentation of enhancements to EHR systems Metric 2 [P-2.2]: Document	target population Metric 1 [P-2.1]: Document implementation strategy; Enroll and deliver treatment to 15% of eligible smokers screened at participating FQHCs. Baseline/Goal: Our goal is to connect 15% of eligible smokers to the Quitline. Data Source: EHR and Alere databases. Milestone 5 Estimated Incentive Payment: $401,747.**14** **Milestone 6** [P-7]: 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.	evidence-based, innovative project for target population Metric 1 [P-2.1]: Document implementation strategy; Enroll and deliver treatment to 15% of eligible smokers screened at participating FQHCs. Baseline/Goal: Our goal is to connect 15% of eligible smokers to the Quitline. Data Source: EHR and Alere databases. Milestone 8 Estimated Incentive Payment: $411,437.05 **Milestone 9** [P-7]: 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	"raise the floor" improvement initiatives agreed upon at each semiannual meeting and documentation that the participating provider implemented the "raise the floor" improvement initiative after the semiannual meeting. Milestone 11 Estimated Incentive Payment: $632,126.49 **Milestone 12** [I-X} Increase adoption of Ask, Advise, Connect protocol by participating FQHC providers. Metric 1 [I-X.2] Intermediate: Increased adherence to Ask, Advise, and Connect guidelines by providers Data Source: Medical record data and primary data collection

UNIQUE IDENTIFIER: *112672402.2.5*	**RHP PP REFERENCE NUMBER:** *2.7.2*	**PROJECT COMPONENTS:** *N/A*	**Project Title:** *Implement innovative evidence-based strategies to reduce tobacco use - Replicating Ask Advise Connect in Federally-Qualified Health Centers*
Performing Provider Name: *The University of Texas MD Anderson Cancer Center*			**TPI -** *112672402*
Related Category 3 Outcome Measure(s):	***112672402.3.8*** ***112672402.3.9***	***IT-11.1*** ***IT-11.6***	*Improvement in Clinical Indicator in identified disparity group (Smoking Cessation);Medical Assistance With Smoking and Tobacco Use Cessation (HEDIS 2012)* *Other Outcome Improvement Target (Smoking Cessation – Quit Attempts)*

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
implementation strategy; Train staff and implement AAC procedures. Baseline/Goal: Front-line staff in FQHCs do not have standard procedures for screening and documenting smoking status and referral to treatment. Goal is to train staff to deliver AAC at intake. Data Source: Documentation of training and booster trainings. Milestone 2 Estimated Incentive Payment: $394,531.20 **Milestone 3** [P-X.2]: Identify baseline prevalence of current smoking among adult patients receiving services at selected FQHCs.	Metric 1 [P-7.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Metric 2 [P-7.2]: 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	shared or similar projects. Metric 1 [P-7.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP. Data Source: Documentation of semiannual meetings including meeting agendas, slides from presentations, and/or meeting notes. Metric 2 [P-7.2]: 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	Milestone 12 Estimated Incentive Payment: $632,126.49

Unique Identifier: *112672402.2.5*	***RHP PP Reference Number:*** *2.7.2*	***Project Components:*** *N/A*	***Project Title:*** *Implement innovative evidence-based strategies to reduce tobacco use - Replicating Ask Advise Connect in Federally-Qualified Health Centers*
Performing Provider Name: *The University of Texas MD Anderson Cancer Center*			***TPI -*** *112672402*
Related Category 3 Outcome Measure(s):	***112672402.3.8*** ***112672402.3.9***	***IT-11.1*** ***IT-11.6***	*Improvement in Clinical Indicator in identified disparity group (Smoking Cessation);Medical Assistance With Smoking and Tobacco Use Cessation (HEDIS 2012)* *Other Outcome Improvement Target (Smoking Cessation – Quit Attempts)*

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Metric 1 [P-X.2]: Screen 75% of adult patients Baseline/Goal: At present, smoking status is not documented systematically. Our goal is to document smoking status among 75% of adult patients. Data Source: Medical record data and primary data collection. Milestone 3 Estimated Incentive Payment: $394,531.20	implemented the "raise the floor" improvement initiative after the semiannual meeting. Milestone 6 Estimated Incentive Payment: $401,747.14	the "raise the floor" improvement initiative after the semiannual meeting. Milestone 9 Estimated Incentive Payment: $411,437.05 **Milestone 10** [I-X} Increase adoption of Ask, Advise, Connect protocol by participating FQHC providers. Metric 1 [I-X.1] Short term: Increased adoption of new Ask, Advise, and Connect guidelines by providers Data Source: Medical record data and primary data collection Milestone 10 Estimated Incentive Payment:	
Year 2 Estimated Milestone Bundle Amount: $1,183,593.60	Year 3 Estimated Milestone Bundle Amount: $1,205,241.41	Year 4 Estimated Milestone Bundle Amount: $1,234,311.15	Year 5 Estimated Milestone Bundle Amount: $1,264,252.98

UNIQUE IDENTIFIER: 112672402.2.5	RHP PP REFERENCE NUMBER: 2.7.2	PROJECT COMPONENTS: N/A	***Project Title:*** *Implement innovative evidence-based strategies to reduce tobacco use - Replicating Ask Advise Connect in Federally-Qualified Health Centers*	
Performing Provider Name: *The University of Texas MD Anderson Cancer Center*				***TPI -*** *112672402*
Related Category 3 Outcome Measure(s):	***112672402.3.8*** ***112672402.3.9***	***IT-11.1*** ***IT-11.6***	*Improvement in Clinical Indicator in identified disparity group (Smoking Cessation);Medical Assistance With Smoking and Tobacco Use Cessation (HEDIS 2012)* *Other Outcome Improvement Target (Smoking Cessation – Quit Attempts)*	

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $4,887,399.15			

West Houston Medical Center

Pass 1

Project Option-2.9.1 Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care: Expand Senior Care Capacity at West Houston

Unique RHP Project Identification Number: 094187402.2.1

Performing Provider Name/TPI: HCA - West Houston Medical Center TPI/094187402

- Provider: West Houston Medical Center is a 276-bed facility in Houston, Texas. The facility is located in the Houston-Sugarland-Baytown MSA, which serves a population of approximately 6,000,000 people.
- Intervention(s): HCA intends to improve the patient throughput, overall experience and quality of care for geriatric patients. Specifically, HCA will create a designated "Senior Care Entrance" at the hospital and assign special hospital beds to accommodate the geriatric population. Additionally, HCA will train and maintain a Senior Care Coordinator dedicated to overseeing protocol-driven geriatric care. The Senior Care Coordinator will assist seniors in managing their appointments, maintaining their individual healthcare regimens, and accessing available support through the hospital and the community.
- Need for the project: Geriatric patient populations face unique challenges in obtaining care, and those challenges must be addressed in order for geriatric patients to have effective access to care. Harris County Hospital District's DSRIP work groups have identified expanding access to care for seniors as a priority for the region. These patients are often on a fixed income, may have increased problems with mobility, memory, and technological savvy which inhibit their ability to effectively access care.
- Target population: The target population of this project is geriatric patients in the community and surrounding areas, particularly those patients who are currently unable to access to care effectively. West Houston Medical Center experiences approximately 15,000-16,000 patient encounters with geriatric patients per year (with geriatric defined as $\geq$ 65 years or older). Of the geriatric patients treated, 20-26% are Medicaid-eligible or uninsured. Thus, while this project will benefit all geriatric patients at the hospital, 20-26% of the benefit will affect Medicaid and uninsured geriatric patients.
- Category 1 or 2 expected patient benefits: HCA will improve geriatric patients' experience at its facility, and improve short- and long-term patient outcomes, by assisting these patients in navigating the often fractured and confusing healthcare continuum. HCA will accomplish a four percent (4%) reduction in ED visits by patients enrolled in the navigator program in DY4, and a seven percent (7%) reduction by the end of DY5, as a result of increased preventative and managed care prior to seniors' conditions reaching an acute or emergent stage.
- Category 3 outcomes: IT 3.1 – Through this project, Bayshore will reduce the number of Potentially Preventable Readmissions (PPRs) for geriatric patients, indicating improved health outcomes and patient quality of life. PPRs are disruptive and often have a substantial impact on a patient's chance of long-term recovery, and PPRs add hefty additional costs to the healthcare delivery system that can be prevented through improved access to primary and preventative care.

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Project Option-2.9.1 Provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care: Expand Senior Care Capacity at West Houston

Unique RHP Project Identification Number: 094187402.2.1
Performing Provider Name/TPI: HCA - West Houston Medical Center TPI/094187402

Project Description:
Through implementing this project, HCA intends to improve the patient throughput, overall experience and quality of care for geriatric patients. Geriatric patients will benefit from the dedicated care designed to meet the needs of patients greater than 65 years of age who live in West Houston's primary and secondary zip codes (77072, 77082, 77083, 77036, 77042, 77077, 77094, 77099, 77450) located in Harris County. This dedicated care includes unique components to address both environmental and clinical service needs. Specifically, HCA will create a designated "Senior Care Entrance" at the hospital and assign special hospital beds which are designed to accommodate the geriatric population. Additionally, HCA will train and maintain a Senior Care Coordinator dedicated to overseeing protocol-driven geriatric care, which will be developed with input from facility geriatricians, and close communication with local SNFs, LTACs, and nursing homes to assure solid continuity of care. The Senior Care Coordinator will assist seniors in managing their appointments, maintaining their individual healthcare regimens, and accessing available support through the hospital and the community.

Goal(s) and relationship to Regional goal(s):
Project goals:
HCA hopes to improve geriatric patients' experience as inpatients and outpatients at its facility, and to improve short- and long-term patient outcomes by assisting these patients in navigating the often fractured and confusing healthcare continuum. Specifically, by enabling geriatric patients to access the care they need, which is tailored to their needs.

This project meets the following Region 3 goals:
While the Region has many specific objectives and improvement targets based on stakeholder input and community needs assessments, the over-arching goals that have guided many of our decisions include the following:

- Develop a regional approach to health care delivery that leverages and improves on existing programs and infrastructure, is responsive to patient needs throughout the entire region, and improves health care outcomes and patient satisfaction.
- Increase access to primary and specialty care services, with a focus on underserved populations, to ensure patients receive the most appropriate care for their condition, regardless of where they live or their ability to pay.
- Transform health care delivery from a disease-focused model of episodic care to a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary or duplicative services, and builds on the accomplishments of our existing health care system, and
- Develop a culture of ongoing transformation and innovation that maximizes the use of technology and best-practices, facilitates regional collaboration and sharing, and engages

patients, providers, and other stakeholders in the planning, implementation, and evaluation processes.

Challenges and how addressed:

- Identifying a qualified Senior Care Coordinator and training that person in geriatric-specific care needs and protocols – HCA will recruit and retain an individual who is qualified to navigate the healthcare continuum and will provide training for geriatric specific services.

- Need for community and provider education regarding the dedicated Senior Care services and geriatric protocols– HCA will address this challenge by training the Senior Care Coordinator to work with providers inside and outside of the hospital and prove the efficacy of managing seniors' health on a consistent basis, as opposed to providing episodic care with little to no support.

- Educating patients and encouraging participation in the program – HCA will address this challenge by having the Senior Care Coordinator and other providers within the hospital explain the program to patients prior to enrollment.

5-year expected outcome for provider and patients:
HCA hopes to accomplish a seven percent (7%) reduction in ED visits by patients enrolled in the navigator program by the end of the Waiver, as a result of increased preventative and managed care prior to seniors' conditions reaching an acute or emergent stage.

Starting Point/Baseline:
West Houston Medical Center does not currently provide patient navigation services to its geriatric patients. The hospital will establish a baseline of the number of geriatric patients visiting the ED in DY2, in order to measure progress going forward.

Rationale:
Geriatric patient populations face unique challenges in obtaining care, and those challenges must be addressed in order for geriatric patients to have effective access to care. Harris County Hospital District's DSRIP work groups have identified expanding access to care for seniors as a priority for the region (see "DSRIP Initiative Prioritization/Ranking," item 71).

Patient navigators assist patients and their families in navigating the fragmented maze of doctors' offices, clinics, hospitals, out-patient centers, payment systems, support organizations and other components of the healthcare system. Services provided by patient navigators vary by program and the needs of the patient, but often include:[257]

- Facilitating communication among patients, family members, survivors and healthcare providers.
- Coordinating care among providers.
- Arranging financial support and assisting with paperwork.
- Arranging transportation.

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- Ensuring that appropriate medical records are available at medical appointments.
- Facilitating follow-up appointments.
- Community outreach and building partnership with local agencies and groups.
- Ensuring access to clinical trials.

Access to the above services is especially imperative for senior patients, as they are often on a fixed income, may have increased problems with mobility, memory, and technological savvy. The Senior Care Coordinator can assist seniors in confronting the challenges associated with access necessary healthcare, in order to prevent the deterioration of otherwise manageable conditions and to improve the quality of life for seniors.

Project Components:
HCA will address the project components as follows:

a. Identify frequent ED users and use navigators as part of a preventable ED reduction program. Train health care navigators in cultural competency. HCA has identified geriatric patients as a patient population with high rates of ED users. The Senior Care Coordinator will target inpatient seniors for education and intervention aimed at preventing future ED use for non-emergent conditions and/or preventing conditions from becoming emergent in the first place.

b. Deploy innovative health care personnel, such as case managers/workers, community health workers and other types of health professionals as patient navigators. HCA will recruit and retain a qualified health worker to be the Senior Care Coordinator, with special consideration for candidates who have experience working with the senior community.

c. Connect patients to primary and preventive care. The Senior Care Coordinator's main function will be to assist seniors in making primary and preventative care appointments, determining the assistance necessary to help seniors keep those appointments, and to work with seniors and their families to assure that their access to support (financial, transportation, in-home care, etc) is adequate.

d. Increase access to care management and/or chronic care management, including education in chronic disease self-management. Currently, senior patients at the hospital do not have access to a dedicated care coordinator to assist in self-management education and chronic care management. The Senior Care Coordinator will be dedicated to providing those services.

e. Conduct quality improvement for project using methods such as rapid cycle improvement. Activities may include, but are not limited to, identifying project impacts, identifying "lessons learned," opportunities to scale all or part of the project to a broader patient population, and identifying key challenges associated with expansion of the project, including special considerations for safety-net populations. As part of Milestone 3, HCA will participate in learning collaboratives with other

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Performing Providers engaging in Care Navigation to share lessons learned, identify best practices, and discuss key challenges.

Unique community need identification number the project addresses:

- CN.1 - Inadequate access to primary care
- CN.6- Inadequate access to treatment and services designed for special needs populations, including disabled, homeless, children, elderly
- CN.7- Insufficient access to care coordination practice management and integrated care treatment programs
- CN.8- High rates of inappropriate emergency department utilization
- CN.9- High rates of preventable hospital readmissions
- CN.10- High rates of preventable hospital admissions
- CN.11-High rates of chronic disease and inadequate access to treatment programs and services for illnesses associated with chronic disease, including: Cancer, Diabetes, Obesity, Cardiovascular disease, Asthma, AIDS/HIV
- CN. 20- Lack of access to programs providing health promotion education, training and support, including screenings, nutrition counseling, patient education programs
- CN.23- Lack of patient navigation, patient and family education and information programs
-

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

Currently, West Houston Medical Center does not provide patient navigation services for the senior population, thus this project is a brand-new initiative for this hospital.

Related Category 3 Outcome Measures: OD-3 Potentially Preventable Re-Admissions; IT 3.1 All cause 30 day readmission rate – NQF 1789 (for patients enrolled in care navigation services).

Reasons/rationale for selecting the outcome measure(s):
HCA chose this Category 3 Outcome because one of the important goals behind implementing the Senior Care Coordination program is to reduce the number of PPRs, which should be indicative of improved health outcomes and patient quality of life. PPRs are disruptive and often have a substantial impact on a patient's chance of long-term recovery, and PPRs add hefty additional costs to the healthcare delivery system that should be preventable through improved access to primary and preventative care.

Relationship to Other Projects: This project is part of HCA's larger plan of expanding and developing specialty services along with delivery improvements targeted to particular populations (e.g., OB/GYN patients and behavioral health patients), while improving access to care.

Relationship to Other Performing Providers' Projects in the RHP: The increased access to primary care visits will naturally generate additional need of specialty care visits based on the condition and acuity of the patients served. Understanding that the patient base targeted through this initiative will generate significant specialty care visits due to chronic conditions and lack of

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previous treatments, this initiative and similar initiatives will focus to 30-day readmission rate reductions, improvement for patient satisfaction scores, and admission rates specific to chronic conditions. Numerous initiatives have been included in the RHP plan and the addendum of the Initiative Grid can directly tie all specialty care projects together by category.

Plan for Learning Collaborative: We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system.

Project Valuation:

Approach for valuing project: The valuation of each HCA project takes into account the degree to which the project accomplishes the triple-aim of the Waiver: community needs, the population served by the project (both number of people and complexity of patient needs), and investment required to implement the project.

Rationale for project valuation: Specifically, the valuation of this project incorporates the need for improved access to care and quality of care among Region 3 geriatric patient populations, and the potential for sustainable improvement in this area as a result of implementing this project. The valuation also takes accounts for the emphasis that the Region 3 DSRIP work groups have placed on the expansion of access to care for seniors.

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094187402.2.1	2.9.1	A-E	PROVIDE NAVIGATION SERVICES TO TARGETED PATIENTS WHO ARE AT HIGH RISK OF DISCONNECT FROM INSTITUTIONALIZED HEALTH CARE: EXPAND SENIOR CARE CAPACITY AT WEST HOUSTON
HCA –West Houston Medical Center			094187402
Related Category 3 Outcome Measure(s): OD-3	***094187402.3.1***	***IT-3.1***	***All cause 30 day readmission rate (for patients enrolled in care navigation program).***
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-2]: Establish/expand a health care navigation program to provide support to patient populations who are most at risk of receiving disconnected and fragmented care including program to train the navigators, develop procedures and establish continuing navigator education. Metric 1[P-2.1]: Number of people trained as patient navigators Baseline/goal: to recruit, retain, and train one (1) Senior Care Coordinator, dedicated to providing navigation services to geriatric patients Data Source: Patient Navigation program materials Milestone 1 Estimated Incentive Payment *(maximum amount):* $3,222,996	**Milestone 2** [P-3]: Provide care/management/navigation services to targeted patients. Metric 1 [P-3.1]: Increase in the percent of targeted patients enrolled in the program Baseline/goal: accomplish enrollment of at least 25% of geriatric patients identified at the West Houston facility Data source: Enrollment reports Milestone 2 Estimated Incentive Payment: $1,758,058 **Milestone 3 [P-X1]**: Establish a baseline Metric [P-X1.1]: ED visits and/or hospitalizations Goal: establish a baseline number of ED visits and/or avoidable hospitalizations for patients initially enrolled in the care navigation	**Milestone 4** [I-7]: Reduce number of ED visits and/or avoidable hospitalizations for patients enrolled in the navigator program Metric 1 [I-7.1]: ED visits and/or avoidable hospitalizations Goal: decrease ED visits by geriatric patients enrolled in the navigation program by 4% over baseline Data Source: EHR, navigation program database, ED records, inpatient records Milestone 4 Estimated Incentive Payment: $1,763,168 **Milestone 5** [P-8]: Participate in face-to-face learning at least twice per year with other providers and the RHP to promote collaborative learning around similar projects. Metric 1 [P-8.1]: Participate in semi-annual face-to-face meetings or	**Milestone 6** [I-7]: Reduce number of ED visits and/or avoidable hospitalizations for patients enrolled in the navigator program Metric 1 [I-7.1]: ED visits and/or avoidable hospitalizations Goal: decrease ED visits by geriatric patients enrolled in the navigation program by 7% over baseline Data Source: EHR, navigation program database, ED records, inpatient records Milestone 6 Estimated Incentive Payment: $2,913,061

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094187402.2.1	*2.9.1*	A-E	***PROVIDE NAVIGATION SERVICES TO TARGETED PATIENTS WHO ARE AT HIGH RISK OF DISCONNECT FROM INSTITUTIONALIZED HEALTH CARE: EXPAND SENIOR CARE CAPACITY AT WEST HOUSTON***
HCA –West Houston Medical Center			094187402
Related Category 3 Outcome Measure(s): OD-3	***094187402.3.1***	***IT-3.1***	***All cause 30 day readmission rate (for patients enrolled in care navigation program).***

Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
	program during DY 3, in order to measure progress going forward. Data source: EHR, navigation program database, ED records, inpatient records Milestone 3 Estimated Incentive Payment: $1,758,058	seminars organized by the RHP Baseline/Goal: Bayshore hopes to share ideas with other providers engaging in care navigation for targeted populations about best practices and addressing key challenges for improvement going forward. Data source: Documentation of semi-annual meetings, including agendas, slides, and/or meeting notes Milestone 5 Estimated Incentive Payment: $1,763,168	
Year 2 Estimated Milestone Bundle Amount: $3,222,996	Year 3 Estimated Milestone Bundle Amount: $3,516,116	Year 4 Estimated Milestone Bundle Amount: $3,526,337	Year 5 Estimated Milestone Bundle Amount: $2,913,061
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:** $13,178,510			

C. Category III

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Title of Outcome Measure (Improvement Target): IT-1.20 Other: Reduction of STI Rate among Adolescents and Young Adults

Unique RHP outcome identification number(s): 082006001.3.1
Performing Provider Name/TPI: Baylor College of Medicine/082006001

Outcome Measure Description:
Because this is a new clinic, process milestone P-2 was selected to establish the baseline to which improvement will be compared. Outcome improvement target IT-1.20 was selected; the measure will be reduction in STI (chlamydia, gonorrhea and syphilis) rates by 5% compared to the baseline in DY5.

Process Milestones:
- DY3: P-2
- DY2: P-1

Outcome Improvement Target(s):
- DY4: IT-1.20
- DY5: IT-1.20

Rationale:
Because the Baylor Teen Health Clinic (BTHC) focuses on prevention, the proposed Category 3 measure is reduced STI rate. The chronic illness milestones identified on the Category 3 do not address the salient health issues faced by adolescents and young adults. Because STIs disproportionately affect this population, the STI rate is a more appropriate metric that clearly measures the success of the STI counseling proposed in the Category 1 improvement measures. Because the goal is to reduce the rate among the population served by the BTHC, baseline data will be established during the first full year the clinic is operational (DY3). The mission of the BTHC is to provide access to affordable care for at-risk, underserved teens in the community. By reducing STI rates and associated sequelae the BTHC will help its young patients avoid long-term health effects associated with STIs.

Outcome Measure Valuation:
The value of this project was determined by an econometrics assessment of STI treatment. Researchers at the CDC have evaluated the cost effectiveness of STI treatment[258] and developed formulae to assess the direct and indirect cost savings of education, screening and treatment. The formula developed for HIV costs averted by HIV counseling and testing was used to calculate the estimated bundle amount for STI counseling, as HIV counseling is included in all STI education, and screening is available to all patients. The estimated bundle amount for STI treatment was based on the pro rata sequelae costs averted for the treatment of gonorrhea, which is a more conservative estimate than that for treatment of chlamydia or syphilis, and it is estimated that 90% of patients treated will be women. The value for decreases in STI rates is based on treatment and pro rata sequelae costs averted because of reductions in the infections in the population, assuming the reductions occur in a patient population of 1,000 patients, or 10 cases avoided per percentage point reduction.

[258] Chesson HW, Collins D, Koski K. Formulas for estimating the costs averted by sexually transmitted infection (STI) prevention programs in the United States. *Cost Effectiveness and Resource Allocation.* 2008; 6:10.

082006001.3.1	*IT-1.20*	*Reduction of STI Rate among Adolescents and Young Adults*	
Baylor College of Medicine			*082006001*
Related Category 1 or 2 Projects:	*082006001.1.1*		
Starting Point/Baseline:	*To be established in DY3*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Complete project plan. Data Source: Project plan document.	**Process Milestone 2** [P-2]**:** Establish STI rate baseline. Data Source: Health Record Process Milestone 1 Estimated Incentive Payment: $ 6,400	**Outcome Improvement Target 1** [IT-1.20]: Decrease STI rate. Improvement Target: Decrease STI rate by 2% compared to baseline. Data Source: Health Record Outcome Improvement Target 1 Estimated Incentive Payment*:* $ 10,300	**Outcome Improvement Target 2** [IT-1.20]: Decrease STI rate. Improvement Target: Decrease STI rate by 5% compared to baseline. Data Source: Health Record Outcome Improvement Target 2 Estimated Incentive Payment*:* $ 14,900
Year 2 Estimated Outcome Amount: $ 0	Year 3 Estimated Outcome Amount: $ 6,400	Year 4 Estimated Outcome Amount: $ 10,300	Year 5 Estimated Outcome Amount: $ 14,900
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $ 31,600			

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Title of Outcome Measure (Improvement Target): IT-1.20 Other: Reduction of Pregnancy Rates among Adolescents and Young Adults

Unique RHP outcome identification number: 082006001.3.2
Performing Provider Name/TPI: Baylor College of Medicine/082006001

Outcome Measure Description:
Because this is a new clinic, process milestone P-2 was selected in order to establish the baseline to which we can compare outcomes. Outcome IT-1.20 was selected to measure reduction in pregnancy rates by 2% compared to the baseline in DY5.

Process Milestones:
- DY2: P-1
- DY3: P-2

Outcome Improvement Target(s):
- DY4: IT-1.20
- DY5: IT-1.20

Rationale:
Because the BTHC focuses on prevention, the proposed Category 3 measure is reduced pregnancy rates. Pregnancy reduction is an appropriate measure for this population. The milestones identified in Category 3 pertain to improvements in low birth weight, infant mortality, etc., which do not apply if pregnancy is avoided altogether. Decreasing teen pregnancies and births will indicate that the BTHC succeeds in providing access to family planning and contraception services. Because the goal is to reduce the rate among the population served by the BTHC, baseline data will be established during the first full year the clinic is operational (DY3). The mission of the BTHC is to provide access to affordable care for at-risk, underserved teens in the community. By reducing teen pregnancy, the BTHC will help its young patients become contributing members of society.

Based on our experience at other Baylor Teen Health Clinics, reducing pregnancy rates takes time as we make the existing population aware of available services. Moving into a new population or geographic area means that we must ramp up our communications efforts. In the first years, pregnant patients come to our clinics to take advantage of prenatal and parenting services. They then use our services to avoid a second unplanned pregnancy. It typically takes up to five years achieve a 5% reduction in pregnancy rates. The speed of reduction increases as the population becomes more aware of our services and takes advantage of them.

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Outcome Measure Valuation:
The value of this project was determined by an econometrics assessment of teen pregnancy. The National Campaign determined that the average cost to taxpayers for teen births between 1991 and 2004 was $15.1 billion[259], or an average of $20,000 per birth. This cost includes medical expenses, welfare services and productivity loss. The costs averted are broken further into episodic costs of $5,000 for the cost of delivery and healthcare for mother and child the first year

[259] The National Campaign. By the Numbers: The Public Costs of Teen Childbearing in Texas, November 2006. http://www.thenationalcampaign.org/costs/pdf/states/texas/fact-sheet.pdf. Accessed October 1, 2012.

after birth. The remaining $15,000 is prorated for the life of the Waiver. Based on the average birth rate for Harris County, successful family planning will help us avoid an additional 63 births per 1,000 patients. Teen pregnancy rates in the neighborhoods currently serviced by the Teen Clinic are higher than the Harris County average. By reducing the pregnancy rate, we will achieve additional savings in healthcare costs and taxpayer burden that are not duplicated in the estimated bundle for the rendering of contraception management services.

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082006001.3.2	*IT-1.20*	*Reduction of Pregnancy Rates among Adolescents and Young Adults*	
Baylor College of Medicine			*082006001*
Related Category 1 or 2 Projects:	*082006001.1.1*		
Starting Point/Baseline:	*To be established in DY3*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project panning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans **Data Source:** Project plan document.	**Process Milestone 2** [P-2]: Establish baseline pregnancy rate. Data Source: Health Record Process Milestone 3 Estimated Incentive Payment: $ 57,600	**Outcome Improvement Target 1** [IT-1.20]: Reduce pregnancy rate. Improvement Target: Reduce pregnancy rate by 1% over baseline. Data Source: Health Record Outcome Improvement Target 1 Estimated Incentive Payment: $ 92,700	**Outcome Improvement Target 2** [IT-1.20]: Reduce pregnancy rate. Improvement Target: Reduce pregnancy rate by 2% over baseline. Data Source: Health Record Outcome Improvement Target 2 Estimated Incentive Payment: $ 134,100
Year 2 Estimated Outcome Amount: $ 0	Year 3 Estimated Outcome Amount: $ 57,600	Year 4 Estimated Outcome Amount: $ 92,700	Year 5 Estimated Outcome Amount: $ 134,100
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $ 284,400			

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Title of Outcome Measure (Improvement Target): IT-1.10 Improved HbA1c Control

Unique RHP outcome identification number(s): 082006001.3.3
Performing Provider Name/TPI: Baylor College of Medicine/082006001

Outcome Measure Description:

Because this is a new clinic, process milestone P-2 was selected in order to establish the baseline to which we can compare outcomes. Outcome IT-1.10 was selected to measure improvement in Diabetes care control by 15% in DY5 compared to the baseline.

Process Milestones:

- DY2: P-1
- DY3: P-2

Outcome Improvement Target(s):

- DY4 and DY5: IT-1.10 Improve Hb1Ac control showing increased improvement year over year

Rationale:

The Fifth Ward has been identified as a medically underserved area[260] and is predominantly comprised of residents who identify themselves as Black, Hispanic or Latino[261]. Improvements in HbA1c control can improve patient quality of life and cost of care by reducing the lifetime incidence of blindness, end-stage renal disease (ESRD) and coronary artery disease[262]. Black and Hispanic patients have higher rates of diabetes and higher mortality rates due to diabetes[263] than white patients. African Americans are more likely to develop ESRD. This measure will reflect the Fifth Ward Clinic's success in implementing continuous process improvements to improve patient outcomes.

Outcome Measure Valuation:

The value of weight reduction was calculated based on the percentage of the population that is obese[18] and not currently diagnosed with diabetes[20]. Of those patients, it is expected that a 5-7% reduction in weight will reduce the risk of diabetes by 58%[21]. The annual savings[21] was applied to the number of diabetes cases avoided due to weight management for the duration of the Waiver.

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[260] U.S. Department of Health and Human Services, Health Resources and Services Administration. Find Shortage Areas: MUA/P by State and County. http://muafind.hrsa.gov/index.aspx. Accessed October 1, 2012
[261] United States Census 2010. 2010 Census Interactive Population Search. http://2010.census.gov/2010census/popmap/. Accessed October 1, 2012. Census Tracts 2111, 2113.
[262] Huang ES, Zhang Q, Brown SES, Drum ML, Meltzer DO, Chin MH. The Cost-Effectiveness of Improving Diabetes Care in the U.S. Federally Qualified Community Health Centers. *Health Services Research*, 2007; 42(6 Pt 1): 2174-2193.
[263] Agency for Healthcare Research and Quality, Diabetes Disparities Among Racial and Ethnic Minorities.

082006001.3.3	3.IT-1.10	Improved HbA1c Control	
Baylor College of Medicine			082006001
Related Category 1 or 2 Projects:	082006001.2.1		
Starting Point/Baseline:	To be established in DY 3		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Complete project plan. Data Source: Project plan document. Process Milestone 1 Estimated Incentive Payment: $ 46,000	**Process Milestone 2** [P-2]: Establish baseline percentage of patients with poor HbA1c control (>9.0%). Data Source: EHR Process Milestone 2 Estimated Incentive Payment: $ 100,000	**Outcome Improvement Target 1** [IT-1.10]: Improve HbA1c control Improvement Target: 10% improvement over baseline. Data Source: EHR Outcome Improvement Target 1 Estimated Incentive Payment: $ 163,300	**Outcome Improvement Target 2** [IT-1.10]: Improve HbA1c control Improvement Target: 15% improvement over baseline. Data Source: EHR Outcome Improvement Target 2 Estimated Incentive Payment: $ 234,000
Year 2 Estimated Outcome Amount: $ 46,000	Year 3 Estimated Outcome Amount: $ 100,000	Year 4 Estimated Outcome Amount: $ 163,300	Year 5 Estimated Outcome Amount: $ 234,000
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $ 543,300			

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Title of Outcome Measure (Improvement Target): IT-1.20 Improved Weight Control

Unique RHP outcome identification number(s): 082006001.3.4
Performing Provider Name/TPI: Baylor College of Medicine/082006001

Outcome Measure Description:

Because this is a new clinic, process milestone P-2 was selected in order to establish the baseline population. Outcome IT-1.20 other outcome improvement target was selected to measure weight loss of at least 5% in 10% of the target population by DY5.

Process Milestones:

- DY2: P-1
- DY3: P-2

Outcome Improvement Target(s) for each year:

- DY4 and DY5: IT-1.20 Improve weight control showing increased improvement year over year

Rationale:

The Fifth Ward has been identified as a medically underserved area[264] and is predominantly comprised of residents who identify themselves as Black, Hispanic or Latino[265]. Weight management is a proposed outcome measure under option IT-1.20. According to the Health of Houston Survey in 2010, 32% of Houston area adults were obese, compared to 29% across the State of Texas[266] with a high prevalence among non-Hispanic blacks (51% higher) and Hispanics (21% higher)[267]. Obese patients face a higher risk of developing diabetes[268], and weight loss can significantly reduce that risk[269]. Helping patients achieve healthier weights can reduce mortality and morbidity and their attendant costs associated with diabetes as well as, creating an overall healthier population with decreased risk of other medical complications.

Outcome Measure Valuation:

The value of weight reduction was calculated based on the percentage of the population that is obese[18] and not currently diagnosed with diabetes[20]. Of those patients, it is expected that a 5-7% reduction in weight will reduce the risk of diabetes by 58%[21]. The annual savings[21] was applied to the number of diabetes cases avoided due to weight management for the duration of the Waiver.

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082006001.3.4	*3.IT-1.20*	Improved Weight Control	
Baylor College of Medicine			*082006001*
Related Category 1 or 2 Projects:	*082006001.2.1*		
Starting Point/Baseline:	To be established in DY 3		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Complete project plan. Data Source: Project plan document. Process Milestone 1 Estimated Incentive Payment: $ 11,800	**Process Milestone 2** [P-2]: Establish baseline number of obese patients (BMI ≥ 30). Data Source: EHR Process Milestone 2 Estimated Incentive Payment: $ 25,700	**Outcome Improvement Target 1** [IT-1.20]: Improve weight control (loss of ≥ 5% of body weight). Improvement Target: Improved control in 5% of target population. Data Source: EHR Outcome Improvement Target 1 Estimated Incentive Payment: $ 42,000	**Outcome Improvement Target 2** [IT-1.20]: Improve weight control (loss of ≥ 5% of body weight). Improvement Target: Improved control in 10% of target population. Data Source: EHR Outcome Improvement Target 2 Estimated Incentive Payment: $ 60,300
Year 2 Estimated Outcome Amount: $ 11,800	Year 3 Estimated Outcome Amount: $ 25,700	Year 4 Estimated Outcome Amount: $ 42,000	Year 5 Estimated Outcome Amount: $ 60,300
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $ 139,800			

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Title of Outcome Measure (Improvement Target): IT-12.2 Improved Cervical Cancer Screening

Unique RHP outcome identification number(s): 082006001.3.5
Performing Provider Name/TPI: Baylor College of Medicine/082006001

Outcome Measure Description:

Because this is a new clinic, process milestone P-2 was selected in order to establish the baseline to which we can compare outcomes. Outcome IT-12.2 was selected to improve cervical cancer screening rates by 10% over the baseline by DY5.

Process Milestones:

- DY2: P-1
- DY3: P-2

Outcome Improvement Target(s):

- DY4 and DY5: IT-12.2 Increase cervical cancer screening showing improvement year over year

Rationale:

The clinic's goals include ensuring access to timely preventative care. Improvement in cervical cancer screening was selected from this outcome domain in order to measure the clinic's success in achieving this goal. It is complimentary to the other outcome measures as an additional screening and preventative measure ensuring that the health and well being of this target population is maintained.

Improvements in cervical cancer screening can reduce the incidence of cervical cancer by as much as 93%, while also decreasing associated mortality and lowering treatment costs[270]. Black and Hispanic women have much higher rates of incidence and mortality when compared to the general population,[271] of which is a large percentage of this target population[272].

Outcome Measure Valuation:

The value of cervical screening was based on the differential costs of treating localized lesions and cancers and treating regional and distant cancers[273]. The initial, interim and pro rata final stage costs are calculated based on the current incidence of cancer rates in Texas[274] and the reduction of invasive rates when screening occurs every two years

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082006001.3.5	*3.IT-12.2*	*Improved Cervical Cancer Screening*	
Baylor College of Medicine			*082006001*
Related Category 1 or 2 Projects:	*082006001.2.1*		
Starting Point/Baseline:	*To be established in DY 3*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Complete project plan. Data Source: Project plan document. Process Milestone 1 Estimated Incentive Payment: $ 7,200	**Process Milestone 2** [P-2]: Establish baseline percentage of women who received a PAP within the past two years. Data Source: EHR Process Milestone 2 Estimated Incentive Payment: $ 16,000	**Outcome Improvement Target 1** [IT-12.2]: Improve percentage of women who received a PAP within the past two years, 5% improvement over baseline. Data Source: EHR Outcome Improvement Target 1 Estimated Incentive Payment: $ 25,700	**Outcome Improvement Target 2** [IT-12.2]: Improve percentage of women who received a PAP within the past two years, 10% improvement over baseline. Data Source: EHR Outcome Improvement Target 2 Estimated Incentive Payment: $ 36,700
Year 2 Estimated Outcome Amount: $ 7,200	Year 3 Estimated Outcome Amount: $ 16,000	Year 4 Estimated Outcome Amount: $ 25,700	Year 5 Estimated Outcome Amount: $ 36,700
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $ 85,600			

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Bayshore Medical Center

Pass 1

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Title of Outcome Measure (Improvement Target): Category 3: Quality Improvements:
Outcome Domain 8: Perinatal Outcomes
Improvement Target 8.2: Percentage of Low Birth Weight births

Performing Provider Name/TPI: HCA Bayshore Medical Center/020817501
Unique RHP outcome identification number(s): 020817501.3.1

Outcome Measure Description:

Bayshore will reduce the number of infants born to mothers seen at its three local OB/Gyn clinics with low birth weight, defined as infants weighing less than 2500 grams at birth. Bayshore will achieve this outcome by providing earlier and more consistent care to expectant mothers, and increased education about maintaining a health pregnancy, which will improve the health outcomes of these pregnancies (both for the infants and the mothers). Healthily maintained pregnancies are more likely to produce full-term babies, and also to produce developmentally on-target infants, both of which should cause higher, healthier birth weights than may have otherwise resulted.

Process Milestones:

HCA chose its DY 2-3 process milestones in order to establish a baseline rate of low birth weights for infants born to mothers treated at Bayshore's clinics (by which to measure progress going forward), and to develop a plan for making sure that the expanded OB/Gyn capacity translates into improved health for newborns, including a healthy birth weight.

Rationale:

HCA selected this outcome because low birth weight is associated with myriad of immediate and long-term health problems, including feeding issues, inhibited growth, cognitive and developmental delays, and chronic diseases later in life. Harris County newborns suffer from a higher rate of low-birth weight than the statewide average, making this an important outcome for Bayshore's community. Factors related to the expectant mother that can result in low-birth weight include smoking, drinking alcohol, diabetes, heart disease, poor nutrition, and stress. Increased access to OB/Gyn services will allow mothers at risk for infants with low-birth weight to receive the education, support, and skills necessary to address these factors before or during pregnancy, thereby reducing the likelihood of giving birth to a child under 2500 gram in weight. Additionally, the cost of treating newborns with low birth weight is hard to measure, as it can lead to so many other health problems in the near and distant future. Needless to say, the systemic cost savings associated with preventing low birth weight would have a meaningful

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impact on the delivery system and allow for reinvestment of funds into much-needed primary and preventative care.

Outcome Improvement Targets for each year:

During DY2, HCA will determine the percentage rate of improvement it will target in DYs 4-5. Upon determining the baseline and creating a plan for improving patient education, awareness, and health during pregnancy, Bayshore will determine in DY3 reasonable, yet impactful, percentages of improvement to target.

Outcome Measure Valuation:

The valuation of each HCA Bayshore Category 3 outcome takes into account the degree to which the project accomplishes the triple-aims of the Waiver, addresses community needs, benefits the population served by the project, and the investment required to implement the project. The value of this outcome incorporates the potential health benefits for infants born at a healthy weight, the increased satisfaction for the mothers and families of the healthy infants, and the immediate and long-term cost savings associated with providing health care to these infants as they mature.

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020817501.3.1	*3.8.2*	*Perinatal Outcomes: Percentage of Low birth weight births*	
HCA – Bayshore			020817501
Related Category 1 or 2 Projects::	**020817501.1.1**		
Starting Point/Baseline:	**TBD in DY2**		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
<u>Process Milestone 1</u> [*P-2*]: Establish a baseline – HCA will measure the number of low birth weight births to women treated at its three local clinics. Data Source: Hospital data reports Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $ 424,794	**<u>Process Milestone 2</u>** [P-1]: Project planning – develop a plan for using the expanded OB/Gyn capacity to reach more expectant mothers and provide the education, support, and interventions they need to maintain healthy, full-term pregnancies, resulting in a reduced rate of low birth weight (including community outreach, classes, and/or patient protocols) Data Source: Program materials. Process Milestone 2 Estimated Incentive Payment: $ 492,392	**Outcome Improvement Target 1**[IT 8.2] **Improvement Target**: Decrease the number of low birth weight births to mothers treated at Bayshore's three local clinics by X% under baseline (TBD) Data Source: Hospital admission records Outcome Improvement Target 1 Estimated Incentive Payment*:* $ 790,117	**Outcome Improvement Target 2**[IT-8.2] **Improvement Target**: Decrease the number of low birth weight births to mothers treated at Bayshore's three local clinics by X% under baseline (TBD) Data Source: Loan documentation Outcome Improvement Target 2 Estimated Incentive Payment*:* $ 1,889,411
Year 2 Estimated Outcome Amount: $ 424,794	Year 3 Estimated Outcome Amount: $ 492,392	Year 4 Estimated Outcome Amount: $ 790,117	Year 5 Estimated Outcome Amount: $ 1,889,411
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $ 3,596,714			

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Title of Outcome Measure (Improvement Target):
Outcome Domain 11: Addressing Health Disparities in Minority Populations
Improvement Target 11.1: Improvement in Clinical Indicator in Identified Disparity Group

Unique RHP outcome identification number(s): 020817501.3.2

Performing Provider/TPI: Bayshore Medical Center/20817501.
Outcome Measure Description:

HCA chose this outcome because one expected outcome of the implementation of tele-psychiatry services at Bayshore and other HCA hospitals in the area is an improvement in the clinical indicators for BH/SA patients. Reduced wait times in the ED for treatment and/or referral to the appropriate care setting is the clinical indicator that Bayshore will measure, as this aspect of the patient's experience in the health care system is tied to improved patient outcomes and satisfaction with the healthcare deliver system.

Process Milestones:

Bayshore chose its DY2 milestone in order to establish the average wait times experienced by BH/SA patients (as a primary or secondary diagnosis) in the EDs at the hospitals participating in the tele-psychiatry program. Bayshore will use this number as a baseline by which to measure improvement going forward.

Outcome Improvement Target(s) for each year:

During DYs 3-5, Bayshore will measure the ED wait time for treatment or referral/transfer, and measure those times against the baseline, looking for improvement in this vital clinical indicator for BH/SA patients. Bayshore will set the actual percentages for the improvement rate targeted in DY3, after establishing a baseline in DY2 and assessing a reasonable, yet impactful, target.

Rationale:

Bayshore selected this project for several reasons. First, most of Houston is comprised of federally-designated Health Provider Shortage Areas (including Harris County Hospital District, and many geographical areas within and around Houston) in the domain of mental health. The shortage of providers results in a disparity in the access to primary, preventative, and specialty care for residents requiring BH/SA health care. As a result of this issue, many patients present at East Houston, West Houston, or Woman's Hospital for BH/SA treatment, and languish in the ED for hours or even days because they simply do not have the capabilities to properly assess their conditions, provide treatment, or refer these patients to the appropriate setting. At Bayshore, there are limited provider resources to treat these patients (being the only hospital in this network with psychiatric beds), meaning that the patients also spend more time than they should in the ED, which takes beds from emergent patients. Finally, this ED crowding and lack of adequate BH/SA provider resources results in more inpatient hospital admissions than would otherwise

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occur. The average cost on a BH inpatient stay at Bayshore is $3,723.00. Inpatient stays have a negative impact on patient short-term health outcomes, and reduce patient satisfaction and quality of life. For each of these reasons, Bayshore will use ED wait time for BH/SA treatment or referral/transfer as a clinical indicator of improvement for this group identified as traditionally underserved by the healthcare system.

Outcome Measure Valuation:

The valuation of each HCA Bayshore Category 3 outcome takes into account the degree to which the project accomplishes the triple-aims of the Waiver, addresses community needs, benefits the population served by the project, and the investment required to implement the project. The value of this outcome lies in the potential for improvement to BH/SA patient outcomes and satisfaction, as well as addressing the rampant overcrowding of area EDs (which is expensive, unhealthy, and unpleasant for all involved).

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020817501.3.2	*IT-11.1*	*Addressing health Disparities in Minority Populations*	
HCA – Bayshore			*094187402*
Related Category 1 or 2 Projects:	**020817501.1.2**		
Starting Point/Baseline:	**TBD in DY2**		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
<u>Process Milestone 1</u> [*P-2]*: Establish a baseline – HCA will measure the number of PPAs for BH/SA related conditions during DY2, in order to measure progress going forward <u>Data Source:</u> Hospital data reports Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $459,950	**<u>Outcome improvement target 1</u>** (IT 11.1] **Improvement Target:** Decrease the ED wait time for BH/SA patients presenting at Bayshore, East Houston Regional Medical Center, West Houston Medical Center, and Woman's Hospital (combined) by X% under baseline (TBD in DY3) <u>Data Source:</u> Hospital ED records, electronic health records Outcome Improvement Target 1 Estimated Incentive Payment*:* $533,142	**<u>Outcome improvement target 1</u>** (IT 11.1] **Improvement Target:** Decrease the ED wait time for BH/SA patients presenting at Bayshore, East Houston Regional Medical Center, West Houston Medical Center, and Woman's Hospital (combined) by X% under baseline (TBD in DY3) <u>Data Source:</u> Hospital ED records, electronic health records Outcome Improvement Target 2 Estimated Incentive Payment*:* $855,506	**<u>Outcome improvement target 1</u>** (IT 11.1] **Improvement Target:** Decrease the ED wait time for BH/SA patients presenting at Bayshore, East Houston Regional Medical Center, West Houston Medical Center, and Woman's Hospital (combined) by X% under baseline (TBD in DY3) <u>Data Source:</u> Hospital ED records, electronic health records Outcome Improvement Target 3 Estimated Incentive Payment*:* $2,045,776
Year 2 Estimated Outcome Amount: $459,950	Year 3 Estimated Outcome Amount: $533,142	Year 4 Estimated Outcome Amount: $855,506	Year 5 Estimated Outcome Amount: $2,045,776
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $ $3,894,374			

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City of Houston Department of Health and Human Services

Pass 1

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Title of Outcome Measure (Improvement Target): IT 7.1- Dental Sealant: Percentage of children age 6-9 with a dental sealant on a permanent first molar tooth (Healthy People 2020; CMS Oral Health Initiative goal

Unique RHP Outcome identification number(s): 0937740-08.3.1

Outcome Measure Description:
IT-7.1 Dental Sealant:
- o Percentage of children age 6-9 with a dental sealant on a permanent first molar tooth (Healthy People 2020; CMS Oral Health Initiative goal

Process Milestones:
- o DY 2
  - o Establish Baseline Rates
- o DY3:
  - o P-4: Milestone: Conduct Plan Do Study Act cycle to continually improve program
  - o P-5: Milestone: Disseminate lessons learned and best practices

Outcome improvement targets for each year:
- DY 4:
  - o IT-7.1 Dental Sealant: Increase by 5% over baseline, Percentage of children age 6-9 with a dental sealant on a permanent first molar tooth (Healthy People 2020; CMS Oral Health Initiative goal
- DY 5
  - o IT-7.1 Dental Sealant: Increase by 10% over baseline, Percentage of children age 6-9 with a dental sealant on a permanent first molar tooth (Healthy People 2020; CMS Oral Health Initiative goal (Non-standalone measure)

Rationale:

The Outcome Improvement target for this project was chosen because application of dental sealants in underserved elementary school children promotes dental health in the future. By increasing the percentage of children who receive dental sealants, this program will promote and enhance dental health in underserved children and help close disparities in dental health. The process milestones P4 and P5 were chosen for this project based on the need for documentation of baseline and continuous quality improvements in program for sealant application and dental care. The PDSA cycle will inform systematic data driven program improvements. Inadequate access to dental services compounds other health issues. It can result in untreated dental disease that not only affects the mouth, but can also have physical, mental, economic and social consequences. Fortunately, many of the adverse effects associated with poor oral health can be prevented with quality regular dental care, both at home and professionally. Increasing, expanding, and enhancing dental services will improve overall health outcomes. The improvement targets are based on the two single most important indicators for childhood dental health. Children who have regular access to a dental provider are more likely to have received dental services that can prevent or treat early dental disease. Additionally, unserved or underserved perinatal women are a specially vulnerable group not only for their own dental health but also for the dental health of their children. Education on the importance of dental health can help promote better dental health in young children.

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Outcome Measure Valuation:

The Outcome measure was valued at 12.29 % of the overall assigned project value for the associated Category 2 project in year 3, 12.29 % in Year 4 and 12.29 % in Year 5. HHDHS utilized the following method to determine the Category 2 project value.

HDHHS utilized two categories to calculate value for each DSRIP project. The first category is Prioritization and the second is Public Health Impact (see attachment for HDHHS Valuation Tool). HDHHS scored the project on a scale of 1 (poor) to 9 (exceptional) for each of the six factors that comprise the Prioritization category. The Prioritization category includes the following factors: 1) Transformational Impact, 2) Population Served / Project Size, 3) Alignment with Community Needs 4)Cost Avoidance 5) Partnership Collaboration and 6)Sustainability. Each factor was then given a weighted score based on the score rated and a pre-determined percentage weight. The six weighted scores were added to get a composite score for the Prioritization category.

Public Health includes activities which seek to achieve the highest level of health for the greatest number of people. Public Health also focuses on preventing problems from happening or re-occurring through programs and activities that promote and protect the health of the entire community. As a public health department, HDHHS added an additional valuation category of Public Health Impact that looked at projects through a public health lens. The Public Health Impact category includes the following factors: 1) Alleviate Health Disparity, 2) Control Communicable and Chronic Disease , 3) Prevention Orientation, 4) Population Health Focus, 5) Access and Connection to Health Services and 6) Evidence Based Health Program. HDHHS scored the project on a scale of 1 (poor) to 9 (exceptional) for each of the six factors that comprise the Public Health Impact category. Each factor was then given a weighted score based on the score rated and a pre-determined percentage weight. The six weighted scores were added to get a composite score for the Public Health Impact category.

HDHHS gave the Prioritization score a weight of 25% and the Public Health Impact score a weight of 75% to determine the overall project value for the plan. Oral Health Service Expansion received a composite Prioritization score of 7.65 and a Public Health Impact score of 7.

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0937740-08.3.1	*IT-7.1*	*Dental Sealant: Percentage of children age 6-9 with a dental sealant on a permanent first molar tooth*	
[RHP Performing Provider involved with this project - Name] City of Houston Health and Human Services			TPI - 0937740-08
Related Category 1 or 2 Projects:	0937740-08.1.1		
Starting Point/Baseline:	Project Baseline will be established in DY 2		
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Process Milestone 1 [P- 2] Establish baseline rates Metric 1: Calculate baseline rate of dental sealants in children age 6-9 in Oral Health Program in DY2 months 6-12 Goals: Establish baseline against which improvements can be measured Data Sources: Program documentation from month 6-12 inDY2 Numerator: # of children age 6-9 years with dental sealant enrolled in Oral Health Program Denominator: Total # of children of same age enrolled in the program Milestone 1 Estimated Incentive Payment: $62,267.21	**Process Milestone 2** [P-4]: Conduct Plan Do Study Act cycle to continually improve Metric 1: Document use of PDSA in planning process Goal: Goal: Ensure highest quality on program process and improvement. Data Source: Step-wise documentation of PDSA in program documentation Milestone 2 Estimated Incentive Payment: $72,845.65 **Process Milestone 3** [P-5]: Disseminate lessons learned and best practices Metric 1: Documentation of best practices Metric 2: Documentation of lessons learned Goal: Provide report documenting identification of best practices and lessons learned Data Source: Documentation of report	**Outcome Improvement Target 1** [IT-7.1] Dental Sealant: Percentage of children age 6-9 with a dental sealant on a permanent first molar tooth (Healthy People 2020; CMS Oral Health Initiative goal (Non-standalone measure) Improvement Target: Increase rate of dental sealant in children by 5% over baseline (Baseline will be determined in DY2) Data Source: Program Electronic Records Numerator: Number of children age 6-9 with a dental sealant on at least one permanent first molar within the measurement period (past 12 months) enrolled in Program Denominator: Total number of children age 6-9 that have seen a dental provider within the measurement period (past 12 months) enrolled in Program Outcome Improvement Target 1 Estimated Incentive Payment: $155,094.92	**Outcome Improvement Target 2** [IT-7.1] Dental Sealant: Percentage of children age 6-9 with a dental sealant on a permanent first molar tooth (Healthy People 2020; CMS Oral Health Initiative goal (Non-standalone measure) Improvement Target: Increase rate of dental sealant in children by 10% over Baseline Data Source: Program Electronic Records Numerator: Number of children age 6-9 with a dental sealant on at least one permanent first molar within the measurement period (past 12 months) enrolled in Program Denominator: Total number of children age 6-9 that have seen a dental provider within the measurement period (past 12 months) enrolled in Program Outcome Improvement Target 2 Estimated Incentive Payment: $337,243

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0937740-08.3.1	*IT-7.1*	*Dental Sealant: Percentage of children age 6-9 with a dental sealant on a permanent first molar tooth*	
[RHP Performing Provider involved with this project - Name] City of Houston Health and Human Services			TPI - 0937740-08
Related Category 1 or 2 Projects:	0937740-08.1.1		
Starting Point/Baseline:	Project Baseline will be established in DY 2		
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
	Milestone 3 Estimated Incentive Payment: $72,845.65		
Year 2 Estimated Outcome Amount:: $62,267	Year 3 Estimated Outcome Amount: $145,691	Year 4 Estimated Outcome Amount: $155,095	Year 5 Estimated Outcome Amount: $337,243
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5): $700,296			

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Title of Outcome Measure (Improvement Target): IT-7.2 Cavities: Percentage of children with untreated dental caries (Healthy People 2020)

Unique RHP Outcome identification number(s): 0937740-08.3.2

Outcome Measure Description:

IT-7.2 Cavities: Percentage of children with untreated dental caries (Healthy People 2020)

(Standalone measure)

Process Milestones :

- DY 2
  - Develop and test data systems
- DY3:
  - P-4: Milestone: Conduct Plan Do Study Act cycle to continually improve program
  - P-5: Milestone: Disseminate lessons learned and best practices

Outcome improvement targets for each year:

- DY 4:
  - IT-7.2 Cavities: Reduce by 2% over baseline Percentage of children with untreated dental caries (Healthy People 2020) (Standalone measure)
- DY 5
  - IT-7.2 Cavities: Reduce by 5% over baseline Percentage of children with untreated dental caries (Healthy People 2020) (Standalone measure)

Rationale:

The process milestones P4 and P5 were chosen for this project based on the need for documentation of baseline and continuous quality improvements in program for reduction of dental caries. The PDSA cycle will inform systematic data driven program improvements. Inadequate access to dental services compounds other health issues. It can result in untreated dental disease that not only affects the mouth, but can also have physical, mental, economic and social consequences. Fortunately, many of the adverse effects associated with poor oral health can be prevented with quality regular dental care, both at home and professionally. Increasing, expanding, and enhancing dental services will improve overall health outcomes. The improvement targets are based on the two single most important indicators for childhood dental

health. Children who have regular access to a dental provider are more likely to have received dental services that can prevent or treat early dental disease. Additionally, unserved or underserved perinatal women are a specially vulnerable group not only for their own dental health but also for the dental health of their children. Education on the importance of dental health can help promote better dental health in young children.

Outcome Measure Valuation:

The Outcome measure was valued at 12.29 % of the overall assigned project value for the associated Category 2 project in year 3, 12.29 % in Year 4 and 12.29 % in Year 5. HHDHS utilized the following method to determine the Category 2 project value.

HDHHS utilized two categories to calculate value for each DSRIP project. The first category is Prioritization and the second is Public Health Impact (see attachment for HDHHS Valuation Tool). HDHHS scored the project on a scale of 1 (poor) to 9 (exceptional) for each of the six factors that comprise the Prioritization category. The Prioritization category includes the following factors: 1) Transformational Impact, 2) Population Served / Project Size, 3) Alignment with Community Needs 4)Cost Avoidance 5) Partnership Collaboration and 6)Sustainability. Each factor was then given a weighted score based on the score rated and a pre-determined percentage weight. The six weighted scores were added to get a composite score for the Prioritization category.

Public Health includes activities which seek to achieve the highest level of health for the greatest number of people. Public Health also focuses on preventing problems from happening or re-occurring through programs and activities that promote and protect the health of the entire community. As a public health department, HDHHS added an additional valuation category of Public Health Impact that looked at projects through a public health lens. The Public Health Impact category includes the following factors: 1) Alleviate Health Disparity, 2) Control Communicable and Chronic Disease , 3) Prevention Orientation, 4) Population Health Focus, 5) Access and Connection to Health Services and 6) Evidence Based Health Program. HDHHS scored the project on a scale of 1 (poor) to 9 (exceptional) for each of the six factors that comprise the Public Health Impact category. Each factor was then given a weighted score based on the score rated and a pre-determined percentage weight. The six weighted scores were added to get a composite score for the Public Health Impact category.

HDHHS gave the Prioritization score a weight of 25% and the Public Health Impact score a weight of 75% to determine the overall project value for the plan. Oral Health Service Expansion received a composite Prioritization score of 7.65 and a Public Health Impact score of 7.

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0937740-08.3.2	IT-7.2	Cavities: Percentage of children with untreated dental caries	
[RHP Performing Provider involved with this project - Name] City of Houston Health and Human Services			TPI - 0937740-08
Related Category 1 or 2 Projects::	Unique Cat 1 ID: 0937740-08.1.1		
Starting Point/Baseline:	TBD in DY2-3		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P- 3] Develop and test data systems Metric 1: Select, install and test data system Goal: Install efficient and effective data system to capture program data Data Source: Documentation of selection, testing and implementation of data system Milestone 1 Estimated Incentive Payment: $62,267.21	**Process Milestone 2** [P-4]: Conduct Plan Do Study Act cycle to continually improve Metric 1: Document use of PDSA in planning process Goal: Utilize a systematic cyclical process for quality improvement Data Source: Program documentation Milestone 2 Estimated Incentive Payment: $72,845.65 **Process Milestone 3** [P-5]: Disseminate lessons learned and best practices Metric 1: Documentation of best practices and lessons learned Goal: Share lessons learned to add to knowledge base and inform others implementing similar projects Data Source: Program Documentation	**Outcome Improvement Target 1** [IT-7.2]: Cavities: Percentage of children with untreated dental caries (Healthy People 2020) Goal: Reduce by 2% over baseline the percentage of children with dental caries in the Oral Health program. (Baseline TBD in DY 2-3) Data Source: Program Electronic Records Numerator: Number of children with untreated dental caries(past 12 months) enrolled in Program Denominator: Total number of children that have seen a dental provider within the measurement period(past 12 months) enrolled in Program Outcome Improvement Target 1 Estimated Incentive Payment: $155,094.92	**Outcome Improvement Target 2** [IT-7.2]: Cavities: Percentage of children with untreated dental caries (Healthy People 2020) Goal: Reduce by 5% over baseline the percentage of children with dental caries in the Oral Health program Data Source: Program Electronic Records Numerator: Number of children with untreated dental caries(past 12 months) enrolled in Program Denominator: Total number of children that have seen a dental provider within the measurement period(past 12 months) enrolled in Program Outcome Improvement Target 2 Estimated Incentive Payment: $337,243

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0937740-08.3.2	IT-7.2	Cavities: Percentage of children with untreated dental caries	
[RHP Performing Provider involved with this project - Name] City of Houston Health and Human Services			TPI - 0937740-08
Related Category 1 or 2 Projects::	Unique Cat 1 ID: 0937740-08.1.1		
Starting Point/Baseline:	TBD in DY2-3		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
	Milestone 3 Estimated Incentive Payment: $72,845.65		
Year 2 Estimated Outcome Amount:: $62,267	Year 3 Estimated Outcome Amount: $145,691	Year 4 Estimated Outcome Amount: $155,095	Year 5 Estimated Outcome Amount: $337,243
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD ***(add outcome amounts over DYs 2-5):*** $700,296			

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Title of Outcome Measure (Improvement Target):IT-9.4 Other Outcome Improvement Target (ED appropriate utilization)

Unique RHP Outcome identification number(s): 0937740-08.3.3

Outcome Measure Description:
IT-9.4Other Improvement Target (ED appropriate utilization of non-life threatening, mild or moderately ill 911 callers). This program provides care coordination, by more accurately assessing the 9-1-1 caller's needs via telehealth services and provide the patient more appropriate care in a more appropriate setting than the emergency center. The performing provider and its partners expect to see a reduction in ER usage among non-emergent 911 callers by using telecommunications technologies and connectivity to provide access to underserved non-emergent populations that called 911 through improved access to specialists, improved care and satisfaction and reduced emergency room usage.

Process Milestones:
- DY2:
  - [P-3]: Develop and test Data systems
- DY 3
  - P-4 : Conduct and Update Plan-Do-Study-Act for quality improvement
  - P-5 : Disseminate findings, lessons learned and best practices

Outcome Improvement Targets for each year
- DY 4:
  - IT-9.4Other Improvement Target (ED appropriate utilization -Stand-alone measure) - Reduce all ED visits that are non-emergent (including ACSC) that call into the 911 system by 5% over baseline.
- DY 5:
  - IT-9.4Other Improvement Target (ED appropriate utilization Stand-alone measure) - Reduce all ED visits that are non-emergent (including ACSC) that call into the 911 system by 10% over baseline.

Rationale:
Using telecommunications for patient consults to provide medical data, which may include audio, still or live images, between a patient and a health professional for use in rendering a diagnosis and treatment plan is a viable way to make medical care more accessible. The development and installation of high-speed wireless telecommunications networks coupled with large-scale search engines and mobile devices will change healthcare delivery as well as the scope of healthcare services. It will allow for real-time monitoring and interactions with patients without bringing them into a hospital or a specialty care center. This real/near-time monitoring and interacting could enable a healthcare team to address patient problems before they require major interventions, creating a potentially patient-centered approach that could undoubtedly change our expectations of our healthcare system.

Process measures for Project Planning and implementation needs to happen before lessons learned and best practices can be documented. These measures will be conducted in DY 2 and 3 so that outcomes can be measured in DY 4 and 5.

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Outcome Measure Valuation:

The Outcome measure was valued at 12.21 % of the overall assigned project value for the associated Category 2 project in year 3, 12.21% Year 4 and 12.21% in Year 5. HHDHS utilized the following method to determine the Category 2 project value.

HDHHS utilized two categories to calculate value for each DSRIP project. The first category is Prioritization and the second is Public Health Impact (see attachment for HDHHS Valuation Tool). HDHHS scored the project on a scale of 1 (poor) to 9 (exceptional) for each of the six factors that comprise the Prioritization category. The Prioritization category includes the following factors: 1) Transformational Impact, 2) Population Served / Project Size, 3) Alignment with Community Needs 4)Cost Avoidance 5) Partnership Collaboration and 6)Sustainability. Each factor was then given a weighted score based on the score rated and a pre-determined percentage weight. The six weighted scores were added to get a composite score for the Prioritization category.

Public Health includes activities which seek to achieve the highest level of health for the greatest number of people. Public Health also focuses on preventing problems from happening or re-occurring through programs and activities that promote and protect the health of the entire community. As a public health department, HDHHS added an additional valuation category of Public Health Impact that looked at projects through a public health lens. The Public Health Impact category includes the following factors: 1) Alleviate Health Disparity, 2) Control Communicable and Chronic Disease , 3) Prevention Orientation, 4) Population Health Focus, 5) Access and Connection to Health Services and 6) Evidence Based Health Program. HDHHS scored the project on a scale of 1 (poor) to 9 (exceptional) for each of the six factors that comprise the Public Health Impact category. Each factor was then given a weighted score based on the score rated and a pre-determined percentage weight. The six weighted scores were added to get a composite score for the Public Health Impact category.
HDHHS gave the Prioritization score a weight of 25% and the Public Health Impact score a weight of 75% to determine the overall project value for the plan. The Care Houston Links Program received a composite Prioritization score of 7.15 and a Public Health Impact score of 7.

References:

1. ER Visits with an ambulance transport. Report from Center for Health Services Research Collaborative. UT School of Public Health, Houston, Texas. Accessed on 10/2/12 from https://sph.uth.edu/research/centers/chsr/hsrc/.
2. Stakeholder input from RHP 3Working Group Members throughout the Region (including providers, consumers, hospital and clinic administrators, government officials, researchers, and advocacy groups)
3. The State of Health – Houston and Harris County, 2012.
4. Dixon BE, Hook JM, McGowan JJ. Using Telehealth to Improve Quality and Safety: Findings from the AHRQ Portfolio (Prepared by the AHRQ National Resource Center for Health IT under Contract No. 290-04-0016). AHRQ Publication No. 09-0012-EF. Rockville, MD: Agency for Healthcare Research and Quality. December 2008.

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0937740-08.3.3	IT-9.4	*ED appropriate utilization (Stand-alone measure)*	
Performing Provider Name: City of Houston Health and Human Services			*TPI -09377740-08*
Related Category 1 or 2 Projects:	0937740-08.1.2		
Starting Point/Baseline:	*To be developed in DY 2*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-3]: Develop and test Data systems Metric 1: Determine and provide documentation of type of system and IT resources needed. Metric 2: Select, install and test data system Goal: Install efficient and effective data system to capture program data Data Source: Documentation of selection, testing and implementation of data system Milestone 1 Estimated Incentive Payment: $123,740.57	**Milestone 2 [P-4]:** Conduct Plan Do Study Act cycle to continually improve Metric 1:Document use of PDSA in planning process Goal: Utilize a systematic cyclical process for quality improvement Data Source: Program documentation Milestone 2 Estimated Incentive Payment: $144,762.60 **Milestone 3 [P-5]:** Disseminate lessons learned and best practices Metric 1: Documentation of best practices and lessons learned Goal: Share lessons learned to add to knowledge base and inform others implementing similar projects Data Source: Program Documentation Milestone 3 Estimated Incentive Payment: $144,762.60	**Outcome Improvement Target 1 [IT-9.4]:** (ED appropriate utilization) (Stand-alone measure) Improvement Target: Reduce non-emergent ED visits among 911 callers by 5% over baseline Data source: HFD data electronic records Numerator: Non Emergent mild or moderately ill 911 callers connected to further medical care/follow-up Denominator: All non-Emergent 911 callers Outcome Improvement Target 1 Estimated Incentive Payment: $308,212.55	**Outcome Improvement Target 2 [IT-9.4]:** (ED appropriate utilization) (Stand-alone measure) Improvement Target: Reduce non emergent ED visits among 911 callers by 10% over baseline. Data source: HFD data electronic records Numerator: Non Emergent 911 mild or moderately ill callers connected to further medical care/follow-up Denominator: All non-Emergent 911 callers Outcome Improvement Target 2 Estimated Incentive Payment: $670,186.51
Year 2 Estimated Outcome Amount: $123,741	Year 3 Estimated Outcome Amount: $289,525	Year 4 Estimated Outcome Amount: $308,213	Year 5 Estimated Outcome Amount: $670,187
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $1,391,665			

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Title of Outcome Measure (Improvement Target): IT-9.4 Other Outcome Improvement Target (ED appropriate utilization)

Unique RHP Outcome Identification Number: 0937740-08.3.4

Outcome Measure Description:
IT-9.4 Milestone: Other Outcome Improvement target (ED appropriate utilization (Stand-alone measure)}
In 2010, the overall rate of nonfatal fall injury episodes for which a health-care professional was contacted was 43 per 1000 persons. Persons aged > 75 years had the highest rate (115 per 1000 persons) of falls. The primary goal of this program is to prevent fall related accidents that result in Emergency Room (ER) visits. Since the primary recruitment source is the EMS database for 911 calls, this program is expected to reduce 911 calls in targeted high risk zip codes for falls in the home setting. This initiative will implement an Evidence-based Health Promotion Program that utilizes community health workers to increase health literacy and provide minor structural changes in homes of a targeted population.
Metric 1: Number of 911 Calls for Falls from specific zip code during measurement period
Metric 2: Number of ED visits for falls from specific zip codes during measurement period
Process Milestones:

- DY 2
  - P-3:: Develop and test Data systems
- DY 3
  - P-4: Milestone: Conduct Plan Do Study Act cycle to continually improve program
  - P-5: Milestone: Disseminate lessons learned and best practices

Outcome Improvement Targets for each year:

- DY 4
  - IT-9.4 Milestone: Other Outcome Measure (ED appropriate utilization)
  - Reduce Number of 911 Calls for Falls from specific zip code during measurement period
  - Reduce Number of ED visits for falls from specific zip codes during measurement period
- DY 5
  - IT-9.4 Milestone: Other Outcome Measure (ED appropriate utilization)
  - Reduce Number of 911 Calls for Falls from specific zip code during measurement period
  - Reduce Number of ED visits for falls from specific zip codes during measurement period

Rationale:
The "Other Outcome Measure" for Category 3 was chosen for this project because it aligns with the goals of the project. Fall related injury and ensuing visit to the ER is one of the 20 most expensive conditions in community dwelling elderly. Preventable falls among community

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dwelling elderly result in costly morbidity. According to a new CDC study published in the *Morbidity and Mortality Weekly Report (MMWR)*, an estimated 234,000 people ages 15 and older were treated in U.S. emergency departments (ED) in 2008 for injuries that occurred in bathrooms. Four out of 5 of these injuries were caused by falls—which can have especially serious consequences for older adults. Almost one-third (30 percent) of adults aged 65 and above who were injured in bathrooms were diagnosed with fractures. Among adults aged 85 and older, 38 percent were hospitalized as a result of their injuries. Eliminating hazards at home is one of the recommended strategies for fall prevention in older adults. This Fall Prevention intervention will focus on reducing hazards at home for older adults from specific zip codes so that a costly ER visit is averted.

Outcome Measure Valuation:

The Outcome measure was valued at 9.25% of the overall assigned project value for the associated Category 2 project in year 3, 9.25% in Year 4 and 9.25% in Year 5.

Houston Department of Health and Human Services (HDHHS) utilized the following method to determine the Category 2 project value:

HDHHS utilized two categories to calculate value for each DSRIP project. The first category is Prioritization and the second is Public Health Impact (see attachment for HDHHS Valuation Tool). HDHHS scored the project on a scale of 1 (poor) to 9 (exceptional) for each of the six factors that comprise the Prioritization category. The Prioritization category includes the following factors: 1) Transformational Impact, 2) Population Served / Project Size, 3) Alignment with Community Needs 4)Cost Avoidance 5) Partnership Collaboration and 6)Sustainability. Each factor was then given a weighted score based on the score rated and a pre-determined percentage weight. The six weighted scores were added to get a composite score for the Prioritization category.

Public Health includes activities which seek to achieve the highest level of health for the greatest number of people. Public Health also focuses on preventing problems from happening or re-occurring through programs and activities that promote and protect the health of the entire community. As a public health department, HDHHS added an additional valuation category of Public Health Impact that looked at projects through a public health lens. The Public Health Impact category includes the following factors: 1) Alleviate Health Disparity, 2) Control Communicable and Chronic Disease , 3) Prevention Orientation, 4) Population Health Focus, 5) Access and Connection to Health Services and 6) Evidence Based Health Program. HDHHS scored the project on a scale of 1 (poor) to 9 (exceptional) for each of the six factors that comprise the Public Health Impact category. Each factor was then given a weighted score based on the score rated and a pre-determined percentage weight. The six weighted scores were added to get a composite score for the Public Health Impact category.

HDHHS gave the Prioritization score a weight of 25% and the Public Health Impact score a weight of 75% to determine the overall project value for the plan. The Healthy Homes Fall Prevention project received a composite Prioritization score of 5.4 and a Public Health Impact score of 6.

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0937740-08.3.4	IT-9.4	Other Outcome Improvement Target	
Performing Provider Name: City of Houston Health and Human Services			*HDHHS -0937740-08*
Related Category 1 or 2 Projects:	*Unique Category 2 identifier - 0937740-08.2.1*		
Starting Point/Baseline:	TBD in DY 3		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-3]: Develop and test Data systems Metric 1: Determine and provide documentation of type of system and IT resources needed. Metric 2: Select, install and test data system Goal: Utilize an efficient and effective data system for reporting Data Source: Program records and documentation Estimated Incentive Payment: $93,757.61	**Process Milestone 2** [P-4]: Conduct Plan Do Study Act cycle to continually improve Metric 1: Document use of PDSA in planning process Goal: Ensure systematic cyclical quality improvement process Data Source: Program Records Process Milestone 2 Estimated Incentive Payment: $109,685.90 **Process Milestone 3** [P-5]:Disseminate lessons learned and best practices Metric 1: Documentation of best practices and lessons learned Goal: Share lessons learned and best practices Data Source: Program Records Process Milestone 3 Estimated Incentive Payment: $109,685.90	**Outcome Improvement Target 1** [IT-9.4]: Other Outcome Improvement Target (ED appropriate utilization) Metric 1: Number of ED visits for falls from specific zip codes during measurement period enrolled in Healthy Homes Fall Prevention Program Metric 2: Number of 911 calls for falls from specific zip codes during measurement period enrolled in Healthy Homes Fall Prevention Program Improvement Target: Reduce by 5% each the number of ED visits among program participants and number of 911 calls made for falls in older adults 60 years and over from specific zip codes over baseline (Baseline TBD in DY 3) Data Source: Program Records, 911 system Outcome Improvement Target 1 Estimated Incentive Payment: $233,531.11	**Outcome Improvement Target 2** [IT-9.4]: Other Outcome Improvement target (ED appropriate utilization) Metric 1: Number of ED visits for falls from specific zip codes during measurement period enrolled in Healthy Homes Fall Prevention Program Metric 2: Number of 911 calls for falls from specific zip codes during measurement period enrolled in Healthy Homes Fall Prevention Program Improvement Target: Reduce by 10% each the number of ED visits among program participants and number of 911 calls made for falls in older adults 60 years and over from specific zip codes over baseline Data Source: Program Records, 911 system Outcome Improvement Target 2 Estimated Incentive Payment: $507,796.98
Year 2 Estimated Outcome Amount: $93,758	Year 3 Estimated Outcome Amount: $219,372	Year 4 Estimated Outcome Amount: $233,531	Year 5 Estimated Outcome Amount: $507,797
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5):* $1,054,458			

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Title of Outcome Measure (Improvement Target): IT-9.4Other Outcome Improvement Target

Unique RHP Outcome identification number(s): 0937740-08.3.5

Outcome Measure Description:

IT-9.4 ED–Other Outcome Improvement Target (EDAppropriate Utilization)

- By providing patient navigation, non-emergent 911 callers and those that were seen by EMS can be redirected to the CareHouston Links Program. This program provides care coordination, by more accurately assessing the non-emergent 911 caller's needs and connecting them to the required services. This will reduce unnecessary repeat calls to 911 and result in savings to the healthcare system.

Process Milestones:

- DY2:
  - P-3: Develop and Test Data System
- DY 3:
  - P-4: Conduct and Update Plan-Do-Study-Act for quality improvement
  - P-5: Disseminate findings, lessons learned and best practices

Outcome Improvement Targets for each year:

- DY 4:
  - IT-9.4Other Outcome Improvement Target (ED appropriate utilization (Stand-alone measure) - Reduce ED visits that are non-emergent (including ACSC)
- DY 5:
  - IT-9.4Other Outcome Improvement Target (ED appropriate utilization (Stand-alone measure**) -** Reduce ED visits that are non emergent (includingACSC)

Rationale:

A version of the proposed CareHouston Links program was previously targeted to the Sunnyside community in Southeast Houstonwhere an HFD-EMS analysis showed that 26% of all 9-1-1 calls were non-emergency related in this low income, underserved community. Since the CareHouston program's implementation in 2006, the HFD EMS unit experienced a 72% decrease in calls in this area allowing them to divert more than $4.6 million in costs associated with the transport of non-emergency callers to the emergency rooms for services. The CareHouston Links program will reduce future emergency room visits by providing navigation services to clients, educating them about the appropriate use of services and linking them with primary and preventive care services. Ineffective navigation of the health care system by patients may lead to poorer outcomes and inefficiencies because of delayed care, failure to receive proper care or treatments, or care being received in more expensive locations (i.e., emergency rooms).

Linking, assessing and referring clients to appropriate services will reduce their need to use emergency services. Each time an ambulance service is dispatched to transport patients; the cost is approximately $1470. During Fiscal Year 2012, the Care Houston program diverted 1,458 clients from using EMS transports to emergency departments for non-emergencies, saving the COH $2,143,260. Each diverted ambulance transport is also associated with a diverted emergency room visit.

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The Other Improvement Target for Reducing Inappropriate ER Use, will be used as our Category 3 Outcome measure. According to Agency for Healthcare Research and Quality, visits to the Emergency Department for non emergent care results in increasing health care costs and overcrowding. A report from Health and Human Services Commission on Rider 56, House Bill 1, from August 2012, states "one of the key strategies to reducing non-emergent ED use is to steer clients to more appropriate sources of care. Integral to achieving this goal is ensuring adequate access to prevention and primary care services. The medical home model is a building block to achieving this objective as is promoting the use of urgent care facilities and retail health clinics when clients cannot go to their medical home." (Article II, Health and Human Services Commission, Rider 56, H.B. 1, 82nd Legislature, Regular Session, 2011).

Outcome Measure Valuation:

The Outcome measure was valued at 11.41% of the overall assigned project value for the associated Category 2 project in year 3, 11.41% in Year 4 and 11.41% in Year 5. HHDHS utilized the following method to determine the Category 2 project value.

HDHHS utilized two categories to calculate value for each DSRIP project. The first category is Prioritization and the second is Public Health Impact (see attachment for HDHHS Valuation Tool HDHHS scored the project on a scale of 1 (poor) to 9 (exceptional) for each of the six factors that comprise the Prioritization category. The Prioritization category includes the following factors: 1) Transformational Impact, 2) Population Served / Project Size, 3) Alignment with Community Needs 4)Cost Avoidance 5) Partnership Collaboration and 6)Sustainability. Each factor was then given a weighted score based on the score rated and a pre-determined percentage weight. The six weighted scores were added to get a composite score for the Prioritization category.

Public Health includes activities which seek to achieve the highest level of health for the greatest number of people. Public Health also focuses on preventing problems from happening or re-occurring through programs and activities that promote and protect the health of the entire community. As a public health department, HDHHS added an additional valuation category of Public Health Impact that looked at projects through a public health lens. The Public Health Impact category includes the following factors: 1) Alleviate Health Disparity, 2) Control Communicable and Chronic Disease , 3) Prevention Orientation, 4) Population Health Focus, 5) Access and Connection to Health Services and 6) Evidence Based Health Program. HDHHS scored the project on a scale of 1 (poor) to 9 (exceptional) for each of the six factors that comprise the Public Health Impact category. Each factor was then given a weighted score based on the score rated and a pre-determined percentage weight. The six weighted scores were added to get a composite score for the Public Health Impact category.

HDHHS gave the Prioritization score a weight of 25% and the Public Health Impact score a weight of 75% to determine the overall project value for the plan. The CareHouston Links Program received a composite Prioritization score of 7.15 and a Public Health Impact score of 7. The following are avenues of cost savings to the health care system that can be facilitated by a program that seeks to reduce ER usage, such as CareHouston Links.

1. Cost savings attributed to using navigators as part of a preventable ED reduction program
2. Cost savings related to connecting patients to medical homes, increase access to primary and specialty care, and increase access to chronic care management
3. CMS reimbursement rate for EMS transports; Cost savings to CMS when alternate transportation is used

4. Cost savings to CMS for ED visit redirected to a clinic

References:

5. ER Visits with an ambulance transport. Report from Center for Health Services Research Collaborative. UT School of Public Health, Houston, Texas. Accessed on 10/2/12 from https://sph.uth.edu/research/centers/chsr/hsrc/.Stakeholder input from RHP 3Working Group Members throughout the Region (including providers, consumers, hospital and clinic administrators, government officials, researchers, and advocacy groups)
6. Agency for Healthcare Research and Quality. Enhancing Primary care Access after Emergency Department Visits .http://www.innovations.ahrq.gov/issue.aspx?id=135The State of Health – Houston and Harris County, 2012.
7. Dixon BE, Hook JM, McGowan JJ. Using Telehealth to Improve Quality and Safety: Findings from the AHRQ Portfolio (Prepared by the AHRQ National Resource Center for Health IT under Contract No. 290-04-0016). AHRQ Publication No. 09-0012-EF. Rockville, MD: Agency for Healthcare Research and Quality. December 2008.

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0937740-08.3.5	*IT-9.4*	*Other Outcome Improvement Target (ED appropriate utilization)*	
Performing Provider Name: City of Houston Health and Human Services			*TPI –0937740-08*
Related Category 1 or 2 Projects:	Unique Cat 2 ID: 0937740-08.2.2		
Starting Point/Baseline:	*Baseline will be established in DY 2-3*		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Process Milestone 1 (P-3): Develop and Test Data System Metric 1: Provide documentation of It resources and system needed Metric 2: Documentation of testing and installation of data system Goal: Set up a workable electronic system through which effective and efficient data can be collected. Data Source: Program documentation and electronic system. Process Milestone 1 Estimated Incentive Payment: $115,664.23	**Process Milestone 2 [P-4]:** Conduct Plan Do Study Act cycle to continually improve Metric 1: Document use of PDSA in planning process Goal: Ensure highest quality on program process and improvement. Data Source: Step-wise documentation of PDSA in program documentation Process Milestone 2 Estimated Incentive Payment: $135,314.19 **Process Milestone 3 [P-5]:** Disseminate lessons learned and best practices Metric 1: Documentation of best practices and lessons learned Goal: Provide report documenting identification of best practices and lessons learned Data Source: Documentation of report Process Milestone 3 Estimated Incentive Payment: $135,314.19	**Outcome Improvement Target 1 [IT-9.4]:**Other Improvement Target(Stand-alone measure) Improvement Target: Reduce all ED visits that are non-emergent (including ACSC) in specific zip codes due to participation in Navigation program by 5% below baseline the proportion of non-emergent ED visits Data source: Program data electronic records, EMS Data (Baseline will be established in Yr.2-3 from program data by establishing the proportion of non-emergent 911 callers that were connected to CareHoustonLinks.) Numerator**:** Non Emergent 911 callers connected to CareHouston Links, who would have otherwise been transported to ED Denominator**:** All non-Emergent 911 callers Outcome Improvement Target 1 Estimated Incentive Payment: $288,096.03	**Outcome Improvement Target 2 [IT-9.4]:**Other Improvement Target(Stand-alone measure) Improvement Target: Reduce all ED visits that are non-emergent (including ACSC) in specific zip codes due to participation in Navigation Program by 5% below Yr. 4 the proportion of non-emergent ED visits that were averted during enrollment in this program Data source: Program data electronic records, EMS Data Numerator: Non Emergent 911 callers connected to CareHouston Links,who would have otherwise been transported to ED Denominator**:** All non-Emergent 911 callers Outcome Improvement Target 2 Estimated Incentive Payment: $626,444.56

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0937740-08.3.5	*IT-9.4*	*Other Outcome Improvement Target (ED appropriate utilization)*	
Performing Provider Name: City of Houston Health and Human Services			*TPI –0937740-08*
Related Category 1 or 2 Projects:	Unique Cat 2 ID: 0937740-08.2.2		
Starting Point/Baseline:	*Baseline will be established in DY 2-3*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Year 2 Estimated Outcome Amount: $115,664	Year 3 Estimated Outcome Amount: $270,628	Year 4 Estimated Outcome Amount: $288,096	Year 5 Estimated Outcome Amount: $626,445
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $1,300,833			

Title of Outcome Measure (Improvement Target): IT-9.4 Other Outcome Improvement Target(ED appropriate utilization)(Stand-alone measure)

Unique RHP Outcome identification number(s):0937740-08.3.6

Outcome Measure Description:
IT-9.4 Other Outcome Improvement Target(ED appropriate utilization)
The performing provider proposes to provide navigation services to targeted HIV patients who are at high risk of disconnect from institutionalized health care is critical to reduce ED and inpatient use for potentially preventable admissions in HIV patients. Providing navigation services to targeted HIV patients who are at high risk of disconnect from institutionalized health care is critical to reduce ED and inpatient use for potentially preventable admissions in HIV patients.
Numerator: Number of HIV patients enrolled in program that used ER in past 6 months
Denominator: Total number of HIV patients enrolled in Service Linkage Program during the same time period
Data Source: Service Linkage Database and follow up data
Process Milestones:
- DY2:
  - P-X1 Development of Outreach and Education Plan
- DY 3:
  - P-4 Metric: Conduct Plan-Do-Study-Act
  - P-5 Milestone: Disseminate findings, lessons learned and best practices

Outcome Improvement Targets for each year:
- DY 4:
  - IT-9.4 Other Outcome Improvement Target(ED appropriate utilization)Reduce rate of ER visits that are non emergent among HIV patients enrolled in Service Linkage program in past 6 months by 3% over baseline
- DY 5:
  - IT-9.4 Other Outcome Improvement Target (ED appropriate utilization) Reduce rate of ER visits that are non emergent among HIV patients enrolled in Service Linkage program in past 6 months by 6% over baseline.

Rationale:
Patient care navigation has been established as a best practice to improve the care of populations at high risk of being disconnected from health care institutions. Tying inpatient and outpatient care can help integrate inpatient and outpatient services and promote accountability for the coordination, cost and quality of care. This service linkage expansion will provide navigation services to targeted patients who are at high risk of disconnect from institutionalized health care (for example, Limited English Proficient patients, recent immigrants, the uninsured, those with low health literacy, frequent visitors to the ED, and others).

Outcome Measure Valuation:
The Outcome measure was valued at 10.71% of the overall assigned project value for the associated Category 2 project in year 3, 10.71% in Year 4 and 10.71% in Year 5. HHDHS utilized the following method to determine the Category 2 project value.

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HDHHS utilized two categories to calculate value for each DSRIP project. The first category is Prioritization and the second is Public Health Impact (see attachment for HDHHS Valuation Tool). HDHHS scored the project on a scale of 1 (poor) to 9 (exceptional) for each of the six factors that comprise the Prioritization category. The Prioritization category includes the following factors: 1) Transformational Impact, 2) Population Served / Project Size, 3) Alignment with Community Needs 4)Cost Avoidance 5) Partnership Collaboration and 6)Sustainability. Each factor was then given a weighted score based on the score rated and a pre-determined percentage weight. The six weighted scores were added to get a composite score for the Prioritization category.
Public Health includes activities which seek to achieve the highest level of health for the greatest number of people. Public Health also focuses on preventing problems from happening or re-occurring through programs and activities that promote and protect the health of the entire community. As a public health department, HDHHS added an additional valuation category of Public Health Impact that looked at projects through a public health lens. The Public Health Impact category includes the following factors: 1) Alleviate Health Disparity, 2) Control Communicable and Chronic Disease , 3) Prevention Orientation, 4) Population Health Focus, 5) Access and Connection to Health Services and 6) Evidence Based Health Program. HDHHS scored the project on a scale of 1 (poor) to 9 (exceptional) for each of the six factors that comprise the Public Health Impact category. Each factor was then given a weighted score based on the score rated and a pre-determined percentage weight. The six weighted scores were added to get a composite score for the Public Health Impact category.
HDHHS gave the Prioritization score a weight of 25% and the Public Health Impact score a weight of 75% to determine the overall project value for the plan. The HIV Service Linkage Expansion received a composite Prioritization score of 6.5 and a Public Health Impact score of 6.

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0937740-08.3.6	*IT-9.4*	*Other Outcome Improvement Target(ED appropriate utilization)*	
Performing Provider Name: City of Houston Health and Human Services			*HDHHS -0937740-08*
Related Category 1 or 2 Projects:	*Unique Category 2 identifier - 0937740-08.2.3*		
Starting Point/Baseline:	To be Determined in DY 2 and 3		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-X1]: Development of Outreach and Education Plan to Target population Metric: Written report on Outreach Education Plan for Service Linkage Program Goal: To disseminate information about program in Target Population Data Source: Program Documentation Milestone 1 Estimated Incentive Payment: $108,511.22	**Process Milestone 2 [P-4]:** Conduct Plan Do Study Act cycle to continually improve Metric: Document use of PDSA in planning process Goal: Utilize a cyclical quality improvement process Milestone 2 Estimated Incentive Payment: $126,945.97 **Process Milestone 3 [P-5]:**Disseminate lessons learned and best practices Metric **:**Documentation of best practices and lessons learned Goal: Share lessons learned Data Source: Program Documentation Milestone 3 Estimated Incentive Payment: $126,945.97	**Outcome Improvement Target 2 [IT-9.4]:** Other Outcome Improvement Target(ED appropriate utilization) Improvement Target: Reduce number of ED visits in Program enrollees by 3% in 6 months over Baseline Numerator: Number of HIV patients enrolled in program that used ER in past 6 months Denominator: Total number of HIV patients enrolled in Service Linkage Program. Data Source: Service Linkage Database and follow up data Outcome Improvement 4Estimated Incentive Payment: $270,279.35	**Outcome Improvement Target 4 [IT-9.4]:** Other Outcome Improvement Target (ED appropriate utilization) Improvement Target: Reduce number of ED visits in Program enrollees by 6% over Baseline Numerator: Number of HIV patients enrolled in program that used ER in past 6 months Denominator: Total number of HIV patients enrolled in Service Linkage Program. Data Source: Service Linkage Database and follow up data Outcome Improvement 5 Estimated Incentive Payment: $587,703.42
Year 2 Estimated Outcome Amount: $108,511	Year 3 Estimated Outcome Amount: $253,892	Year 4 Estimated Outcome Amount: $270,279	Year 5 Estimated Outcome Amount: $587,703
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $1,220,386			

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<u>Title of Outcome Measure (Improvement Target):</u> IT-4.10 Other Outcome Improvement Target: Average length of stay for patients diagnosed with TB.

<u>Unique RHP Outcome identification number(s):</u> 0937740-08.3.7

<u>Outcome Measure Description:</u>
Outcome Improvement Target 1 [IT-4.10] Other Outcome Improvement Target: Average length of stay for patients diagnosed with TB.
Numerator: Total number of inpatient days for patients diagnosed with TB
Denominator: Total number of patients diagnosed with TB contacted by TB Program

Process Milestones:

- DY2:
  - P-1 Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
- DY 3:
  - P-4 Metric: Conduct Plan-Do-Study-Act
  - P-5 Milestone: Disseminate findings, lessons learned and best practices

Outcome Improvement Targets for each year:

- DY 4:
  - IT-4.10 Other Outcome Improvement Target: Reduce Average length of stay for patients diagnosed with TB by 2% over Baseline

- DY 5:
  - IT-4.10 Other Outcome Improvement Target: Average length of stay for patients diagnosed with TB by 5% over Baseline

<u>Rationale:</u>
We chose the outcome improvement target IT-4.10 Other Outcome Improvement Target: Average length of stay for patients diagnosed with TB. The comprehensive testing package to ensure early diagnosis, accurate diagnosis and reduction in number of days of treatment will help us achieve our goals. By providing tests that conduct rapid and accurate identification, short duration of therapy and connecting patients to primary care, where they can receive appropriate care decreases the likelihood of length of stay in the hospital. The performing provider (Houston TB Bureau) will utilize the CDC guidelines to accurately and rapidly identify and rule out TB disease for this project. Based on guidelines from Texas Department of State Health Services Tuberculosis Branch standing delegation orders, the Houston TB Bureau will implement the use of 3HP in the treatment latent tuberculosis patients in order to increase patient compliance and completion of LTBI therapy and decrease the number of patient at risk for progression to active TB disease. Studies have shown about 5 to 10 percent of those with latent TB infection in the United States will develop TB disease if not treated. People with latent TB infection who have weakened immune systems, including those with HIV/AIDS or diabetes, are more likely to develop TB disease after infection. For those reasons, treatment is important (3). These potential future TB cases could be admitted to hospitals for diagnoses and treatment.

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CDC recommends a minimum of two week hospital stay for patients who are infectious with a positive bacteriology smear results. This project plans to reduce the number of hospital days during admissions for treatment of tuberculosis every year and preventing future TB cases. These efforts will provide cost savings to the health care system.

Outcome Measure Valuation:

The Outcome measure was valued at 11.67% of the overall assigned project value for the associated Category 2 project in year 3, 11.67% in Year 4 and 11.67% in Year 5. HHDHS utilized the following method to determine the Category 2 project value.

HDHHS utilized two categories to calculate value for each DSRIP project. The first category is Prioritization and the second is Public Health Impact (see attachment for HDHHS Valuation Tool). HDHHS scored the project on a scale of 1 (poor) to 9 (exceptional) for each of the six factors that comprise the Prioritization category. The Prioritization category includes the following factors: 1) Transformational Impact, 2) Population Served / Project Size, 3) Alignment with Community Needs 4)Cost Avoidance 5) Partnership Collaboration and 6)Sustainability. Each factor was then given a weighted score based on the score rated and a pre-determined percentage weight. The six weighted scores were added to get a composite score for the Prioritization category.

Public Health includes activities which seek to achieve the highest level of health for the greatest number of people. Public Health also focuses on preventing problems from happening or re-occurring through programs and activities that promote and protect the health of the entire community. As a public health department, HDHHS added an additional valuation category of Public Health Impact that looked at projects through a public health lens. The Public Health Impact category includes the following factors: 1) Alleviate Health Disparity, 2) Control Communicable and Chronic Disease , 3) Prevention Orientation, 4) Population Health Focus, 5) Access and Connection to Health Services and 6) Evidence Based Health Program. HDHHS scored the project on a scale of 1 (poor) to 9 (exceptional) for each of the six factors that comprise the Public Health Impact category. Each factor was then given a weighted score based on the score rated and a pre-determined percentage weight. The six weighted scores were added to get a composite score for the Public Health Impact category.

HDHHS gave the Prioritization score a weight of 25% and the Public Health Impact score a weight of 75% to determine the overall project value for the plan. The TB Rapid Identification, Treatment and Recovery Project received a composite Prioritization score of 7.15 and a Public Health Impact score of 7.

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0937740-08.3.7	*IT-4.10*	*Other Outcome Improvement Target*	
Performing Provider Name: City of Houston Health and Human Services			*HDHHS* -0937740-08
Related Category 1 or 2 Projects:	Unique Category 2 Identifier - 0937740-08.2.4		
Starting Point/Baseline:	*TBD in DY3*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1] Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data source: Project plan documentation Process Milestone 1 Estimated Incentive Payment: $118,214.65	**Process Milestone 2** [P-4]: Conduct Plan Do Study Act cycle to continually improve Metric: Document use of PDSA in planning process Goal: Utilize a cyclical quality improvement process Data Source: PDSA documentation Process Milestone 2 Estimated Incentive Payment: $138,297.89 **Process Milestone 3** [P-5]:Disseminate lessons learned and best practices Metric : Documentation of best practices and lessons learned Goal: Share lessons learned Data Source: Program Documentation Process Milestone 3 Estimated Incentive Payment: $138,297.89	**Outcome Improvement Target 1** [IT-4.10] Other Outcome Improvement Target: Average length of stay for patients diagnosed with TB. Improvement Target: Decrease average length of hospital stay by 2% over baseline Data Source: Hospital and Program data Outcome Improvement Target 1 Estimated Incentive Payment: $294,448.62	**Outcome Improvement Target 2** [IT-4.10] Other Outcome Improvement Target: Average length of stay for patients diagnosed with TB. Improvement Target: Decrease average length of hospital stay by 5% over baseline Data Source: Hospital and Program data Outcome Improvement Target 2 Estimated Incentive Payment: $640,257.80
Year 2 Estimated Outcome Amount: $118,215	Year 3 Estimated Outcome Amount: $276,596	Year 4 Estimated Outcome Amount: $294,449	Year 5 Estimated Outcome Amount: $640,258
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $1,329,517			

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Title of Outcome Measure (Improvement Target):IT-1.10 Diabetes care: *HbA1c poor control (>9.0%)*

Unique RHP Outcome Identification Number: 0937740-08.3.8

Outcome Measure Description:
IT-1.10 Diabetes care: *HbA1c poor control (>9.0%)*

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.
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: Percentage of patients 18-75 years of age with diabetes (Type 1 or Type 2) who had hemoglobin A1c (HbA1c) control > 9.0%.

Process Milestones:

- DY 2
  - P-X1: Milestone: Conduct Community Education and Outreach
- DY 3
  - P-4: Milestone: Conduct Plan Do Study Act cycle to continually improve
  - P-5: Milestone: Disseminate lessons learned and best practices

Outcome Improvement Target(s) for each year:

- DY 4:
  - IT-1.10 Diabetes care: Decrease HbA1c poor control by 2% over baseline in DAWN enrollees (>9.0%)17- NQF 0059 (Stand-alone measure)
    - a Numerator: Percentage of patients 18-75 years of age with diabetes (Type 1 or Type 2) who hadhemoglobin A1c (HbA1c) control > 9.0%.
    - b Denominator: Members 18 to 75 years of age as of December 31 of the measurement year withdiabetes (Type 1 and Type 2)
  - c Data Source: DAWN Case Management Registry
- DY 5:
  - IT-1.10 Diabetes care: Decrease HbA1c poor controlby 5% over baseline in DAWN enrollees (>9.0%)17- NQF 0059 (Stand-alone measure)
    - a Numerator: Percentage of patients 18-75 years of age with diabetes (Type 1 or Type 2) who hadhemoglobin A1c (HbA1c) control > 9.0%.
    - b Denominator: Members 18 to 75 years of age as of December 31 of the measurement year withdiabetes (Type 1 and Type 2)
  - c Data Source: DAWN Case Management Registry

Rationale:

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The process and improvement targets have been chosen based on the project goals of chronic care self-management, care transitions, self-management goal setting, and a community based coordinated system of care. Clinically healthy range for HbA1c is less than 5.7 %, values between 5.7% and 6.4% are considered pre-diabetes and values higher than 6.4 are referred to as diabetes. For a diabetic patient, it is recommended to maintain the HbA1C level below 6.5-7 % [(1).] HbA1C indicates how well one is controlling the blood sugar over the last 60-90 days, which helps the patients and their care providers to adjust the diet, physical activity and medication accordingly. HbA1C is also considered as the' gateway' to care for individuals with type-2 diabetes. This projectinvolves establishing a comprehensive Diabetes Wellness Center will offer a community based center in an underserved community with one of the highest incidence of diabetes.

According to the *Houston Hospitalizations at a Glance Report,* chronic conditions accounted for 78% of all adult preventable hospitalizations in Houston, with 26% of those being related to diabetes. This same report indicates that in Council District D, (most consistent with the targeted service area of the DAWN Center) the annual average cost of adult preventable hospitalizations for District D is $69,644,160 (the highest annual average cost for any District). Additionally, 22% of adult preventable hospitalizations in District D are diabetes-related. City Council District D has the second highest number of preventable diabetes hospitalizations (2,420). It also has the highest average cost per discharge of adult preventable hospitalizations by Council District ($32,038).

Additionally, the literature (*Economic Costs of Diabetes in the U.S. in 2007,Diabetes Care31: 596-615, 2008*) indicates that a program similar to the Diabetes Awareness and Wellness Network (DAWN) Center that focuses on enhanced education, physical activity, self-management education, hemoglobin A1C tracking and monitoring, BMI measurements, behavioral change coaching, and case management can reduce costs based on less hospitalizations, decrease in loss of productivity decrease in absenteeism, and decrease in unemployment from disease-related disability.

(1) American Diabetes Association. Diabetes Statistics. Website. 2010. http://www.diabetes.org/diabetes-basics/diabetes-statistics/

Outcome Measure Valuation:

The Outcome measure was valued at 11.67% of the overall assigned project value for the associated Category 2project in year 3, 11.67% in Year 4 and 11.67% in Year 5. HHDHS utilized the following method to determine the Category 2 project value.

HDHHS utilized two categories to calculate value for each DSRIP project. The first category is Prioritization and the second is Public Health Impact (see attachment for HDHHS Valuation Tool). HDHHS scored the project on a scale of 1 (poor) to 9 (exceptional) for each of the six factors that comprise the Prioritization category. The Prioritization category includes the following factors: 1) Transformational Impact, 2) Population Served / Project Size, 3) Alignment with Community Needs 4)Cost Avoidance 5) Partnership Collaboration and 6)Sustainability. Each factor was then given a weighted score based on the score rated and a pre-determined percentage weight. The six weighted scores were added to get a composite score for the Prioritization category.

Public Health includes activities which seek to achieve the highest level of health for the greatest number of people. Public Health also focuses on preventing problems from happening or re-

occurring through programs and activities that promote and protect the health of the entire community. As a public health department, HDHHS added an additional valuation category of Public Health Impact that looked at projects through a public health lens. The Public Health Impact category includes the following factors: 1) Alleviate Health Disparity, 2) Control Communicable and Chronic Disease , 3) Prevention Orientation, 4) Population Health Focus, 5) Access and Connection to Health Services and 6) Evidence Based Health Program. HDHHS scored the project on a scale of 1 (poor) to 9 (exceptional) for each of the six factors that comprise the Public Health Impact category. Each factor was then given a weighted score based on the score rated and a pre-determined percentage weight. The six weighted scores were added to get a composite score for the Public Health Impact category.

HDHHS gave the Prioritization score a weight of 25% and the Public Health Impact score a weight of 75% to determine the overall project value for the plan. DAWN received a composite Prioritization score of 7.10 and a Public Health Impact score of 7.

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0937740-08.3.8	*IT-1.10*	*Diabetes care: HbA1c poor control*	
Performing Provider Name: City of Houston Department of Health and Human Services			*HDHHS* - 0937740-08
Related Category 1 or 2 Projects:	0937740-08.2.5		
Starting Point/Baseline	To be developed by DY 3		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-X1]: Conduct community education and outreach to build awareness about Diabetes risks (moty, prevalence and control) Metric 1: Documentation of at least ten unique outreach activities/products in target community in DY 2 Goal: Build awareness of diabetes in target community Data Source: Program Documentation, Outreach Materials, Meeting Minutes Milestone 1 Estimated Incentive Payment: $118,220.28	**Process Milestone 2 [P-4]:** Conduct Plan Do Study Act cycle to continually improve Metric 1: Document use of PDSA in planning process Goal: development of report documenting use of PDSA in planning process Data Source: Report documentation Milestone 2 Estimated Incentive Payment: $138,304.48 **Process Milestone 3 [P-5]:** Disseminate lessons learned and best practices to stakeholders Metric 1: Documentation of best practices and lessons learned Goal: Development of report documenting best practices and lessons learned Data Source: Report documentation Process Milestone 2 Milestone 3 Estimated Incentive Payment:$138,304.48	**Outcome Improvement Target 1 [IT-1.10]:**HbA1c poor control (>9.0%)17-NQF 0059 (Stand-alone measure) Goal: Decrease the percentage of patients who have poor HbA1C control by 2% over baseline Data Source: Case Management Registry Numerator: Percentage of patients 18-75 years of age with diabetes (Type 1 or Type 2) who hadhemoglobin A1c (HbA1c) control > 9.0% enrolled in DAWN Denominator: DAWN Members 18 to 75 years of age as of December 31 of the measurement year withdiabetes (Type 1 and Type 2) Outcome Improvement Target 1 Estimated Amount: $294,462.64	**Outcome Improvement Target 3 [IT-1.10]:** HbA1c poor control (>9.0%)17-NQF 0059 (Stand-alone measure) Goal: Decrease the percentage of patients who have poor HbA1C control by 5% over baseline Data Source: Case Management Registry Numerator: Percentage of patients 18-75 years of age with diabetes (Type 1 or Type 2) who hadhemoglobin A1c (HbA1c) control > 9.0% enrolled in DAWN. Denominator: DAWN Members 18 to 75 years of age as of December 31 of the measurement year withdiabetes (Type 1 and Type 2) Outcome Improvement Target 2 Estimated Amount: $640,288.30
Year 2 Estimated Outcome Amount: $118,220	Year 3 Estimated Outcome Amount: $276,609	Year 4 Estimated Outcome Amount: $294,463	Year 5 Estimated Outcome Amount: $640,288
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $1,329,580			

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<u>Title of Outcome Measure (Improvement Target):</u>IT-9.4 Other Outcome Improvement Target; (Non emergent ER visits and hospitalizations in Sobering Center Participants)

<u>Unique RHP Outcome identification number(s):</u>0937740-08. 3.9

<u>Outcome Measure Description:</u>
IT – 9.4 Other Outcome Improvement Target (Non emergent ER visits and hospitalizations in Sobering Center Participants)
Rate: Preventable admissions to ER and hospitals due to non emergent alcohol/other substance use intoxication symptoms in Sobering Center Participants in previous 6 month period
The performing provider, along with its partner, the Houston Police Department will establish a short-term care facility called the "Sobering Center", designed as a medically supervised location to transport and house individuals who are under the influence or alcohol or other substances. Many of these individuals would either travel to or are taken to the emergency room for follow up care and the Sobering Center will serve as an alternative to a non emergent ER Visit. Others recycle through the criminal justice system due to non emergent Alcohol or Drug disorder (and frequently, comorbid other mental health conditions). The Sobering Center offers an alternative that saves health care system costs. The individual will remain at the Sobering Center until they are sober enough to safely return to the community. Prior to discharge from the center, every individual will be offered alcohol and/or drug treatment options tailored to their specific needs and followed up to ensure appropriate utilization of care according to protocol.
Data Source: Program Data System
Project Milestones:

- DY2: [P-X1]: Development of Outreach and Education Plan to Target population
- DY 3
  - P-4: Milestone: Conduct Plan Do Study Act cycle to continually improve
  - P-5: Milestone: Disseminate lessons learned and best practices

Outcome Improvement Target(s) for each year:

- DY 4:
  - IT-9.4 Other Outcome Improvement Target
    - Reduce rate of all ER visits or hospitalization related to intoxication or substance use that are non emergent by 2% over baseline among program participants during a 6 month period
- DY 5:
    - IT-9.4 Other Outcome Improvement target
    - Reduce rate of all ER visits or hospitalization related to intoxication or substance use that are non emergent by 4% over baseline among program participants during a 6 month period.

<u>Rationale:</u>
We chose our outcome measure from outcome domain "Right Setting Right Care" under Other Outcome Improvement target. We will be measuring **preventable admissions to ER/ hospitals/criminal justice setting due to non-emergent alcohol/other substance use intoxication** as our outcome indicator. Frequent visits to the emergency room is an indicator of alcohol or drug disorders and mental illness, according to a report by DSHS Research and Data Analysis Division in Washington State. This study reports that **55 percent** of clients who visited the ER 21 times or more in Fiscal Year (FY) 2002 had diagnoses **of both an Alcohol or Drug**

(AOD) disorder and mental illness An additional 7 percent of the most frequent ER visitors had an AOD disorder only and 23 percent had a mental illness only. Only 15 percent of the most frequent ER visitors had no indication of an AOD disorder or mental illness. Few Frequent Emergency Room Visitors With Alcohol Or Drug Disorders Receive AOD Treatment www.dshs.wa.gov/pdf/ms/rda/research/11/119-31.pdf.

The Sobering Center will provide a cost-effective alternative to using **ER/ hospitals/criminal justice settings** for non-emergent AOD disorders (frequently with comorbidity such as mental illness), at no cost to the patient. Other cities adopting such sobering centers have seen reductions in arrests and jail time for these offenders, as well as fewer emergency room and hospital check-ins for this often indigent population, on top of the cost savings found in jail bed diversions. This approach is more effective because it addresses the underlying issue of alcohol and or other substance abuse inherent in most public intoxication offenses. A 2003 study on the Impact of the San Diego Serial Inebriate Program on Use of Emergency Resources concluded that the program reduced the use of EMS, Emergency Department and inpatient resources by individuals who were repeatedly intoxicated in public. By using patient care navigators and assisting patients to get appropriate care and referrals as necessary, there is less of a burden on the health care system.

Outcome Valuation

The Outcome measure was valued at 9.04% of the overall assigned project value for the associated Category 2 project in year 3, 9.04% in Year 4 and 9.04% in Year 5. HHDHS utilized the following method to determine the Category 2 project value.

HDHHS utilized two categories to calculate value for each DSRIP project. The first category is Prioritization and the second is Public Health Impact (see attachment for HDHHS Valuation Tool). HDHHS scored the project on a scale of 1 (poor) to 9 (exceptional) for each of the six factors that comprise the Prioritization category. The Prioritization category includes the following factors: 1) Transformational Impact, 2) Population Served / Project Size, 3) Alignment with Community Needs, 4)Cost Avoidance, 5) Partnership Collaboration, and 6)Sustainability. Each factor was then given a weighted score based on the score rated and a pre-determined percentage weight. The six weighted scores were added to get a composite score for the Prioritization category.

Public Health includes activities which seek to achieve the highest level of health for the greatest number of people. Public Health also focuses on preventing problems from happening or re-occurring through programs and activities that promote and protect the health of the entire community. As a public health department, HDHHS added an additional valuation category of Public Health Impact that looked at projects through a public health lens. The Public Health Impact category includes the following factors: 1) Alleviate Health Disparity, 2) Control Communicable and Chronic Disease , 3) Prevention Orientation, 4) Population Health Focus, 5) Access and Connection to Health Services and 6) Evidence Based Health Program. HDHHS scored the project on a scale of 1 (poor) to 9 (exceptional) for each of the six factors that comprise the Public Health Impact category. Each factor was then given a weighted score based on the score rated and a pre-determined percentage weight. The six weighted scores were added to get a composite score for the Public Health Impact category.

HDHHS gave the Prioritization score a weight of 25% and the Public Health Impact score a weight of 75% to determine the overall project value for the plan. The Care Houston Links Program received a composite Prioritization score of 5.35 and a Public Health Impact score of 6.

References:
http://www.rightoncrime.com/2012/05/sobering-centers-cutting-jail-populations-costs-and-crime/

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<table>
<tr><td>0937740-08.3.9</td><td>IT-9.4</td><td colspan="2">Other Outcome Improvement Target; (Non emergent ER visits and hospitalizations in Sobering Center Participants)</td></tr>
<tr><td colspan="3">Performing Provider Name: City of Houston Department of Health and Human Services</td><td>HDHHS -0937740-08</td></tr>
<tr><td>Related Category 1 or 2 Projects:</td><td colspan="3">Unique Category 2 identifier - 0937740-08.2.6</td></tr>
<tr><td>Starting Point/Baseline:</td><td colspan="3">To Be Determined in DY 3</td></tr>
<tr><th>Year 2
(10/1/2012 – 9/30/2013)</th><th>Year 3
(10/1/2013 – 9/30/2014)</th><th>Year 4
(10/1/2014 – 9/30/2015)</th><th>Year 5
(10/1/2015 – 9/30/2016)</th></tr>
<tr><td>Process Milestone 1
[P-X1]: Development of Outreach and Education Plan to Target population

Metric: Written report on Outreach Education Plan for Service Linkage Program

Goal: To disseminate information about Sobering Center program in Target Population

Data Source: Program Documentation

Estimated Process Milestone 1 Amount: $91,637.89</td><td>Process Milestone 2[P-4]: Conduct Plan Do Study Act cycle to continually improve

Metric: Document use of PDSA in planning process

Process Milestone 2 Estimated Incentive Payment: $107,206.06

Process Milestone 3[P-5]: Disseminate lessons learned and best practices
Metric 1: Documentation of best practices and lessons learned
Process Milestone 3 Estimated Incentive Payment: $107,206.06</td><td>Outcome Improvement Target 1 [IT-9.4]Decrease in preventable admissions to ER/ hospitals/criminal justice setting due to non-emergent alcohol/other substance use intoxication in a 6 month period
Goal: Decrease admission and readmission to ER and hospitals and criminal justice settings by 2% over baseline. (Baseline TBD in DY 3)
Numerator: The number of individuals receiving project intervention(s) who had a potentially preventable admission/readmission to an ER or hospital facility or to the criminal justice system within the measurement period (every 6 months)
Denominator: The number of individuals receiving project intervention(s)
Data Sources: criminal justice system records, Program records
Outcome Improvement Target 1 Estimated Incentive Payment: $228,251.32</td><td>Outcome Improvement Target 2 [IT-9.4]Decrease in preventable admissions to ER/hospitals/criminal justice settings due to non-emergent alcohol/other substance use intoxication in a 6 month period
Goal: Decrease admission and readmission to ER and hospitals and criminal justice settings by 4%over baseline.
Numerator: The number of individuals receiving project intervention(s) who had a potentially preventable admission/readmission to an ER or hospital facility or to the criminal justice system within the measurement period.(every 6 months)
Denominator: The number of individuals receiving project intervention(s)
Data Sources: criminal justice system records, Program records
Outcome Improvement Target 2 Estimated Incentive Payment: $496,316.43</td></tr>
<tr><td>Year 2 Estimated Outcome Amount: $ $91,638</td><td>Year 3 Estimated Outcome Amount: $214,412</td><td>Year 4 Estimated Outcome Amount: $228,251</td><td>Year 5 Estimated Outcome Amount: $496,316</td></tr>
<tr><td colspan="4">TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5): $1,030,618</td></tr>
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Title of Outcome Measure (Improvement Target): IT-8.2 Percentage of Low Birth- weight births (CHIPRA/NQF # 1382)263 *(Standalone measure)*

Unique RHP Outcome identification number(s): 0937740-08.3.10

Outcome Measure Description:

IT-8.2 Percentage of Low Birth- weight births (CHIPRA/NQF # 1382)263 ***(Standalone measure)***

Numerator: The number of babies born weighing <2,500 grams at birth enrolled in NFP program

Denominator: All births of women enrolled in NFP program

Process Milestones:

- DY2:
  - P – 2: Establish Baseline
  - P-3: Develop and test Data systems
  - P – 1: Project Planning
- DY 3:
  - P-4: Milestone: Conduct Plan Do Study Act cycle to continually improve
    - Metric: Document use of PDSA in planning process
  - P-5: Milestone: Disseminate lessons learned and best practices
    - Metric 1: Documentation of best practices and lessons learned

Outcome Improvement Targets for each year:

- DY 4:

  IT-8.2 Percentage of Low Birth- weight births (CHIPRA/NQF # 1382)263 *(Standalone measure)*
  - Reduce Low Birth Weight Births by 2% over baseline
- DY 5:

  IT-8.2 Percentage of Low Birth- weight births (CHIPRA/NQF # 1382)263 *(Standalone measure)*
  - Reduce Low Birth Weight Births by additional 4% over baseline

Rationale:

The outcome measure selected for this program was Percentage of Low Birth Weight Births. This outcome was selected because:

Pre-term birth is defined as babies born alive before 37 weeks of pregnancy is completed. Being born too soon places the life of the baby in a precarious position. According to the World Health Organization, pre-term birth is the leading cause of newborn deaths (death during the first 4 weeks of life) and the second leading cause of death in children under the age of five. Many cost effective strategies have been identified to reduce pre-term birth and produce better birth outcomes such as home visitation programs and other interventions.

Nurse Family Partnership is one such evidence based home visitation program that has demonstrated better birth outcomes and better outcomes for the new mother by providing care before, during and after pregnancy. According to the Nurse Family Partnership website, data from the 1990 Nurse Family Partnership (NFP) Memphis trial noted that the NFP nurse-visited families gained academic and employment skills to become economically self-sufficient.

According to this analysis, NFP services resulted in lower enrollment in Medicaid and Food Stamps, with a 9% reduction in Medicaid costs and an 11% reduction in Food Stamps costs in the 10 years following the birth of the child. Federal savings were estimated at 154% of costs, yielding a net 54% return on the federal investment.

Outcome Measure Valuation:

The Outcome measure was valued at 11.75% of the overall assigned project value for the associated Category 2 project in year 3, 11.75% in Year 4 and 11.75% in Year 5. HHDHS utilized the following method to determine the Category 2 project value.

HDHHS utilized two categories to calculate value for each DSRIP project. The first category is Prioritization and the second is Public Health Impact (see attachment for HDHHS Valuation Tool). HDHHS scored the project on a scale of 1 (poor) to 9 (exceptional) for each of the six factors that comprise the Prioritization category. The Prioritization category includes the following factors: 1) Transformational Impact, 2) Population Served / Project Size, 3) Alignment with Community Needs 4)Cost Avoidance 5) Partnership Collaboration and 6)Sustainability. Each factor was then given a weighted score based on the score rated and a pre-determined percentage weight. The six weighted scores were added to get a composite score for the Prioritization category.

Public Health includes activities which seek to achieve the highest level of health for the greatest number of people. Public Health also focuses on preventing problems from happening or re-occurring through programs and activities that promote and protect the health of the entire community. As a public health department, HDHHS added an additional valuation category of Public Health Impact that looked at projects through a public health lens. The Public Health Impact category includes the following factors: 1) Alleviate Health Disparity, 2) Control Communicable and Chronic Disease , 3) Prevention Orientation, 4) Population Health Focus, 5) Access and Connection to Health Services and 6) Evidence Based Health Program. HDHHS scored the project on a scale of 1 (poor) to 9 (exceptional) for each of the six factors that comprise the Public Health Impact category. Each factor was then given a weighted score based on the score rated and a pre-determined percentage weight. The six weighted scores were added to get a composite score for the Public Health Impact category.

HDHHS gave the Prioritization score a weight of 25% and the Public Health Impact score a weight of 75% to determine the overall project value for the plan. NFP received a composite Prioritization score of 6.95 and a Public Health Impact score of 7.

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0937740-08.3.10	IT-8.2	*Percentage of Low Birth- weight births (CHIPRA/NQF # 1382)263 (Standalone measure)*	
RHP Performing Name: City of Houston Health and Human Services			*[RHP Performing Provider - 0937740-08*
Related Category 1 or 2 Projects::	0937740-08.2.7		
Starting Point/Baseline:	*Determined in DY 3*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P – 2]: Establish Baseline Metric 1: Current rates for low birth weight in Sunnyside Metric 2: Current rates for infant mortality in Sunnyside Baseline: Establish baseline metrics Data Source: Vital Statistics data Process Milestone 1 Estimated Incentive Payment: $19,847.89 **Process Milestone 2 [P-3]:** Develop and test Data systems Metric 1: Documentation of discussions of partnership with of established national data system Metric 2: Documentation of established partnership with national data system Goal: Implement user friendly data system that can ease reporting of program participation and outcomes. Data Source: Data systems Process Milestone 2 Estimated Incentive Payment: $19,847.89 **Milestone 3 [P – 1]:** Project Planning Milestone– Identify and engage partners,	**Process Milestone 4 [P-4]:** Conduct Plan Do Study Act cycle to continually improve Metric 1: Document use of PDSA in planning process Goal: Use a cyclical PDSA process and implementation improvement starategy Data Source: Program Documentation Process Milestone 4 Estimated Incentive Payment: $69,659.41 **Process Milestone 5 [P-5]:** Disseminate lessons learned and best practices Metric 1: Documentation of best practices and lessons learned. Goal: Share best practices and lessons learned with community partners. Data Source: Program Documents Process Milestone 5 Estimated Incentive Payment:$69,659.41	**Outcome Improvement Target 1 [IT-8.2]: IT-8.2 Percentage of Low Birth-weight births (CHIPRA/NQF # 1382)263 *(Standalone measure)*** Improvement Target: Reduce low birth weight birth rate by 2% from Baseline numbers in program participants. Baseline will be determined in DY 3. Data Source: Medical Record/other Numerator: The number of babies born weighing <2,500 grams at birth in program participants Denominator: All births among program participants. Data source: Electronic Records Outcome Improvement Target 1 Estimated Incentive Payment: $148,311.12	**Outcome Improvement Target 2 [IT-8.2]: IT-8.2 Percentage of Low Birth- weight births (CHIPRA/NQF # 1382)263 *(Standalone measure)*** Improvement Target: Reduce low birth weight birth rate by 4% from Baseline in program participants. Data Source: Medical Record/other Numerator: The number of babies born weighing <2,500 grams at birth among program participants Denominator: All births among program participantsc. Data source: Electronic Records Outcome Improvement Target 2 Estimated Incentive Payment: $322,492.10

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0937740-08.3.10	*IT-8.2*	*Percentage of Low Birth- weight births (CHIPRA/NQF # 1382)263 (Standalone measure)*	
RHP Performing Name: City of Houston Health and Human Services			*[RHP Performing Provider - 0937740-08*
Related Category 1 or 2 Projects::	0937740-08.2.7		
Starting Point/Baseline:	*Determined in DY 3*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
establish current capacity and needed resources and timeline Metric 1: Documentation of project plan, capacity, scope, and timeline Goal: Complete all planning steps to ensure successful implementation of program. Data Source: Program documentation Process Milestone 3 Estimated Incentive Payment: $19,847.89			
Year 2 Estimated Outcome Amount: $59,544	Year 3 Estimated Outcome Amount: $139,319	Year 4 Estimated Outcome Amount: $148,311	Year 5 Estimated Outcome Amount: $322,492
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $669,666			

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Title of Outcome Measure (Improvement Target): IT-8.1 Timeliness of Prenatal/Postnatal Care45 (CHIPRA Core Measure/NQF #1517)

Unique RHP Outcome identification number(s): 0937740-08.3.11

Outcome Measure Description:

IT-8.1 Prenatal/Postnatal Care45 (CHIPRA Core Measure/NQF #1517) (Non-standalone measure)

Numerator: Deliveries of live births for which women receive the following facets of prenatal and postpartum care: Received a prenatal care visit as a member of the organization in the first trimester or within 42 days of enrollment in the organization.

Denominator: Deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year

Process Milestones:

- DY2:
    - P – 2:Establish Baseline
    - P-3: Develop and test Data systems
    - P – 1: Project Planning
- DY 3
    - P-4: Milestone: Conduct Plan Do Study Act cycle to continually improve
        - Metric: Document use of PDSA in planning process
    - P-5: Milestone: Disseminate lessons learned and best practices
        - Metric 1: Documentation of best practices and lessons learned

Outcome Improvement Targets for each year:

- DY 4:
    - IT-8.1 Timeliness of Prenatal/Postnatal Care262 (CHIPRA Core Measure/NQF #1517) (Nonstandalone

      measure)
        - Increase the percentage of women receiving timely prenatal and postnatal careby 5% over baseline
    - IT-8.1 Timeliness of Prenatal/Postnatal Care262 (CHIPRA Core Measure/NQF #1517) (Nonstandalone

measure)

- Increase the percentage of women receiving timely prenatal and postnatal careby 10% over baseline

Rationale:

The outcome measures selected for this program was Timeliness of Prenatal Care. This outcome was selected because:

Provision of timely and adequate recommended prenatal care is extremely important to improve birth outcomes in low-income women who may typically not have access to regular primary and preventive care. Prenatal care given starting the first 3 months of pregnancy can have an impact on the health of the baby as well as the mother. Access to early prenatal care By allowing women and providers to identify and address health problems and behaviors that may cause particular harm during early fetal development, first-trimester prenatal care can lead to improved outcomes, according to the US Department of Health and Human Services. Early prenatal care is likely to matter most for women who are at elevated risk of poor birth outcomes due to smoking, poor nutritional status, HIV-positive status, or other serious health problems prior to pregnancy.

Extensive evaluation of the NFP program indicates that it is predictive of better birth outcomes, including fewer pre-term births. According to the Nurse Family Partnership website, data from the 1990 Nurse Family Partnership (NFP) Memphis trial noted that the NFP nurse-visited families gained academic and employment skills to become economically self-sufficient. According to this analysis, NFP services resulted in lower enrollment in Medicaid and Food Stamps, with a 9% reduction in Medicaid costs and an 11% reduction in Food Stamps costs in the 10 years following the birth of the child. Federal savings were estimated at 154% of costs, yielding a net 54% return on the federal investment.

Outcome Measure Valuation:

The Outcome measure was valued at 11.75% of the overall assigned project value for the associated Category 2 project in year 3, 11.75% in Year 4 and 11.75% in Year 5. HHDHS utilized the following method to determine the Category 2 project value.

HDHHS utilized two categories to calculate value for each DSRIP project. The first category is Prioritization and the second is Public Health Impact (see attachment for HDHHS Valuation Tool). HDHHS scored the project on a scale of 1 (poor) to 9 (exceptional) for each of the six factors that comprise the Prioritization category. The Prioritization category includes the following factors: 1) Transformational Impact, 2) Population Served / Project Size, 3) Alignment with Community Needs, 4) Cost Avoidance, 5) Partnership Collaboration, and 6) Sustainability. Each factor was then given a weighted score based on the score rated and a pre-determined percentage weight. The six weighted scores were added to get a composite score for the Prioritization category.

Public Health includes activities which seek to achieve the highest level of health for the greatest number of people. Public Health also focuses on preventing problems from happening or re-occurring through programs and activities that promote and protect the health of the entire community. As a public health department, HDHHS added an additional valuation category of Public Health Impact that looked at projects through a public health lens. The Public Health Impact category includes the following factors: 1) Alleviate Health Disparity, 2) Control Communicable and Chronic Disease , 3) Prevention Orientation, 4) Population Health Focus, 5) Access and Connection to Health Services and 6) Evidence Based Health Program. HDHHS scored the project on a scale of 1 (poor) to 9 (exceptional) for each of the six factors that comprise the Public Health Impact category. Each factor was then given a weighted score based on the score rated and a pre-determined percentage weight. The six weighted scores were added to get a composite score for the Public Health Impact category.

HDHHS gave the Prioritization score a weight of 25% and the Public Health Impact score a weight of 75% to determine the overall project value for the plan. NFP received a composite Prioritization score of 6.95 and a Public Health Impact score of 7.

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0937740-08.3.11	IT-8.1	Timeliness of Prenatal/Postnatal Care	
RHP Performing Name: City of Houston Health and Human Services			[RHP Performing Provider - 0937740-08
Related Category 1 or 2 Projects::	0937740-08.2.7		
Starting Point/Baseline:	Established in DY 2-3		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P – 2]: Establish Baseline Metric 1: Current rates for prenatal care in Sunnyside Metric 2: Current rates for infant mortality in Sunnyside Baseline: Establish overall baseline metrics for area Data Source: Vital Statistics data Process Milestone 1 Estimated Incentive Payment: $19,847.89 **Process Milestone 2 [P-3]:** Develop and test Data systems Metric 1: Documentation of discussions of partnership with of established national data system Metric 2: Documentation of established partnership with national data system Goal: Implement user friendly data system that can ease reporting of	**Process Milestone 4 [P-4]:** Conduct Plan Do Study Act cycle to continually improve Metric 1: Document use of PDSA in planning process Goal: Use a cyclical PDSA process and implementation improvement starategy Data Source: Program Documents Process Milestone 4 Estimated Incentive Payment: $69,659.41 **Process Milestone 5 [P-5]:** Disseminate lessons learned and best practices Metric 1: Documentation of best practices and lessons learned.Goal: Share best practices and lessons learned with community Data Source: Program Documents Goal: Share best practices and lessons learned with community partners. Process Milestone 5 Estimated Incentive	**Outcome Improvement Target 1** **[IT-8.1]:** Timeliness of Prenatal/Postnatal Care45 (CHIPRA Core Measure/NQF #1517) (Non-standalone measure) Improvement Target: Increase by 5% over baseline number of women that receive recommended prenatal and postnatal Data source: Electronic Records Numerator: Deliveries of live births among women enrolled in the program for which women receive the following facets of prenatal and postpartum care: Received a prenatal care visit as a member of the organization in the first trimester or within 42 days of enrollment in the organization. Denominator: Deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year in women	**Outcome Improvement Target 2 [IT-8.1] :** Timeliness of Prenatal/Postnatal Care45 (CHIPRA Core Measure/NQF #1517) (Non-standalone measure) Improvement Target: Increase by 10% over baseline number of women that receive recommended prenatal and postnatal care. Data source: Electronic Records Numerator: Deliveries of live births among women enrolled in the program for which women receive the following facets of prenatal and postpartum care: Received a prenatal care visit as a member of the organization in the first trimester or within 42 days of enrollment in the organization. Denominator: Deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year in women enrolled in the program.

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0937740-08.3.11	*IT-8.1*	*Timeliness of Prenatal/Postnatal Care*	
RHP Performing Name: City of Houston Health and Human Services			*[RHP Performing Provider - 0937740-08*
Related Category 1 or 2 Projects::	*0937740-08.2.7*		
Starting Point/Baseline:	*Established in DY 2-3*		
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)**
program participation and outcomes. Data Source: Data systems Process Milestone 2 Estimated Incentive Payment: $19,847.89 **Milestone 3 [P – 1]:** Project Planning Milestone– Identify and engage partners, establish current capacity and needed resources and timeline Metric 1: Documentation of project plan, capacity, scope, and timeline Goal: Complete all planning steps to ensure successful implementation of program. Data Source: Program documentation Process Milestone 3 Estimated Incentive Payment: $19,847.89	Payment: $69,659.41	enrolled in program care. (Program Baseline will be established in DY 2-3) Outcome Improvement Target 1 Estimated Incentive Payment: $148,311.12	Outcome Improvement Target 2 Estimated Incentive Payment: $322,492.10
Year 2 Estimated Outcome Amount: $ $59,544	Year 3 Estimated Outcome Amount: $139,319	Year 4 Estimated Outcome Amount: $148,311	Year 5 Estimated Outcome Amount: $322,492
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)*: $669,666			

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City of Houston Department of Health and Human Services

Pass 2

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Title of Outcome Measure (Improvement Target): IT-12.3 Colorectal Cancer Screening

Unique RHP Outcome identification number(s): 0937740-08.3.12 / Pass 2

Outcome Measure Description:
IT-12.3 Colorectal Cancer Screening
Number of adults aged 50-75 years of age that received colorectal cancer screening by FOBT in target zip codes.

Process Milestones:
DY2:

- P-3: Develop and test data system

DY3:

- P-4: Milestone: Conduct Plan Do Study Act cycle to continually improve program
- P-5: Milestone: Disseminate lessons learned and best practices

Outcome improvement targets for each year:
DY4:

- IT-12.3 Colorectal Cancer Screening: Increase by 2% over baseline the number of people in target population that were screened for CRC by FOBT each year, in accordance with screening guidelines.

DY5:

- IT-12.3 Colorectal Cancer Screening: Increase by 5% over baseline the number of people in target population that were screened for CRC by FOBT yearly, in accordance with screening guidelines.

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.

Outcome Measure Valuation:
The Outcome measure was valued at 18.63 % of the overall assigned project value for the associated Category 2 project in year 3, 18.63% in Year 4 and 18.63 % in Year 5. HHDHS utilized the following method to determine the Category 2 project value.
HDHHS utilized two categories to calculate value for each DSRIP project. The first category is Prioritization and the second is Public Health Impact (see attachment for HDHHS Valuation Tool). HDHHS scored the project on a scale of 1 (poor) to 9 (exceptional) for each of the six factors that comprise the Prioritization category. The Prioritization category includes the

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following factors: 1) Transformational Impact, 2) Population Served / Project Size, 3) Alignment with Community Needs 4)Cost Avoidance 5) Partnership Collaboration and 6)Sustainability. Each factor was then given a weighted score based on the score rated and a pre-determined percentage weight. The six weighted scores were added to get a composite score for the Prioritization category.

Public Health includes activities which seek to achieve the highest level of health for the greatest number of people. Public Health also focuses on preventing problems from happening or re-occurring through programs and activities that promote and protect the health of the entire community. As a public health department, HDHHS added an additional valuation category of Public Health Impact that looked at projects through a public health lens. The Public Health Impact category includes the following factors: 1) Alleviate Health Disparity, 2) Control Communicable and Chronic Disease , 3) Prevention Orientation, 4) Population Health Focus, 5) Access and Connection to Health Services and 6) Evidence Based Health Program. HDHHS scored the project on a scale of 1 (poor) to 9 (exceptional) for each of the six factors that comprise the Public Health Impact category. Each factor was then given a weighted score based on the score rated and a pre-determined percentage weight. The six weighted scores were added to get a composite score for the Public Health Impact category.

HDHHS gave the Prioritization score a weight of 50% and the Public Health Impact score a weight of 50% to determine the overall project value for the plan. CRC received a composite Prioritization score of 2.29 and a Public Health Impact score of 2.29.

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0937740-08.3.12	IT-12.3	*Colorectal Cancer Screening*	
City of Houston Health and Human Services			*TPI* - 0937740-08
Related Category 1 or 2 Projects:	Unique Cat 1 ID: 0937740-08.2.8		
Starting Point/Baseline:	*Project Baseline will be established in DY 2-3*		
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Process Milestone 1 [P- 2]: Develop and test data system in DY2 months 6-12 <u>Metric 1:</u> Documentation of testing and selection of data system Goals: Establish efficient data system that can track program outcomes. Data Sources: Program documentation from month 6-12 inDY2 Milestone 1 Estimated Incentive Payment: $14,592.61	**Process Milestone 2** [P-4]: Conduct Plan Do Study Act cycle to continually improve <u>Metric 1:</u> Document use of PDSA in planning process Goal: Ensure highest quality on program process and improvement. Data Source: Step-wise documentation of PDSA in program documentation Milestone 2 Estimated Incentive Payment: $17,287.30 **Process Milestone 3** [P-5]: Disseminate lessons learned and best practices <u>Metric 1</u>: Documentation of best practices <u>Metric 2</u>: Documentation of lessons learned Goal: Provide report documenting identification of best practices and lessons learned Data Source: Documentation of report	**Outcome Improvement Target 1** [IT-12.3]: Increase Colorectal Cancer Screening in target population by 2% over baseline Goal: Increase by 2% over baseline Data Source: Program electronic records (Baseline to be established in DY2-3) Outcome Improvement Target 1 Estimated Incentive Payment: $37,414.57	**Outcome Improvement Target 2** [[IT-12.3]: Increase Colorectal Cancer Screening in target population by 5% over baseline Goal: Increase by 5% over baseline(Baseline to be established in DY2-3) Data Source: Program Electronic records Outcome Improvement Target 2 Estimated Incentive Payment: $81,048.09

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0937740-08.3.12	IT-12.3	*Colorectal Cancer Screening*	
City of Houston Health and Human Services			*TPI* - 0937740-08
Related Category 1 or 2 Projects:	Unique Cat 1 ID: 0937740-08.2.8		
Starting Point/Baseline:	*Project Baseline will be established in DY 2-3*		
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
	Milestone 3 Estimated Incentive Payment: $17,287.30		
Year 2 Estimated Outcome Amount: $14,592.61	Year 3 Estimated Outcome Amount: $34,574.60	Year 4 Estimated Outcome Amount: $37,414.57	Year 5 Estimated Outcome Amount: $81,048.09
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5: $167,629.87*			

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<u>Title of Outcome Measure (Improvement Target):</u> IT-11.3 Improve utilization rates of clinical preventive services (testing, preventive services, treatment) in target population with identified disparity

<u>Unique RHP Outcome identification number(s):</u> 0937740-08.3.13 / Pass 2

<u>Outcome Measure Description:</u>
IT-11.3 Improve utilization rates of clinical preventive services (testing, preventive services, treatment) in target population with identified disparity.
Increase utilization of preventive services among individuals enrolled in the COCAS program.

Process Milestones:
DY2:

- P-X1: Establish partnerships and protocol for COCAS project for follow up after FOBT screening.

DY3:

- P-4: Milestone: Conduct Plan Do Study Act cycle to continually improve program
- P-5: Milestone: Disseminate lessons learned and best practices

Outcome improvement targets for each year:
DY4:

- Increase utilization rates of clinical preventive services by 5% (testing, preventive services) in target population with identified disparity over baseline.

DY5:

- Increase utilization rates of clinical preventive services by 10% (testing, preventive services) in target population with identified disparity over baseline.

<u>Rationale:</u>
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 ofa 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.

<u>Outcome Measure Valuation:</u>
The Outcome measure was valued at 18.63 % of the overall assigned project value for the associated Category 2 project in year 3, 18.63 % in Year 4 and 18.63 % in Year 5. HHDHS utilized the following method to determine the Category 2 project value.
HDHHS utilized two categories to calculate value for each DSRIP project. The first category is Prioritization and the second is Public Health Impact (see attachment for HDHHS Valuation Tool). HDHHS scored the project on a scale of 1 (poor) to 9 (exceptional) for each of the six

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factors that comprise the Prioritization category. The Prioritization category includes the following factors: 1) Transformational Impact, 2) Population Served / Project Size, 3) Alignment with Community Needs 4)Cost Avoidance 5) Partnership Collaboration and 6)Sustainability. Each factor was then given a weighted score based on the score rated and a pre-determined percentage weight. The six weighted scores were added to get a composite score for the Prioritization category.

Public Health includes activities which seek to achieve the highest level of health for the greatest number of people. Public Health also focuses on preventing problems from happening or re-occurring through programs and activities that promote and protect the health of the entire community. As a public health department, HDHHS added an additional valuation category of Public Health Impact that looked at projects through a public health lens. The Public Health Impact category includes the following factors: 1) Alleviate Health Disparity, 2) Control Communicable and Chronic Disease , 3) Prevention Orientation, 4) Population Health Focus, 5) Access and Connection to Health Services and 6) Evidence Based Health Program. HDHHS scored the project on a scale of 1 (poor) to 9 (exceptional) for each of the six factors that comprise the Public Health Impact category. Each factor was then given a weighted score based on the score rated and a pre-determined percentage weight. The six weighted scores were added to get a composite score for the Public Health Impact category.

HDHHS gave the Prioritization score a weight of 50% and the Public Health Impact score a weight of 50% to determine the overall project value for the plan. CRC received a composite Prioritization score of 2.29 and a Public Health Impact score of 2.29.

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0937740-08.3.13	*IT- 11.3*	Improve utilization rates of clinical preventive services (testing, preventive services, treatment) in target population with identified disparity.	
City of Houston Health and Human Services			*TPI* - 0937740-08
Related Category 1 or 2 Projects:	Unique Cat 1 ID: 0937740-08.2.8		
Starting Point/Baseline:	*TBD in DY2-3*		
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Process Milestone 1 [P-X1]: Establish partnerships and protocol for COCAS project for follow up procedures after FOBT screening. Metric 1: Document and formalize partnerships and processes for patient follow-up after FOBT testing Goal: Establish protocol for patient follow-up Data Source: Documentation of protocol and program documentation Process Milestone 1 Estimated Incentive Payment: $14,592.61	**Process Milestone 2** [P-4]: Conduct Plan Do Study Act cycle to continually improve Metric 1: Document use of PDSA in planning process Goal: Utilize a systematic cyclical process for quality improvement Data Source: Program documentation Process Milestone 2 Estimated Incentive Payment: $17,287.30 **Process Milestone 3** [P-5]: Disseminate lessons learned and best practices Metric 1: Documentation of best practices and lessons learned Goal: Share lessons learned to add to knowledge base and inform others implementing similar projects Data Source: Program Documentation Process Milestone 3 Estimated Incentive	**Outcome Improvement Target 1** [IT-11.3]: Improve by 5% over baseline utilization rates of clinical preventive services (testing, preventive services) in target population with identified disparity. Goal: Increase utilization of preventive services by 5% over baseline. (Baseline to be established in year 2-3) Data Source: Program electronic database Outcome Improvement Target 1 Estimated Incentive Payment: $37,414.57	Outcome Improvement Target 2 [IT-11.3] Improve by 10% over baseline utilization rates of clinical preventive services (testing, preventive services) in target population with identified disparity. Goal: Increase utilization of preventive services by 10% over baseline. (Baseline to be established in year 2-3) Data Source: Program electronic database Outcome Improvement Target 2 Estimated Incentive Payment: $81,048.09

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0937740-08.3.13	*IT- 11.3*	Improve utilization rates of clinical preventive services (testing, preventive services, treatment) in target population with identified disparity.	
City of Houston Health and Human Services			*TPI* - 0937740-08
Related Category 1 or 2 Projects:	Unique Cat 1 ID: 0937740-08.2.8		
Starting Point/Baseline:	*TBD in DY2-3*		
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)
	Payment: $17,287.30		
Year 2 Estimated Outcome Amount: $14,592.61	Year 3 Estimated Outcome Amount: $34,574.60	Year 4 Estimated Outcome Amount: $37,414.57	Year 5 Estimated Outcome Amount: $81,048.09
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5:* $167,629.87			

DRAFT

Title of Outcome Measure (Improvement Target): IT-9.4 Other Outcome Improvement Target (Right Care, Right Setting)

Unique RHP Outcome identification number(s): 0937740-08.3.14 / Pass 2

Outcome Measure Description:
IT-9.4 Other Outcome Improvement Target (Right Care Right Setting) – Reduce ER use in homeless population enrolled in program
Numerator: Number of non-emergent ED visits for target population served by the program in past 12 months
Denominator: Total number of target population served by the program in past 12 months

Process Milestones:
DY2:
- P-X1 Needs Assessment to determine number and types of needs of the target population

DY 3:
- P-4 Metric: Conduct Plan-Do-Study-Act
- P-5 Milestone: Disseminate findings, lessons learned and best practices

Outcome Improvement Targets for each year:
DY 4:
- IT-9.4 Other Outcome Improvement Target
  - Metric: Reduce non emergent ED usage in program participants by 5% over baseline

DY 5:
- IT-9.4 Other Outcome Improvement Target
  - Metric: Reduce non emergent ED usage in program participants by 10% over baseline

Rationale:
The outcome measure chosen for this project under Outcome Domain "Right Setting Right Care" is "Other Outcome Improvement Target. We anticipate that comprehensive navigation and care management will reduce the number of homeless program participants that end up in ER due to any number of comorbidities. This program plans to provide housing, program services, physical and behavioral health services, financial services and other services (peer trainers etc.) to homeless individuals enrolled in the program. Provision of this type of an integrated service to this indigent group with special needs along with follow-up will improve physical and behavioral health outcomes as well as address their acute housing needs.

Outcome Measure Valuation:
The Outcome measure was valued at 11.67% of the overall assigned project value for the associated Category 2 project in year 3, 11.67% in Year 4 and 11.67% in Year 5. HHDHS utilized the following method to determine the Category 2 project value.

HDHHS utilized two categories to calculate value for each DSRIP project. The first category is Prioritization and the second is Public Health Impact (see attachment for HDHHS Valuation Tool). Consistent with other participants in the regional partnership, HDHHS scored the project on a scale of 1 (poor) to 9 (exceptional) for each of the six factors that comprise the Prioritization category. The Prioritization category includes the following factors: 1)

Transformational Impact, 2) Population Served / Project Size, 3) Alignment with Community Needs 4)Cost Avoidance 5) Partnership Collaboration and 6)Sustainability. Each factor was then given a weighted score based on the score rated and a pre-determined percentage weight. The six weighted scores were added to get a composite score for the Prioritization category.

Public Health includes activities which seek to achieve the highest level of health for the greatest number of people. Public Health also focuses on preventing problems from happening or re-occurring through programs and activities that promote and protect the health of the entire community. As a public health department, HDHHS added an additional valuation category of Public Health Impact that looked at projects through a public health lens. The Public Health Impact category includes the following factors: 1) Alleviate Health Disparity, 2) Control Communicable and Chronic Disease , 3) Prevention Orientation, 4) Population Health Focus, 5) Access and Connection to Health Services and 6) Evidence Based Health Program. HDHHS scored the project on a scale of 1 (poor) to 9 (exceptional) for each of the six factors that comprise the Public Health Impact category. Each factor was then given a weighted score based on the score rated and a pre-determined percentage weight. The six weighted scores were added to get a composite score for the Public Health Impact category.

HDHHS gave the Prioritization score a weight of 25% and the Public Health Impact score a weight of 75% to determine the overall project value for the plan. Integrated services for the homeless received a composite Prioritization score of 10 and a Public Health Impact score of 10.

DRAFT

Reference

1. Kushel MB, Perry S, Bangsberg D, Clark R, Moss AR. Emergency department use among the homeless and marginally housed: results from a community-based study. Am J Public Health. 2002;92(5):778-784
2. Larimer, M.E. et al. (2009). Health Care and Public Service Use and costs before and after Provision of Housing for Chronically Homeless Persons with Severe Alcohol Problems. JAMA; 301(13):1349-1357.

<table>
<tr><td>0937740-08.3.11</td><td>IT-9.4</td><td colspan="2">Other Outcome Improvement Target</td></tr>
<tr><td colspan="3">City of Houston Health and Human Services</td><td>HDHHS -0937740-08</td></tr>
<tr><td>Related Category 1 or 2 Projects:</td><td colspan="3">Unique Category 2 Identifier - 0937740-08.2.9</td></tr>
<tr><td>Starting Point/Baseline:</td><td colspan="3">TBD in DY3</td></tr>
<tr><th>Year 2
(10/1/2012 – 9/30/2013)</th><th>Year 3
(10/1/2013 – 9/30/2014)</th><th>Year 4
(10/1/2014 – 9/30/2015)</th><th>Year 5
(10/1/2015 – 9/30/2016)</th></tr>
<tr><td>Process Milestone 1 [P-X1]: Needs Assessment to determine number and types of needs of the target population

<u>Metric 1:</u> Needs assessment conducted
Goal: Develop program to match needs of the target population
Data Source: Program needs assessment and data documentation

Process Milestone 1 Estimated Incentive Payment: $127,446</td><td>Process Milestone 2 [P-4]: Conduct Plan Do Study Act cycle to continually improve

<u>Metric 1:</u> Document use of PDSA in planning process
Goal: Utilize a cyclical quality improvement process
Data Source: Program Documentation

Process Milestone 2 Estimated Incentive Payment: $150,981

Process Milestone 3 [P-5]:Disseminate lessons learned and best practices

<u>Metric 1:</u> Documentation of best practices and lessons learned
Goal: Share lessons learned

Process Milestone 3 Estimated Incentive Payment: $150,981</td><td>Other Outcome Improvement Target 1 [IT-9.4]: Other Outcome Improvement Target

<u>Metric 1:</u> Reduce non emergent ED usage in program participants
Goal: Decrease non emergent ED visits by 5% over baseline (will be established in DY 3)
Data Source: Program Data and Follow-up data
Numerator: Number of non-emergent ED visits for target population served by the program in past 12 months
Denominator: Total number of target population served by the program in past 12 months

Outcome Improvement Target 1 Estimated Incentive Payment: $326,765</td><td>Other Outcome Improvement Target 2 [IT-9.4]: Other Outcome Improvement Target

<u>Metric 1:</u> Reduce non emergent ED usage in program participants
Goal: Decrease non emergent ED visits by 10% over baseline (will be established in DY 3)
Data Source: Program Data and Follow-up data
Numerator: Number of non-emergent ED visits for target population served by the program in past 12 months
Denominator: Total number of target population served by the program in past 12 months

Outcome Improvement Target 2 Estimated Incentive Payment: $707,844</td></tr>
<tr><td>Year 2 Estimated Outcome Amount: $127,446.34</td><td>Year 3 Estimated Outcome Amount: $301,961.59</td><td>Year 4 Estimated Outcome Amount: $326,764.77</td><td>Year 5 Estimated Outcome Amount: $707,843.61</td></tr>
<tr><td colspan="4">TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5): $1,464,016</td></tr>
</table>

DRAFT

City of Houston Department of Health and Human Services

Pass 3

DRAFT

Title of Outcome Measure (Improvement Target): IT-7.8 Chronic Disease Patients Accessing Dental Services: Percentage of patients with chronic disease conditions accessing dental services following referral by their medical provider

Unique RHP Outcome identification number(s): 0937740-08.3.15 / Pass 3

Outcome Measure Description:

IT-7.8 Chronic Disease Patients Accessing Dental Services: Percentage of patients with chronic disease conditions accessing dental services following referral by their medical provider

(Standalone measure)

Process Milestones :

- DY 2
  - Develop and test data systems
- DY3:
  - P-4: Milestone: Conduct Plan Do Study Act cycle to continually improve program
  - P-5: Milestone: Disseminate lessons learned and best practices

Outcome improvement targets for each year:

- DY 4:
  - IT-7.8 Chronic Disease Patients Accessing Dental Services: Increase by 5% over baseline percentage of patients with chronic disease conditions accessing dental services following referral by their medical provider
- DY 5
  - IT-7.8 Chronic Disease Patients Accessing Dental Services: Increase by 10% over baseline percentage of patients with chronic disease conditions accessing dental services following referral by their medical provider

Rationale:

The process milestones P4 and P5 were chosen for this project based on the need for documentation of baseline and continuous quality improvements in program for reduction of dental caries. The PDSA cycle will inform systematic data driven program improvements. Inadequate access to dental services compounds other health issues. Chronic diseases and oral diseases share many common risk factors.

Poor oral health can result in untreated dental disease that not only affects the mouth, but can also have physical, mental, economic and social consequences. Severe gum disease is associated with chronic disease and severe health conditions such as diabetes, heart disease, stroke and respiratory disease. Fortunately, many of the adverse effects associated with poor oral health can be prevented with quality on-going dental care, both at home and professionally. Increasing, expanding, and enhancing dental services will improve overall health outcomes in the elderly.

Outcome Measure Valuation:

The Outcome measure was valued at 15.82 % of the overall assigned project value for the associated Category 2 project in year 3, 15.82 % in Year 4 and 15.82 % in Year 5. HHDHS utilized the following method to determine the Category 2 project value.

The HDHHS utilized two categories to calculate value for each DSRIP project. The first category is Prioritization and the second is Public Health Impact (see attachment for HDHHS Valuation Tool). HDHHS scored the project on a scale of 1 (poor) to 9 (exceptional) for each of the six factors that comprise the Prioritization category. The Prioritization category includes the following factors: 1) Transformational Impact, 2) Population Served / Project Size, 3) Alignment with Community Needs 4)Cost Avoidance 5) Partnership Collaboration and 6)Sustainability. Each factor was then given a weighted score based on the score rated and a pre-determined percentage weight. The six weighted scores were added to get a composite score for the Prioritization category.

Public Health includes activities which seek to achieve the highest level of health for the greatest number of people. Public Health also focuses on preventing problems from happening or re-occurring through programs and activities that promote and protect the health of the entire community. As a public health department, HDHHS added an additional valuation category of Public Health Impact that looked at projects through a public health lens. The Public Health Impact category includes the following factors: 1) Alleviate Health Disparity, 2) Control Communicable and Chronic Disease , 3) Prevention Orientation, 4) Population Health Focus, 5) Access and Connection to Health Services and 6) Evidence Based Health Program. HDHHS scored the project on a scale of 1 (poor) to 9 (exceptional) for each of the six factors that comprise the Public Health Impact category. Each factor was then given a weighted score based on the score rated and a pre-determined percentage weight. The six weighted scores were added to get a composite score for the Public Health Impact category.

HDHHS gave the Prioritization score a weight of 50% and the Public Health Impact score a weight of 50% to determine the overall project value for the plan. Geriatric Oral Health received a composite Prioritization score of 1.88 and a Public Health Impact score of 1.88.

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0937740-08.3.15	*IT-7.8*	*Chronic Disease patients accessing oral health services*	
[RHP Performing Provider involved with this project - Name] Houston Department of Health and Human Services			*TPI - 0937740-08*
Related Category 1 or 2 Projects::	*Unique Cat 1 ID: 0937740-08.1.3*		
Starting Point/Baseline:	*TBD in DY2-3*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P- 3] Develop and test data systems Metric 1: Select, install and test data system Goal: Install efficient and effective data system to capture program data Data Source: Documentation of selection, testing and implementation of data system Milestone 1 Estimated Incentive Payment: $9,640	**Process Milestone 2** [P-4]: Conduct Plan Do Study Act cycle to continually improve Metric 1: Document use of PDSA in planning process Goal: Utilize a systematic cyclical process for quality improvement Data Source: Program documentation Milestone 2 Estimated Incentive Payment: $11,552 **Process Milestone 3** [P-5]: Disseminate lessons learned and best practices Metric 1: Documentation of best practices and lessons learned Goal: Share lessons learned to add to knowledge base and inform others implementing similar projects	**Outcome Improvement Target 1** [IT-7.8] Chronic Disease Patients Accessing Dental Services: Percentage of patients with chronic disease conditions accessing dental services following referral by their medical provider Goal: Increase by 5% over baseline percentage of patients with chronic disease conditions accessing dental services (Baseline TBD in DY 2-3) Data Source: Program Electronic Records Numerator: Number of chronic disease patients who access dental services as the result of a referral Denominator: Total number of referrals for dental services for chronic disease patient by medical providers Outcome Improvement Target 1	**Outcome Improvement Target 1** [IT-7.8] Chronic Disease Patients Accessing Dental Services: Percentage of patients with chronic disease conditions accessing dental services following referral by their medical provider Goal: Increase by 10% over baseline percentage of patients with chronic disease conditions accessing dental services Data Source: Program Electronic Records Numerator: Number of chronic disease patients who access dental services as the result of a referral Denominator: Total number of referrals for dental services for chronic disease patient by medical providers Outcome Improvement Target 2

DRAFT

0937740-08.3.15	*IT-7.8*	*Chronic Disease patients accessing oral health services*	
[RHP Performing Provider involved with this project - Name] Houston Department of Health and Human Services			*TPI - 0937740-08*
Related Category 1 or 2 Projects::	*Unique Cat 1 ID: 0937740-08.1.3*		
Starting Point/Baseline:	*TBD in DY2-3*		
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)**
	Data Source: Program Documentation Milestone 3 Estimated Incentive Payment: $11,551	Estimated Incentive Payment: $25,247	Estimated Incentive Payment: $54,638
Year 2 Estimated Outcome Amount:: $ $9,640	Year 3 Estimated Outcome Amount: $23,103	Year 4 Estimated Outcome Amount: $25,247	Year 5 Estimated Outcome Amount: $54,638
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD ***(add outcome amounts over DYs 2-5):*** $112,628			

DRAFT

Title of Outcome Measure (Improvement Target): IT-3.2 Congestive Heart Failure 30 day readmission rate *(Standalone measure)*

Unique RHP Outcome identification number(s): 0937740-08.3.16 / Pass 3

Outcome Measure Description:

IT-3.2 Congestive Heart Failure 30 day readmission rate *(Standalone measure)*

Process Milestones:

- DY 2
  - Develop and test data systems
- DY3:
  - P-4: Milestone: Conduct Plan Do Study Act cycle to continually improve program
  - P-5: Milestone: Disseminate lessons learned and best practices

Outcome improvement targets for each year:

- DY 4:
  - IT-3.2 Reduce Congestive Heart Failure 30 day readmission rate by 10% over baseline.
- DY 5
  - IT-3.2 Reduce Congestive Heart Failure 30 day readmission rate by 25% over baseline.

Rationale:

The process milestones P4 and P5 were chosen for this project based on the need for documentation of baseline and continuous quality improvements in program for reduction of dental caries. The PDSA cycle will inform systematic data driven program improvements. Inadequate access to dental services compounds other health issues.

Congestive heart failure is one of the most common conditions that is associated with rehospitalizations. Each year over 1 million people are admitted to an inpatient setting for HF, and 27% of patients with HF on Medicare are readmitted within 30 days (Jencks, Williams, & Coleman, 2009). For chronic heart failure patients, case management interventions involving telephone follow-up reduce all-cause readmissions and all-cause mortality a year after discharge. Therefore, our outcome measure relates to reducing readmissions due to congestive heart failure.

Some of the reasons identified for re-admissions are nonadherence (medications, diet, self-monitoring, and communication with provider) is a significant problem in patients with heart failure and frequently contributes to morbidity and increased resource utilization.

Outcome Measure Valuation:

The Outcome measure was valued at 84.18% of the overall assigned project value for the associated Category 2 project in year 3, 84.18% in Year 4 and 84.18% in Year 5. HHDHS utilized the following method to determine the Category 2 project value.

HDHHS utilized two categories to calculate value for each DSRIP project. The first category is Prioritization and the second is Public Health Impact (see attachment for HDHHS Valuation Tool). HDHHS scored the project on a scale of 1 (poor) to 9 (exceptional) for each of the six factors that comprise the Prioritization category. The Prioritization category includes the following factors: 1) Transformational Impact, 2) Population Served / Project Size, 3) Alignment with Community Needs 4)Cost Avoidance 5) Partnership Collaboration and 6)Sustainability. Each factor was then given a weighted score based on the score rated and a pre-determined percentage weight. The six weighted scores were added to get a composite score for the Prioritization category.

Public Health includes activities which seek to achieve the highest level of health for the greatest number of people. Public Health also focuses on preventing problems from happening or re-occurring through programs and activities that promote and protect the health of the entire community. As a public health department, HDHHS added an additional valuation category of Public Health Impact that looked at projects through a public health lens. The Public Health Impact category includes the following factors: 1) Alleviate Health Disparity, 2) Control Communicable and Chronic Disease , 3) Prevention Orientation, 4) Population Health Focus, 5) Access and Connection to Health Services and 6) Evidence Based Health Program. HDHHS scored the project on a scale of 1 (poor) to 9 (exceptional) for each of the six factors that comprise the Public Health Impact category. Each factor was then given a weighted score based on the score rated and a pre-determined percentage weight. The six weighted scores were added to get a composite score for the Public Health Impact category.

HDHHS gave the Prioritization score a weight of 50% and the Public Health Impact score a weight of 50% to determine the overall project value for the plan. Community Care Transitions received a composite Prioritization score of 10 and a Public Health Impact score of 10.

Reference

Jencks, S.F., Williams, M.V. and Coleman, E.A. (2009). Rehospitalizations among patients in the Medicare Fee-for-Service program. The New England Journal of Medicine; 360:1418-1428.

DRAFT

0937740-08.3.16	*IT-3.2*	*Congestive Heart Failure 30 day Readmission Rate*	
[RHP Performing Provider involved with this project - Name] City of Houston Health and Human Services			*TPI - 0937740-08*
Related Category 1 or 2 Projects::	*Unique Cat 1 ID: 0937740-08.2.10*		
Starting Point/Baseline:	*TBD in DY2-3*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P- X1] Develop and implement an outreach and marketing strategy to engage partners and stakeholders Metric 1: Implement appropriate strategy for promotion of program Goal: Promotion of program and engagement of stakeholders Data Source: Documentation of promotional materials. Milestone 1 Estimated Incentive Payment: $51,277	**Process Milestone 2** [P-4]: Conduct Plan Do Study Act cycle to continually improve Metric 1: Document use of PDSA in planning process Goal: Utilize a systematic cyclical process for quality improvement Data Source: Program documentation Milestone 2 Estimated Incentive Payment: $61,446 **Process Milestone 3** [P-5]: Disseminate lessons learned and best practices Metric 1: Documentation of best practices and lessons learned Goal: Share lessons learned to add to knowledge base and inform others implementing similar projects Data Source: Program	**Outcome Improvement** Target 1 [IT-3.2] Congestive Heart Failure 30 day readmission rate *(Standalone measure)* Numerator: The number of readmissions (for patients 18 years and older), for any cause, within 30 days of discharge from the index HF admission, who enrolled and completed the program. Denominator: The number of admissions (for patients 18 years and older), for patients discharged from the hospital with a principal diagnosis of HF and with a complete claims history for the 12 months prior to admission, enrolled in the program. Improvement Target: Reduce readmission rate by 10% over baseline Outcome Improvement Target 1 Estimated Incentive Payment: $134,292	**Outcome Improvement Target 2** [IT-3.2] Congestive Heart Failure 30 day readmission rate *(Standalone measure)* Numerator: The number of readmissions (for patients 18 years and older), for any cause, within 30 days of discharge from the index HF admission, who enrolled and completed the program. Denominator: The number of admissions (for patients 18 years and older), for patients discharged from the hospital with a principal diagnosis of HF and with a complete claims history for the 12 months prior to admission, enrolled in the program. Improvement Target: Reduce readmission rate by 25% over baseline Outcome Improvement Target 2 Estimated Incentive Payment: $290,628

DRAFT

0937740-08.3.16	*IT-3.2*	*Congestive Heart Failure 30 day Readmission Rate*	
[RHP Performing Provider involved with this project - Name] City of Houston Health and Human Services			*TPI - 0937740-08*
Related Category 1 or 2 Projects::	*Unique Cat 1 ID: 0937740-08.2.10*		
Starting Point/Baseline:	*TBD in DY2-3*		
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)**
	Documentation Milestone 3 Estimated Incentive Payment: $61,445		
Year 2 Estimated Outcome Amount:: $51,277	Year 3 Estimated Outcome Amount: $122,891	Year 4 Estimated Outcome Amount: $134,292	Year 5 Estimated Outcome Amount: $290,628
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD ***(add outcome amounts over DYs 2-5):*** $599,088			

DRAFT

Columbus Community Hospital

Pass 1

DRAFT

Title of Outcome Measure (Improvement Target): IT-3.1 All cause 30 day readmission rate – NQF 1789 [250] (Standalone measure)

Unique RHP Outcome Identification Number: 135033204.3.1

Outcome Measure Description

OD-3 Potentially Preventable Re-Admissions – 30 day Re-admission rates IT-3.1 All cause 30 day readmission rate – NQF 1789[250] (Standalone measure)

Process Milestones:

- DY2 – P-1
- DY3 – P-3

Outcome Improvement Targets:

- DY4 – IT-3.1
- DY5 – IT-3.1

Rationale:

Telehealth is being implemented at Columbus Community Hospital for the purpose of expanding weekend pharmacist oversight to include Saturdays, Sundays and Holidays. Presently there is no pharmacist coverage on those days. The presence of an oversight pharmacist via telehealth capabilities will lead to a reduction in medication errors. This is a direct relationship to readmission rates which has been increasing and on the last Pepper report (March 2012) had risen to 21.4%.

Improvement measure 3.1 will help us tract the readmission rate for all-cause admissions. The population will only include patients 65 are older.

Outcome Measure Valuation

The addition of the telehealth service is the primary cost in year two and three. This will require implementation and training of the staff to use the service effectively. In subsequent years the hospital will experience a reduction in the rate of unplanned readmissions thereby initiating cost savings to respective payers such as CMS. The total anticipated values are estimated to be (total of years 2, 3, 4, 5).

DRAFT

135033204.3.1	IT-3.1	All cause 30 day readmission rate – NQF 1789	
Columbus Community Hospital 13503304			
Related Category 1:	135033204.1.1		
Starting Point/ Baseline:	TBD		
Year 2 **10/10/2012-9/30/2013**	**Year 3** **10/01/2013-9/30/2014**	**Year 4** **10/01/2014-9/30/2015**	**Year 5** **10/01/2015-09/30/2016**
Process Milestone 1 [P-1]: Project planning engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Goal: Reduction in the readmission rate of 1% Data Source: EHR, project data Process Milestone 1 Estimated Incentive Payment: $30,640.00	**Process Milestone 2** [P-3]: Develop and test data systems to ensure capture of all inpatient discharges for program of specialist consultation Goal: Reduction in readmission rate of 1% from year 2 Data Source: EHR, project data Process Milestone 3 Estimated Incentive Payment : $36,600.00	**Outcome Improvement Target 1** [IT-3.1]: All cause 30 day readmission rate – NQF 1789[250](Standalone measure) Goal: Reduction in the readmission rate of 2% from year 3 Data Source: EHR, claims Outcome Improvement Target 2 Estimated Incentive Payment: $42,300.00	**Outcome Improvement Target 2** [IT-3.1]: All cause 30 day readmission rate NQF 1789[250](Standalone measure) Goal: reduction in the readmission rate of 2% from year 4 Data Source: EHR, claims Outcome Improvement Target 2 Estimated Incentive Payment: $68,200.00
Year 2 Estimated Outcome Amount: $30,640.00	Year 3 Estimated Outcome Amount: $36,600.00	Year 4 Estimated Outcome Amount: $42,300.00	Year 5 Estimated Outcome Amount: $68,200.00
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5): $177,740.00			

El Campo Memorial Hospital

Pass 1

DRAFT

Title of Outcome Measure (Improvement Target): IT-6.1(1) Percent improvement over baseline of patient satisfaction scores

Unique RHP outcome identification number(s): 131045004.3.1

Outcome Measure Description:

Since this is a new project for El Campo Memorial Hospital, we will use DY 2 & DY 3 to plan the project and establish baseline rates. In DY 4 & DY 5, we will measure IT-6.1 Percent improvement over baseline of patient satisfaction scores specifically related to the measure IT-6.1.1 Patients are getting timely care, appointments, and information. Currently, a patient satisfaction survey does not exist to capture this measure at El Campo Memorial Hospital. Therefore, the baseline will be set at 0. However, we expect to improve this measure by 5% by the end of the waiver.

Rationale:

El Campo Memorial Hospital has selected the process milestones and outcome improvement targets because we are certain if the patient receives timely healthcare and education, they are more likely to continue leading healthy lives and obtaining preventing healthcare on a regular basis which ultimately leads to reduced healthcare costs.

Outcome Measure Valuation:

We considered both the costs and benefits to our organization and community in order to value the Outcome Measure – IT-6.1 Percent improvement over baseline of patient satisfaction scores. We believe it will take DY2 and DY3 to effectively develop and plan the Outcome Improvement Targets in DY4 and DY5. We do not currently perform or contract with a company to perform surveys for outpatient services, but we intend to select a vendor in DY 2. We believe with the improvement in patient satisfaction scores specifically the improvement target of patients getting timely care, appointments and information, this will decrease unnecessary Emergency Room visits, hospital stays, etc. because patients will be receiving the care and attention they need on a consistent and dependable basis. This Outcome Measure will serve the total outpatient service population of El Campo Memorial Hospital, and it will ultimately assist El Campo and the surrounding communities to live healthier lives and be healthier communities.

DRAFT

131045004.3.1	*3.IT-6.1(1)*	*Percent improvement over baseline of patient satisfaction scores*	
El Campo Memorial Hospital			*131045004*
Related Category 1 or 2 Projects:	*131045004.2.4*		
Starting Point/Baseline:	*To be established in DY3.*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project Planning – identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Meeting minutes, agenda and plan Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $21,110	**Process Milestone 2** [P-4]: Establish baseline rates Data Source: Meeting minutes, agenda and plan Process Milestone 2 Estimated Incentive Payment: $24,469	**Outcome Improvement Target 1** [IT-6.1]: Percent improvement over baseline of patient satisfaction scores – TBD. Improvement Target: Increase patient satisfaction scores for measure 1) Patient is getting timely care, appointments, and information. Data Source: Patient Survey Outcome Improvement Target 1 Estimated Incentive Payment*:* $39,264	**Outcome Improvement Target 2** [IT-6.1]: Percent improvement over baseline of patient satisfaction scores – TBD. Improvement Target: Additional increase of patient satisfaction scores for measure 1) Patient is getting timely care, appointments, and information. Data Source: Patient Survey Outcome Improvement Target 2 Estimated Incentive Payment*:* $93,892
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $21,110	Year 3 Estimated Outcome Amount: $24,469	Year 4 Estimated Outcome Amount: $39,264	Year 5 Estimated Outcome Amount: $93,892
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $178,734			

DRAFT

Fort Bend County Clinical Health Services

Pass 1

DRAFT

Title of Outcome Measure (Improvement Target): IT-9.2 ED appropriate utilization

Unique RHP Outcome Identification Number: 2967606-01 3.1

Outcome Measure Description:
OD- 9 – Right Care, Right setting will be defined as the number of persons with behavioral health crisis who had a preventable visit to emergency rooms (ER)

Process Milestones:
DY2: P-1
DY3: P-2, P-3
DY4: P-4, P-5
DY5: P-4, P-5
Outcome Improvement Target(s) for each year:
DY 4: IT 9.2 Emergency Room visits for target conditions
- Reduce % (TBD) of ER visits for behavioral health/ substance abuse

Dy 5: DY 4: IT 9.2 Emergency Room visits for target conditions
- Reduce % (TBD) of ER visits for behavioral health/ substance abuse

Rationale:
Process milestone P-1 was chosen to ensure engagement of multiple stakeholders, delineation of project timeliness and activities. Process milestones P-2 and P-3 are especially critical to the project and include definition of data to be collected, data sources, data tracking mechanisms, and establishment of baselines. The success of the FBC project will be determined by the ability to track outcomes for persons with behavioral health needs who are in "crisis" and access crisis services. Data systems need to be integrated to facilitate communication about the patients' needs, linking to appropriate services and measuring outcomes. The project will work with various partners in the region as well as the county's IT department to develop the most efficient data tracking system. The data will be used as part of the project's quality improvement cycle.

Process milestones P-4 and P-5 ensure continuous quality improvement, data driven decision making, identification of "lessons learned" and dissemination to stakeholders. These will allow the use of real time data for continuous quality improvement, engagement of multiple stakeholders, and identification of best practices. The need for information sharing and continuous evaluation cannot be overstated. Within the project, staff will implement the Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities. Achieving high quality outcomes depends on continuous assessment of what has been done and flexibility to apply lessons learned to the next phase of a process. The PDSA improvement process will provide for a continuous quality improvement process, which will guide decision making and timelines developed to reach milestones while delivering quality products.

Findings will need to be disseminated, including lessons learned and best practices, so that stakeholders can, in turn, provide additional input and/or validation. To achieve this feedback loop, the project will conduct meetings of stakeholders, project staff, RHP partners, and other key parties to gather relevant information. These stakeholder meetings will be quarterly.

Stakeholder input is not only critical to the design and implementation of this project but also to its sustainability. Dissemination of our activities to the community and the various stakeholders will be critical. Persons with behavioral health disorders or their families often

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access 911 crisis services as their first choice for help, and first responders have become the default interveners for behavioral health crisis in FBC. First responders have limited options for these patients and complex situations often arise that require a diligent assessment and delineation of safety and clinical need. The goal is to direct the person to the right level of care and to ensure patient and community safety. There will be many challenges as we implement this project including community education and awareness of a new "response" system.

The Improvement Target will be defined in DY4 and DY5 based on the data collected in DY2 and DY3. The baseline percentage will be determined in DY3. The outcome measure chosen, reduction of ER utilization for behavioral health/substance abuse crises is of great significance and directly related to the Category 1 project. In 2011, FBC Emergency Management Services (EMS) responded to 1, 171 mental health crisis calls, representing almost a 100% percent increase in the past 6 years. Analysis of the EMS response calls indicated that the majority of the behavioral health calls are not medical emergencies and unnecessary. The FBC project will create a "Behavioral Health Crisis Response and Intervention" system that will reduce EMS transports and ED visits and admissions.

Outcome Measure Valuation:

Outcome valuation follows the same process as for the program metrics. Cost avoidance of State Hospital visits, incarceration, EMS transport, ER visits and in-patient stays for the county indigent program if the established targets are met. The total cost avoidance value anticipated is in excess of $16 million. This value is distributed among the initiatives and outcome measures using the RHP formulation to achieve an estimated maximum payment of $10,016,863.

Plan for Learning Collaborative: We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region, 3 Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our region's healthcare system.

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2967606-01 3.1	*IT-9.2*	*ED Appropriate utilization – Behavioral health/ Substance abuse*	
Fort Bend County Clinical Health Services			*2967606-01*
Related Category 1 or 2 Projects:	*2967606-01 1.1*		
Starting Point/Baseline:	*TBD*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Metric 1: Conduct quarterly meetings of stakeholders, project staff, RHP partners and other key parties to gather relevant information Data Source: Meetings minutes, project flow charts and timelines, meeting feedback forms Goal: To gather information that guides project activities toward completion of milestones, while integrating stakeholder input in a meaningful way Process Milestone 1 Estimated Incentive Payment: $54,594 **Process Milestone 2** [P-2]: Establish baseline rates Metric 1: Number of crisis intervention team contacts Data Source: CIT reports; monthly management reports Goal: Establish baseline number served in year 2.	**Process Milestone 3** [P-3]: Develop and test data systems Metric 1: Review data tracking systems for target population Data Source: Project records, summary of reviews Goal: Develop data tracking systems that allow for identification of behavioral health needs and outcomes Process Milestone 3 Estimated Incentive Payment$78,755 **Process Milestone 4** [P- 4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Metric 1: Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles Data Source: Project reports including examples of how real-time data has been used to guide continuous quality improvement Goal: To improve processes and outcomes by implementing data-driven course corrections and	**Outcome Improvement Target 1** [IT- 9.2] ED appropriate utilization Baseline/Goal: TBD / Reduce emergency visits for behavioral health/ substance abuse by 10% Improvement Target: TBD Data Source: TBD Outcome Improvement Target Estimated Incentive Payment*:* $262,322	**Outcome Improvement Target 2** [IT- 9.2] ED appropriate utilization Baseline/Goal: DY4 baseline / Reduce emergency visits for behavioral health/ substance abuse by 10% versus DY4 baseline Improvement Target : TBD Data Source: TBD Outcome Improvement Target Estimated Incentive Payment*:* $569,260

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2967606-01 3.1	*IT-9.2*	*ED Appropriate utilization – Behavioral health/ Substance abuse*	
Fort Bend County Clinical Health Services			*2967606-01*
Related Category 1 or 2 Projects:	*2967606-01 1.1*		
Starting Point/Baseline:	*TBD*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 2 Estimated Incentive Payment: $54,594	innovations Process Milestone 4 Estimated Incentive Payment $78,755 **Process Milestone 5** [P- 5]: Disseminate findings, including lessons learned and best practices, to stakeholders Metric 1: Report status, progress and lessons learned to stakeholders (4 times per year) Data Source: Minutes of meetings, report to Commissioner's Court Goal: To disseminate information about the project and solicit input from stakeholders representing consumers, families, public agencies and private providers Process Milestone 5 Estimated Incentive Payment: $78,755		
Year 2 Estimated Outcome Amount: $109,188	Year 3 Estimated Outcome Amount: $236,264	Year 4 Estimated Outcome Amount: $262,322	Year 5 Estimated Outcome Amount: $569,260
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $1,177,034			

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Title of Outcome Measure (Improvement Target): IT-1.10 Diabetes Care

Unique RHP Outcome Identification Number: 2967606-01 3.2

Outcome Measure Description:

DY2 and DY3 will focus on the Process Milestones necessary to establish and test the system prior to measuring health outcomes for the patients and cost avoidance for the program.

DY2 Process Milestones:

- P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
- P-3 Develop and test data systems

DY3 Process Milestones:

- P-2 Establish baseline rates of HbA1c in the targeted population with diabetes.
- P-4 Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities.

DY4 and DY5 Outcome Improvement Target

IT-1.10: Reduce the percentage of referred diabetic patients with HbA1c poor control (>9%)

Rationale:

The process milestones were selected to help expand a new program of Care Coordination (patient navigation) within the local FQHC. The project with involve coordination of several entities who provide care for or interact with the target population of medically indigent, uninsured or underinsured individuals in the county, particularly those who inappropriately or repeatedly use high cost medical resources for chronic conditions that could better be managed in a medical home on an outpatient basis with effective care coordination and other resource provision. The planning stage and development of a data system will be the focus of DY2. During DY3, the project will be implemented and as patients are identified and referred in to the program, baseline data, which is not currently available on the population will be gathered. At the same time, PDSA cycle evaluation will be initiated to modify the program to fit the needs of the population and the entities involved.

The focus of DY4 and DY5 will be to continue the program as designed or modified and measure the outcome change for the target population. Target change for the outcomes were developed from similar program outcomes in other locations. As a measure of the success of the program in handling chronic disease conditions in the population, one measure of positive outcome was selected, that of reduction in poor control of blood glucose levels in diabetics measured by the HbA1c level.

Outcome Measure Valuation:

Outcome valuation follows the same process as for the program metrics. Cost avoidance of EMS transport, ED visits and in-patient stays for the county indigent program if the established targets are met, to be replaced by the lower cost Care Coordination at the FQHC. The total cost avoidance value anticipated for the related category 2 project 2967606-01 2.1 is $2,997,280. This value is distributed among the initiatives and outcome measures using the RHP formulation to achieve an estimated maximum payment of $2,942,005. $2,611,029 of the total maximum payment is distributed to the category 2 project 2967606-01 2.1. The remaining

$330,976 of the maximum payment is distributed evenly among the 3 outcome measure improvement targets (IT-1.10, IT-9.2, and IT-9.4).

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2967606-01 3.2	*IT-1.10*	*Diabetes Care*	
Fort Bend County			2967606-01
Related Category 1 or 2 Projects:	**2967606-01 2.1**		
Starting Point/Baseline:	*TBD*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Documentation of activities and plans Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $5,347 **Process Milestone 2** [P-3]: Develop and test data systems Data Source: Documentation of systems and results of tests Process Milestone 2 Estimated Incentive Payment: $5,347	**Process Milestone 3** [P-2]: Establish baseline rates – of baseline HbA1c in the targeted population with diabetes. Data Source: EHR, ePCR Process Milestone 3 Estimated Incentive Payment: $7,713 **Process Milestone 4** [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities. Data Source: PDSA data and actions Process Milestone 3 Estimated Incentive Payment: $7,713 **Process Milestone 5** [P-5]: Disseminate findings, including lessons learned and best practices, to stakeholders Data Source: Reports provided Process Milestone 3 Estimated Incentive Payment: $7,714	**Outcome Improvement Target 1** [IT-1.10]: Diabetes care: HbA1c poor control (>9.0%) Baseline / Goal: DY3 baseline Improvement Target: 10% reduction from baseline Data Source: ePCR, HER Outcome Improvement Target 1 Estimated Incentive Payment*:* $25,693	**Outcome Improvement Target 2** [IT-1.10]: Diabetes care: HbA1c poor control (>9%) Baseline / Goal: DY3 baseline Improvement Target:20% reduction from baseline Data Source: ePCR, HER Outcome Improvement Target 2 Estimated Incentive Payment*:* $55,755
Year 2 Estimated Outcome Amount: $10,694	Year 3 Estimated Outcome Amount: $23,140	Year 4 Estimated Outcome Amount: $25,693	Year 5 Estimated Outcome Amount: $55,755
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $115,282			

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Title of Outcome Measure (Improvement Target): OD-9 Right Care, Right Setting - IT 9.2 – ED Appropriate Utilization / Reduce ED use in target population referred to Care Coordination Program

Unique RHP Outcome Identification Number: 2967606-01 3.3

Outcome Measure Description:

DY2 and DY3 will focus on the Process Milestones necessary to establish and test the system prior to measuring health outcomes for the patients and cost avoidance for the program.

DY2 Process Milestones:

- P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
- P-3 Develop and test data systems

DY3 Process Milestones:

- P-2 Establish baseline rates – of ED use by target population encountered and referred.
- P-4 Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities.

DY4 and DY5 Outcome Improvement Target

- IT-9.2: ED Appropriate Utilization / Reduce ED use in target population referred to Care Coordination Program

Rationale:

The process milestones were selected to help expand a new program of Care Coordination (patient navigation) within the local FQHC. The project with involve coordination of several entities who provide care for or interact with the target population of medically indigent, uninsured or underinsured individuals in the county, particularly those who inappropriately or repeatedly use high cost medical resources for non-urgent or chronic conditions that could better be managed in a medical home on an outpatient basis with effective care coordination and other resource provision. The planning stage and development of a data system will be the focus of DY2. During DY3, the project will be implemented and as patients are identified and referred in to the program, baseline data, which is not currently available on the population will be gathered. At the same time, PDSA cycle evaluation will be initiated to modify the program to fit the needs of the population and the entities involved.

The focus of DY4 and DY5 will be to continue the program as designed or modified and measure the outcome changes for the target population in terms of use of the ED. Target changes for this outcome were developed from similar program outcomes in other locations.

Outcome Measure Valuation:

Outcome valuation follows the same process as for the program metrics. Cost avoidance of EMS transport, ED visits and in-patient stays for the county indigent program if the established targets are met, to be replaced by the lower cost Care Coordination at the FQHC. The total cost avoidance value anticipated for the related category 2 project 2967606-01 2.1 is $2,997,280. This value is distributed among the initiatives and outcome measures using the RHP formulation to achieve an estimated maximum payment of $2,942,005. $2,611,029 of the total maximum payment is distributed to the category 2 project 2967606-01 2.1. The remaining $330,976 of the

maximum payment is distributed evenly among the 3 outcome measure improvement targets (IT-1.10, IT-9.2, and IT-9.4).

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2967606-01 3.3	*IT 9.2*	*Reduce ED Use*	
	Fort Bend County		**2967606-01**
Related Category 1 or 2 Projects:	**2967606-01 2.1**		
Starting Point/Baseline:	*TBD*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning **-** engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Documentation of activities and plans Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $5,347 **Process Milestone 2** [P-3]: Develop and test data systems Data Source: Documentation of systems and results of tests Process Milestone 2 Estimated Incentive Payment: $5,347	**Process Milestone 3** [P-2]: Establish baseline rates – of ED use by target population encountered and referred. Data Source: EHR, ePCR Process Milestone 3 Estimated Incentive Payment: $7,714 **Process Milestone 4** [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities. Data Source: PDSA data and actions Process Milestone 3 Estimated Incentive Payment: $7,713 **Process Milestone 5** [P-5]: Disseminate findings, including lessons learned and best practices, to stakeholders Data Source: Reports provided Process Milestone 3 Estimated Incentive Payment: $7,713	**Outcome Improvement Target 1** [IT-9.2]: ED Appropriate Utilization (Reduce ED use in target population referred to Care Coordination Program) Baseline/Goal: DY 3 ED use for target population / Improvement Target:25% reduction from baseline Data Source: ePCR, EHR Outcome Improvement Target 1 Estimated Incentive Payment*:* $25,693	**Outcome Improvement Target 1** [IT-9.2]: ED Appropriate Utilization (Reduce ED use in target population referred to Care Coordination Program) Baseline/Goal: DY 3 ED use for target population / Improvement Target:30% reduction from baseline Data Source: ePCR, EHR Outcome Improvement Target 2 Estimated Incentive Payment*:* $55,755
Year 2 Estimated Outcome Amount: $10,694	Year 3 Estimated Outcome Amount: $23,140	Year 4 Estimated Outcome Amount: $25,693	Year 5 Estimated Outcome Amount: $55,755
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $115,282			

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Title of Outcome Measure (Improvement Target): OD-9 Right Care, Right Setting - IT 9.4 – Other Outcome Improvement Target / Reduce EMS transport use in target population referred to Care Coordination Program

Unique RHP Outcome Identification Number: 2967606-01 3.4

Outcome Measure Description:

DY2 and DY3 will focus on the Process Milestones necessary to establish and test the system prior to measuring health outcomes for the patients and cost avoidance for the program.

DY2 Process Milestones:

- P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
- P-3 Develop and test data systems

DY3 Process Milestones:

- P-2 Establish baseline rates – of EMS transport use by target population encountered and referred
- P-4 Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities

DY4 and DY5 Outcome Improvement Target:

- IT-9.4: Other Outcome Improvement Target (Reduce EMS transport use in target population referred to Care Coordination Program)

Rationale:

The process milestones were selected to help expand a new program of Care Coordination (patient navigation) within the local FQHC. The project with involve coordination of several entities who provide care for or interact with the target population of medically indigent, uninsured or underinsured individuals in the county, particularly those who inappropriately or repeatedly use high cost medical resources for non-urgent or chronic conditions that could better be managed in a medical home on an outpatient basis with effective care coordination and other resource provision. The planning stage and development of a data system will be the focus of DY2. During DY3, the project will be implemented and as patients are identified and referred in to the program, baseline data, which is not currently available on the population will be gathered. At the same time, PDSA cycle evaluation will be initiated to modify the program to fit the needs of the population and the entities involved.

The focus of DY4 and DY5 will be to continue the program as designed or modified and measure the outcome change for the target population in terms of use of EMS transport. Target change for this outcome was developed from similar program outcomes in other locations.

Outcome Measure Valuation:

Outcome valuation follows the same process as for the program metrics. Cost avoidance of EMS transport, ED visits and in-patient stays for the county indigent program if the established targets are met, to be replaced by the lower cost Care Coordination at the FQHC. The total cost avoidance value anticipated for the related category 2 project 2967606-01 2.1 is $2,997,280. This value is distributed among the initiatives and outcome measures using the RHP formulation to achieve an estimated maximum payment of $2,942,005. $2,611,029 of the total maximum payment is distributed to the category 2 project 2967606-01 2.1. The remaining $330,976 of the maximum payment is distributed evenly among the 3 outcome measure improvement targets (IT-1.10, IT-9.4, and IT-9.5).

Plan for Learning Collaborative: We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region, 3 Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our region's healthcare system.

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2967606-01 3.4	*IT 9.4*	*Other Outcome Improvement Target: (Reduce EMS use in the target population)*	
Fort Bend County			**2967606**
Related Category 1 or 2 Projects:	2967606 – 2.1		
Starting Point/Baseline:	*Data not available*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Documentation of activities and plans Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $5,347 **Process Milestone 2** [P-3]: Develop and test data systems Data Source: Documentation of systems and results of tests Process Milestone 2 Estimated Incentive Payment: $5,347	**Process Milestone 3** [P-2]: Establish baseline rates – of EMS use by target population encountered and referred. Data Source: EHR, ePCR Process Milestone 3 Estimated Incentive Payment: $7,714 **Process Milestone 4** [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities. Data Source: PDSA data and actions Process Milestone 3 Estimated Incentive Payment: $7,713 **Process Milestone 5** [P-5]: Disseminate findings, including lessons learned and best practices, to stakeholders Data Source: Reports provided Process Milestone 3 Estimated Incentive Payment: $7,713	**Outcome Improvement Target 1** [IT-9.4]: Other outcome improvement target / Reduce EMS transport use in target population referred to Care Coordination Program Baseline/Goal: DY3 EMS transport use for the target population / Improvement Target:15% reduction from baseline Data Source: ePCR, HER Outcome Improvement Target 1 Estimated Incentive Payment*:* $25,693	**Outcome Improvement Target 2** [IT-9.4]: Other outcome improvement target / Reduce EMS transport use in target population referred to Care Coordination Program Baseline/Goal: DY3 EMS transport use for the target population / Improvement Target:20% reduction from baseline Data Source: ePCR, HER Outcome Improvement Target 2 Estimated Incentive Payment*:* $55,755

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<table>
<tr><td>2967606-01 3.4</td><td>IT 9.4</td><td colspan="2">Other Outcome Improvement Target: (Reduce EMS use in the target population)</td></tr>
<tr><td colspan="3">Fort Bend County</td><td>2967606</td></tr>
<tr><td>Related Category 1 or 2 Projects:</td><td colspan="3">2967606 – 2.1</td></tr>
<tr><td>Starting Point/Baseline:</td><td colspan="3">Data not available</td></tr>
<tr><td>Year 2
(10/1/2012 – 9/30/2013)</td><td>Year 3
(10/1/2013 – 9/30/2014)</td><td>Year 4
(10/1/2014 – 9/30/2015)</td><td>Year 5
(10/1/2015 – 9/30/2016)</td></tr>
<tr><td>Year 2 Estimated Outcome Amount: $10,694</td><td>Year 3 Estimated Outcome Amount: $23,140</td><td>Year 4 Estimated Outcome Amount: $25,693</td><td>Year 5 Estimated Outcome Amount: $55,755</td></tr>
<tr><td colspan="4">TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5): $115,282</td></tr>
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Fort Bend County Clinical Health Services

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Title of Outcome Measure (Improvement Target): OD-9- Right Care, Right Setting

Unique RHP Outcome Identification Number: 2967606-01 3.5
Performing Provider: Fort Bend County Clinical Health Services / 297606-01

Outcome Measure Description:
IT9.1 – Decrease in mental health admissions and readmissions to criminal justice settings (juvenile detention)

Process Milestones:
DY2: P-1
DY3: P-2, P-3
DY4: P-4, P-5
DY5: P-4, P-5
Outcome Improvement Target(s) for each year:
DY 4: IT 9.1 Admissions to juvenile detention for youth with complex behavioral health needs

- Reduce % (TBD) admissions to juvenile detention for youth with complex behavioral health needs

Dy 5: IT 9.1 Admissions to juvenile detention for youth with complex behavioral health needs
Reduce % (TBD) of admissions to juvenile detention for youth with complex behavioral health needs

Rationale: Process milestone P-1 was chosen to ensure engagement of multiple stakeholders, delineation of project timeliness and activities. Process milestones P-2 and P-3 are especially critical to the project and include definition of data to be collected, data sources, data tracking mechanisms, and establishment of baselines. The success of the FBC project will be determined by the ability to track outcomes for persons with youth with behavioral health needs who come into contact with law enforcement and are diverted into appropriate community based clinical services. The project will work with various partners in the region as well as the county's IT department to develop the most efficient data tracking system. The data will be used as part of the project's quality improvement cycle.

Process milestones P-4 and P-5 ensure continuous quality improvement, data driven decision making, identification of "lessons learned" and dissemination to stakeholders. These will allow the use of real time data for continuous quality improvement, engagement of multiple stakeholders, and identification of best practices. The need for information sharing and continuous evaluation cannot be overstated. Within the project, staff will implement the Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities. Achieving high quality outcomes depends on continuous assessment of what has been done and flexibility to apply lessons learned to the next phase of a process. The PDSA improvement process will provide for a continuous quality improvement process, which will guide decision making and timelines developed to reach milestones while delivering quality products.

Findings will need to be disseminated, including lessons learned and best practices, so that stakeholders can, in turn, provide additional input and/or validation. To achieve this feedback

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loop, the project will conduct meetings of stakeholders, project staff, RHP partners, and other key parties to gather relevant information. These stakeholder meetings will be quarterly. Stakeholder input is not only critical to the design and implementation of this project but also to its sustainability. Dissemination of our activities to the community and the various stakeholders will be critical.

The Improvement Target will be defined in DY4 and DY5 based on the data collected in DY2 and DY3. The baseline percentage will be determined in DY3. The outcome measure chosen, reduction in mental health admissions and readmissions to criminal justice settings (juvenile detention) is of great significance and directly related to the Category 2 (Fort Bend County Behavioral Health Juvenile Diversion) project. In 2011, approximately 40 to 45% of the youth "booked" into the Fort Bend County Juvenile Detention had a mental health disorder. This represents an estimated 100% increase in the last 6 years. The length of stay for youth with mental illness (average of 41 days for 2011) is 51% higher than youth without out a mental health disorder (average of 27 days). The average daily cost for treating a youth in detention facility is also significantly higher (approximately $350 per day). Juvenile probation departments and detention facilities have become the default mental health treatments centers for many youth with behavioral health disorders especially those with no insurance or Medicaid. The scarcity of appropriate clinical services for these youth and their families is a significant gap in Fort Bend County. As a result, juvenile probation, much like the adult criminal justice systems, has become the default intervention system. Yet, we know that many of these youth would achieve better outcomes if treated in community based programs with appropriate level of services. The cost effectiveness of community based programs versus incarceration has been well documented throughout the literature. The FBC BHJD project will implement and evaluate evidence based interventions for youth with complex behavioral health needs at risk of involvement in juvenile probation with the goal of improving outcomes for these youth and reducing admission to juvenile detention.

Outcome Measure Valuation:

Outcome valuation follows the same process as for the program metrics. Cost avoidance of days in Juvenile Detention if the established targets are met. The total cost avoidance value anticipated is in excess of $750,000. This value is distributed among the initiatives and outcome measures using the RHP formulation to achieve an estimated maximum payment of $750,000.

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2967606-01 3.5	*IT 9.1*	*Decrease in mental health admissions and readmission to criminal justice settings – Juvenile Behavioral Health*	
Fort Bend County Clinical Health Services			297606-01
Related Category 1 or 2 Projects:	**2967606-01 2.2**		
Starting Point/Baseline:	*TBD*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Metric: Conduct quarterly meetings of stakeholders, project staff, RHP partners and other key parties to gather relevant information Data Source: Meetings minutes, project flow charts and timelines, meeting feedback forms Goal: To gather information that guides project activities toward completion of milestones, while integrating stakeholder input in a meaningful way Process Milestone 1 Estimated Incentive Payment: $7,724 .	**Process Milestone 2** [P-2]: Establish baseline rates Metric: Number of youth referred and served by BHJD project Data Source: juvenile probation reports, booking data, law enforcement, monthly project reports Goal: Establish baseline number served in year 3. Process Milestone 2 Estimated Incentive Payment: $9,150 **Process Milestone 3** [P-3]: Develop and test data systems Metric: Review data tracking systems for target population Data Source: Project records, summary of reviews Goal: Develop data tracking systems that allow for identification of behavioral health needs and outcomes Process Milestone 3 Estimated Incentive Payment: $9,150	**Outcome Improvement Target** [IT- 9.1] decrease in incarceration Baseline/Goal: TBD / Reduce incarceration for youth with behavioral health disorders % (TBD) Metric: TBD Data Source: TBD Outcome Improvement Target Estimated Incentive Payment*: $6,602* **Process Milestone 4:** [P- 4] Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Metric: Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles Data Source: Project reports including examples of how real-time data has been used to guide continuous quality improvement Goal: To improve processes and outcomes by implementing data-driven course corrections and innovations	**Outcome Improvement Target** [IT- 9.1] decrease in incarceration Baseline/Goal: TBD / Reduce incarceration for youth with behavioral health disorders % (TBD) Metric: TBD Data Source: TBD Outcome Improvement Target Estimated Incentive Payment*:$14,300* **Process Milestone 4:** [P- 4] Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Metric: Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles Data Source: Project reports including examples of how real-time data has been used to guide continuous quality improvement Goal: To improve processes and outcomes by implementing data-driven course corrections and innovations

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2967606-01 3.5	*IT 9.1*	*Decrease in mental health admissions and readmission to criminal justice settings – Juvenile Behavioral Health*	
Fort Bend County Clinical Health Services			297606-01
Related Category 1 or 2 Projects:	**2967606-01 2.2**		
Starting Point/Baseline:	*TBD*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
		Process Milestone 4 Estimated Incentive Payment $ 6,601 **Process Milestone 5** [P- 5] Disseminate findings, including lessons learned and best practices, to stakeholders Metric: Report status, progress and lessons learned to stakeholders (4 times per year) Data Source: Minutes of meetings, report to Commissioner's Court Goal: To disseminate information about the project and solicit input from stakeholders representing consumers, families, public agencies and private providers Process Milestone 5 Estimated Incentive Payment $ 6,601	Process Milestone 4 Estimated Incentive Payment $ 14,299 **Process Milestone 5** [P- 5] Disseminate findings, including lessons learned and best practices, to stakeholders Metric: Report status, progress and lessons learned to stakeholders (4 times per year) Data Source: Minutes of meetings, report to Commissioner's Court Goal: To disseminate information about the project and solicit input from stakeholders representing consumers, families, public agencies and private providers Process Milestone 5 Estimated Incentive Payment $ 14,299
Year 2 Estimated Milestone Bundle Amount: $7,724	**Year 3 Estimated Milestone Bundle Amount: $18,300**	**Year 4 Estimated Milestone Bundle Amount: $19,804**	**Year 5 Estimated Milestone Bundle Amount: $42,898**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over DYs 2-5):* $88,726			

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Title of Outcome Measure (Improvement Target): IT 9.2 – ED Appropriate Utilization / Reduce ED use in target population managed by the Community Paramedic Program

Unique RHP Outcome Identification Number: 2967606-01 3.6 / Pass 2

Performing Provider: Fort Bend County Clinical Health Services / 297606-01

Outcome Measure Description:

DY2 will focus on the Process Milestones necessary to establish and test the system prior to measuring number of successful interventions for the patients and cost avoidance for the program.

DY2 Process Milestones:

P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans

P-3 Develop and test data systems

DY3 Process Milestones:

P-2 Establish baseline rates – of projected ED use by target population encountered.

P-4 Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities.

DY4 and DY5 Outcome Improvement Target

IT-9.2: ED Appropriate Utilization / Reduce ED use in target population managed by the Community Paramedic Program.

Rationale:

The process milestones were selected to establish a Community Paramedic Program in Fort Bend County. The project will involve coordination of several entities who provide care for or interact with the target population of medically indigent, uninsured or underinsured individuals in the county, particularly those who inappropriately or repeatedly use high cost medical resources for non-urgent or chronic conditions. The planning stage and development of a data system will be the focus of DY2. During DY3, the project will be implemented and as patients are identified and managed by the program, baseline data, which is not currently available on the population will be gathered. At the same time, PDSA cycle evaluation will be initiated to modify the program to fit the needs of the population and the entities involved.

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The focus of DY4 and DY5 will be to continue the program as designed or modified and measure the outcome changes for the target population in terms of use of the ED. Target changes for this outcome were developed from similar program outcomes in other locations.

Outcome Measure Valuation:

Outcome valuation follows the same process as for the program metrics. Cost avoidance of EMS transport, ED visits and in-patient stays for the county indigent program will be attained if the established targets are met The total cost avoidance value anticipated for the related category 2 project is $1.4 million. This value is distributed among the initiatives and outcome measures using the RHP formulation to achieve an estimated maximum payment of $750,000.

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<table>
<tr><td>2967606-01 3.6</td><td>IT 9.2</td><td colspan="2">ED Appropriate Utilization</td></tr>
<tr><td colspan="3">Fort Bend County</td><td>2967606-01</td></tr>
<tr><td>Related Category 1 or 2 Projects:</td><td colspan="3">2967606-01 2.3</td></tr>
<tr><td>Starting Point/Baseline:</td><td colspan="3">TBD</td></tr>
<tr><th>Year 2
(10/1/2012 – 9/30/2013)</th><th>Year 3
(10/1/2013 – 9/30/2014)</th><th>Year 4
(10/1/2014 – 9/30/2015)</th><th>Year 5
(10/1/2015 – 9/30/2016)</th></tr>
<tr><td>Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
Data Source: Documentation of activities and plans

Process Milestone 1 Estimated Incentive Payment (maximum amount): $1,931

Process Milestone 2 [P-3]: Develop and test data systems
Data Source: Documentation of systems and results of tests

Process Milestone 2 Estimated Incentive Payment: $1,931</td><td>Process Milestone 3 [P-2] Establish baseline rates – of projected ED use by target population encountered.
Data Source: EHR, ePCR

Process Milestone 3 Estimated Incentive Payment: $3,050

Process Milestone 4 [P-4] Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities.
Data Source: PDSA data and actions

Process Milestone 3 Estimated Incentive Payment: $3,050

Process Milestone 5 [P-5
Disseminate findings, including lessons learned and best practices, to stakeholders
Data Source: Reports provided

Process Milestone 3 Estimated Incentive Payment: $3,050</td><td>Outcome Improvement Target 1
[IT-9.2]: ED Appropriate Utilization (Reduce ED use in target population managed by the Community Paramedic Program)
Baseline/Goal: DY 3 ED projected use for target population / Improvement Target:25% reduction from baseline
Data Source: ePCR, EHR

Outcome Improvement Target 1 Estimated Incentive Payment: $9,902</td><td>Outcome Improvement Target 1
[IT-9.2]: ED Appropriate Utilization (Reduce ED use in target population managed by the Community Paramedic Program)
Baseline/Goal: DY 3 ED use for target population / Improvement Target:30% reduction from baseline
Data Source: ePCR, EHR

Outcome Improvement Target 2 Estimated Incentive Payment: $21,449</td></tr>
<tr><td>Year 2 Estimated Outcome Amount: $3,862</td><td>Year 3 Estimated Outcome Amount: $9,150</td><td>Year 4 Estimated Outcome Amount: $9,902</td><td>Year 5 Estimated Outcome Amount: $21,449</td></tr>
<tr><td colspan="4">TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5): $44,363</td></tr>
</table>

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Title of Outcome Measure (Improvement Target): IT 9.4 – Other Outcome Improvement Target / Reduce EMS transport use in target population managed by the Community Paramedic Program

Unique RHP Outcome Identification Number: 2967606-01 3.7 / Pass 2

Performing Provider: Fort Bend County Clinical Health Services / 297606-01

Outcome Measure Description:

DY2 will focus on the Process Milestones necessary to establish and test the system prior to measuring number of successful interventions for the patients and cost avoidance for the program.

DY2 Process Milestones:

P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans

P-3 Develop and test data systems

DY3 Process Milestones:

P-2 Establish baseline rates – of projected ED use by target population encountered.

P-4 Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities.

DY4 and DY5 Outcome Improvement Target

IT-9.2: ED Appropriate Utilization / Reduce EMS transport use in target population managed by the Community Paramedic Program.

Rationale:

The process milestones were selected to establish a Community Paramedic Program in Fort Bend County. The project will involve coordination of several entities who provide care for or interact with the target population of medically indigent, uninsured or underinsured individuals in the county, particularly those who inappropriately or repeatedly use high cost medical resources for non-urgent or chronic conditions. The planning stage and development of a data system will be the focus of DY2. During DY3, the project will be implemented and as patients are identified and managed by the program, baseline data, which is not currently available on the population will be gathered. At the same time, PDSA cycle evaluation will be initiated to modify the program to fit the needs of the population and the entities involved.

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The focus of DY4 and DY5 will be to continue the program as designed or modified and measure the outcome changes for the target population in terms of use of the ED. Target changes for this outcome were developed from similar program outcomes in other locations.

Outcome Measure Valuation:

Outcome valuation follows the same process as for the program metrics. Cost avoidance of EMS transport, ED visits and in-patient stays for the county indigent program will be attained if the established targets are met The total cost avoidance value anticipated for the related category 2 project is $1.4 million. This value is distributed among the initiatives and outcome measures using the RHP formulation to achieve an estimated maximum payment of $750,000.

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2967606-01 3.7	*IT 9.4*	**Other Outcome Improvement Target (Reduce EMS transport use in the target population)**	
Fort Bend County			**2967606-01**
Related Category 1 or 2 Projects:	**2967606-01 – 2.3**		
Starting Point/Baseline:	*TBD*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Documentation of activities and plans Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $1,931 **Process Milestone 2** [P-3]: Develop and test data systems Data Source: Documentation of systems and results of tests Process Milestone 2 Estimated Incentive Payment: $1,931	**Process Milestone 3 [P-2]** Establish baseline rates – of projected EMS transport use by target population encountered. Data Source: EHR, ePCR Process Milestone 3 Estimated Incentive Payment: $3,050 **Process Milestone 4 [P-4]** Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities. Data Source: PDSA data and actions Process Milestone 4 Estimated Incentive Payment: $3,050 **Process Milestone 5 [P-5** Disseminate findings, including lessons learned and best practices, to stakeholders Data Source: Reports provided Process Milestone 5 Estimated Incentive Payment: $3,050	**Outcome Improvement Target 1** [IT-9.4]: Other outcome improvement target / Reduce EMS transport use in target population managed by the Community Paramedic Program Baseline/Goal: DY3 EMS transport use for the target population / Improvement Target:25% reduction from baseline Data Source: ePCR, EHR Outcome Improvement Target 1 Estimated Incentive Payment: $9,902	**Outcome Improvement Target 2** [IT-9.4]: Other outcome improvement target / Reduce EMS transport use in target population managed by the Community Paramedic Program Baseline/Goal: DY3 EMS transport use for the target population / Improvement Target:30% reduction from baseline Data Source: ePCR, EHR Outcome Improvement Target 2 Estimated Incentive Payment: *$21,449*
Year 2 Estimated Outcome Amount: $3,862	Year 3 Estimated Outcome Amount: $9,150	Year 4 Estimated Outcome Amount: $9,902	Year 5 Estimated Outcome Amount: $21,449
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $44,363			

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Title of Outcome Measure (Improvement Target): IT-6.1 Patient Experience with Access to Specialist, Shared Decision Making

Unique RHP Outcome Identification Number: 2967606-01 3.8 / Pass 2

Performing Provider: Fort Bend County Clinical Health Services / 297606-01

Outcome Measure Description:

DY2 and part of DY3 will focus on the Process Milestones and baseline data gathering necessary to establish and test the system prior to measuring patient satisfaction with the increased screenings and access to specialty care.

DY2 Process Milestones:

P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans

P-3 Develop and test data systems

DY3 Process Milestones:

P-2 Establish baseline rates of colonoscopy screening in the targeted population.

P-4 Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities.

DY4 and DY5 Outcome Improvement Target:

IT-6.1: Patient Experience with Access to Specialist, Shared Decision Making

Rationale:

The process milestones were selected to help establish a colonoscopy screening program for the prevention and early detection of colorectal cancer. The project will involve coordination of several entities who provide care for or interact with the target population of medically indigent, uninsured or underinsured individuals in the county. The planning stage and development of a data system will be the focus of DY2.

The outcome measure of patient satisfaction was selected to determine the acceptance and satisfaction of the program in the targeted population. Baseline experience with access to specialists and shared decision making using the CG-CAHPS survey will be undertaken for the target population in DY2. During DY3, the project will be implemented, and at the same time, PDSA cycle evaluation will be initiated to modify the program to fit the needs of the population and the entities involved. The focus of DY4 and DY5 will be to continue the program as

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designed or modified and measure the experience of the target population after program implementation.

Outcome Measure Valuation:

Outcome valuation follows the same process as for the program metrics. Cost avoidance of colorectal cancer treatment costs for the county indigent program if the established targets are met, to be replaced by the lower cost colonoscopy screening and cancer prevention procedures. The total cost avoidance value anticipated for the related category 2 project 2967606-01 2.2 is $660,000. This value is distributed among the initiatives and outcome measures using the RHP formulation to achieve an estimated maximum payment of $539,044.

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2967606-01 3.8	*IT-6.1*	**Patient Satisfaction: Access to Specialists, and Shared Decision Making**	
Fort Bend County			**2967606-01**
Related Category 1 or 2 Projects:	**2967606-01 2.4**		
Starting Point/Baseline:	*TBD*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Documentation of activities and plans Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $926 **Process Milestone 2** [P-3]: Develop and test data systems Data Source: Documentation of systems and results of tests Process Milestone 2 Estimated Incentive Payment: $925 **Process Milestone 3** [P-2] Establish baseline patient satisfaction with access to specialists and with shared decision making using the CG-CAHPS survey components in the targeted population. Data Source: EHR, ePCR, Survey Process Milestone 3 Estimated Incentive Payment: $925	**Process Milestone 4** [P-4] Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities. Data Source: PDSA data and actions Process Milestone 4 Estimated Incentive Payment: $3,288 **Process Milestone 5** [P-5] Disseminate findings, including lessons learned and best practices, to stakeholders Data Source: Reports provided Process Milestone 5 Estimated Incentive Payment: $3,288	**Outcome Improvement Target 1** [IT-6.1]: Increased patient satisfaction with their experience with access to specialist and with shared decision making Baseline / Goal: DY2 baseline / Improvement Target: 20% increase from baseline Data Source: EHR, survey Outcome Improvement Target 1 Estimated Incentive Payment: $7,116	**Outcome Improvement Target 2** [IT-6.1]: Increased patient satisfaction with their experience with access to specialist and with shared decision making Baseline / Goal: DY2 baseline / Improvement Target: 40% increase from baseline Data Source: EHR, survey Outcome Improvement Target 1 Estimated Incentive Payment: $15,416

2967606-01 3.8	*IT-6.1*	**Patient Satisfaction: Access to Specialists, and Shared Decision Making**	
Fort Bend County			**2967606-01**
Related Category 1 or 2 Projects:	**2967606-01 2.4**		
Starting Point/Baseline:	*TBD*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Year 2 Estimated Outcome Amount: $2,776	Year 3 Estimated Outcome Amount: $6,576	Year 4 Estimated Outcome Amount: $7,116	Year 5 Estimated Outcome Amount: $15,416
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $31,884			

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Title of Outcome Measure (Improvement Target): IT 12.3 – Colorectal Cancer Screening

Unique RHP Outcome Identification Number: 2967606-01 3.9 / Pass 2

Performing Provider: Fort Bend County Clinical Health Services / 297606-01

Outcome Measure Description:

DY2 and part of DY3 will focus on the Process Milestones necessary to establish and test the system prior to measuring increased screening and results for the patients and cost avoidance for the program.

DY2 Process Milestones:

P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans

P-3 Develop and test data systems

P-2 Establish Baseline Rates of Colonoscopy Screening in the target population

DY3 Process Milestones:

P-4 Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities.

DY3 Outcome Improvement Target:

IT 12.3 – Colorectal Cancer Screening

DY4 and DY5 Outcome Improvement Target:

IT 12.3 – Colorectal Cancer Screening

Rationale:

The process milestones were selected to help expand a new program of colorectal cancer screening in the uninsured and underinsured population of Fort Bend County. The project with involve coordination of several entities who provide care for or interact with the target population of medically indigent, uninsured or underinsured individuals in the county. The planning stage and development of a data system will be the focus of DY2, and rates of colonoscopy screening in the population will be measured. The program will be implemented in DY3. At the same time, PDSA cycle evaluation will be initiated to modify the program to fit the needs of the population and the entities involved.

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The focus of DY4 and DY5 will be to continue the program as designed or modified and measure the outcome change for the target population. The outcome measure is the proportion of the target population screened for colorectal cancer using a colonoscopy.

Outcome Measure Valuation:

Outcome valuation follows the same process as for the program metrics. Cost avoidance of colorectal cancer treatment costs for the county indigent program if the established targets are met, to be replaced by the lower cost colonoscopy screening and cancer prevention procedures. The total cost avoidance value anticipated for the related category 2 project 2967606-01 2.2 is $600,000. This value is distributed among the initiatives and outcome measures using the RHP formulation to achieve an estimated maximum payment of 539,044.

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2967606-01 3.9	*IT-12.3*	**Colorectal Screening**	
Fort Bend County			**2967606-01**
Related Category 1 or 2 Projects:	**2967606-01 2.4**		
Starting Point/Baseline:	*TBD*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Documentation of activities and plans Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $925 **Process Milestone 2** [P-3]: Develop and test data systems Data Source: Documentation of systems and results of tests Process Milestone 2 Estimated Incentive Payment: $925 **Process Milestone 3** [P-2] Establish baseline rates of colonoscopy screening in the targeted population. Data Source: EHR, survey Process Milestone 3 Estimated Incentive Payment: $925	**Process Milestone 4** [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities. Data Source: PDSA data and actions Process Milestone 4 Estimated Incentive Payment: $2,192 **Process Milestone 5** [P-5]: Disseminate findings, including lessons learned and best practices, to stakeholders Data Source: Reports provided Process Milestone 5 Estimated Incentive Payment: $2,192 **Outcome Improvement Target 1** [IT-12.3]: Colorectal Cancer Screening Baseline / Goal: DY2 baseline / Improvement Target: 25% increase from baseline Data Source: EHR, records of referrals and appointments Outcome Improvement Target 1 Estimated Incentive Payment: $2,192	**Outcome Improvement Target 2** [IT-12.3]: Colorectal Cancer Screening Baseline / Goal: DY2 baseline / Improvement Target: 50% increase from baseline Data Source: EHR, records of referrals and appointments Outcome Improvement Target 2 Estimated Incentive Payment: $7,116	**Outcome Improvement Target 3** [IT-12.3]: Colorectal Cancer Screening Baseline / Goal: DY2 baseline / Improvement Target: 100% increase from baseline Data Source: EHR, records of referrals and appointments Outcome Improvement Target 2 Estimated Incentive Payment: $15,416

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<table>
<tr><td>2967606-01 3.9</td><td>IT-12.3</td><td colspan="2">Colorectal Screening</td></tr>
<tr><td colspan="3">Fort Bend County</td><td>2967606-01</td></tr>
<tr><td>Related Category 1 or 2 Projects:</td><td colspan="3">2967606-01 2.4</td></tr>
<tr><td>Starting Point/Baseline:</td><td colspan="3">TBD</td></tr>
<tr><td>Year 2
(10/1/2012 – 9/30/2013)</td><td>Year 3
(10/1/2013 – 9/30/2014)</td><td>Year 4
(10/1/2014 – 9/30/2015)</td><td>Year 5
(10/1/2015 – 9/30/2016)</td></tr>
<tr><td>Year 2 Estimated Outcome Amount: $2,776</td><td>Year 3 Estimated Outcome Amount: $6,576</td><td>Year 4 Estimated Outcome Amount: $7,116</td><td>Year 5 Estimated Outcome Amount: $15,416</td></tr>
<tr><td colspan="4">TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5): $44,363</td></tr>
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Fort Bend County Clinical Health Services

Pass 3

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Title of Outcome Measure (Improvement Target): OD-1 – Primary Care and Chronic Disease Management / IT 1.1 – Third Next Available Appointment

Unique RHP Outcome Identification Number: 2967606-01 3.10 / Pass 3

Outcome Measure Description:

DY2 and DY3 will focus on the Process Milestones necessary to establish and test the system prior to measuring access outcomes for the patients and cost avoidance for the program.

DY2 Process Milestones:

- P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
- P-3 Develop and test data systems

DY3 Process Milestones:

- P-2 Establish baseline rates – of third next available appointment for the target population.
- P-4 Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities.

DY4 and DY5 Outcome Improvement Target

- IT-1.1: Third Next Available Appointment

Rationale:

The process milestones were selected to help expand the hours of operation within the local FQHC. The project will involve staffing a new care team of medical providers and support staff to allow for standard 7am to 7pm hours on weekdays and to include Saturday hours. Promotion of the hours and referral for use will take coordination with several entities who provide care for or interact with the target population of medically indigent, uninsured or underinsured individuals in the county, particularly those patients who inappropriately or repeatedly use high cost medical resources for non-urgent or chronic conditions that could better be managed in a medical home on an outpatient basis with effective care coordination and other resource provision. The planning stage and development of a data system will be the focus of DY2. During DY3, the project will be implemented and as patients are identified and referred to the program, baseline data, which is not currently available on the population will be gathered. At the same time, PDSA cycle evaluation will be initiated to modify the program to fit the needs of the population and the entities involved.

The focus of DY4 and DY5 will be to continue the expanded hours as initiated in DY3 and to measure the change for the target population in terms of third next available appointment.

Outcome Measure Valuation:

Outcome valuation follows the same process as for the program metrics. Cost avoidance of EMS transport, ED visits and in-patient stays for the county indigent program if the established targets are met, to be replaced by the lower cost Care Coordination at the FQHC. The total cost avoidance value anticipated for the related category 1 project 2967606-01 1.2 is $2,195,200. This value is distributed among the initiatives and outcome measures using the RHP formulation to achieve an estimated maximum payment of $2,100,000. $1,855,899 of the total maximum payment is distributed to the category 1 project 2967606-01 1.2. The remaining $249,101 of the maximum payment is distributed evenly among the 3 outcome measure improvement targets (IT-1.1, and IT-9.2).

2967606-01 3.10	*IT-1.1*	*Third Next Available Appointment*	
	Fort Bend County		**2967606-01**
Related Category 1 or 2 Projects:	**2967606-01 1.2**		
Starting Point/Baseline:	*TBD*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning **-** engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Documentation of activities and plans Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $5,331 **Process Milestone 2** [P-3]: Develop and test data systems Data Source: Documentation of systems and results of tests Process Milestone 2 Estimated Incentive Payment: $5,330	**Process Milestone 3** [P-2]: Establish baseline rates – of third next available appointment. Data Source: EHR, ePCR Process Milestone 3 Estimated Incentive Payment: $8,517 **Process Milestone 4** [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities. Data Source: PDSA data and actions Process Milestone 3 Estimated Incentive Payment: $8,516 **Process Milestone 5** [P-5]: Disseminate findings, including lessons learned and best practices, to stakeholders Data Source: Reports provided Process Milestone 3 Estimated Incentive Payment: $8,516	**Outcome Improvement Target 1** [IT-1.1]: Third next available appointment(Reduce average length of time in days between the day a patient makes a request for an appointment with a physician and the third available appointment for a new patient physical, routine exam, or return visit exam) Baseline/Goal: DY 3 third next available appointment for target population / Improvement Target:10% reduction from baseline (DY3) Data Source: ePCR, EHR Outcome Improvement Target 1 Estimated Incentive Payment*:* $27,920	**Outcome Improvement Target 1** [IT-1.1]: Third next available appointment(Reduce average length of time in days between the day a patient makes a request for an appointment with a physician and the third available appointment for a new patient physical, routine exam, or return visit exam) Baseline/Goal: DY 3 third next available appointment for target population / Improvement Target:20% reduction from baseline (DY3) Data Source: ePCR, EHR Outcome Improvement Target 1 Estimated Incentive Payment*:* $60,422
Year 2 Estimated Outcome Amount: $10,661	Year 3 Estimated Outcome Amount: $25,549	Year 4 Estimated Outcome Amount: $27,920	Year 5 Estimated Outcome Amount: $60,422
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $124,552			

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Title of Outcome Measure (Improvement Target): OD-9 Right Care, Right Setting - IT 9.2 – ED Appropriate Utilization / Reduce ED use in target population referred to Care Coordination Program

Unique RHP Outcome Identification Number: 2967606-01 3.11

Outcome Measure Description:

DY2 and DY3 will focus on the Process Milestones necessary to establish and test the system prior to measuring health outcomes for the patients and cost avoidance for the program.

DY2 Process Milestones:

- P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
- P-3 Develop and test data systems

DY3 Process Milestones:

- P-2 Establish baseline rates – of ED use by target population encountered and referred.
- P-4 Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities.

DY4 and DY5 Outcome Improvement Target

- IT-9.2: ED Appropriate Utilization / Reduce ED use in target population referred to Care Coordination Program

Rationale:

The process milestones were selected to help expand the hours of operation within the local FQHC. The project will involve staffing a new care team of medical providers and support staff to allow for standard 7am to 7pm hours on weekdays and to include Saturday hours. Promotion of the hours and referral for use will take coordination with several entities who provide care for or interact with the target population of medically indigent, uninsured or underinsured individuals in the county, particularly those patients who inappropriately or repeatedly use high cost medical resources for non-urgent or chronic conditions that could better be managed in a medical home on an outpatient basis with effective care coordination and other resource provision. The planning stage and development of a data system will be the focus of DY2. During DY3, the project will be implemented and as patients are identified and referred to the program, baseline data, which is not currently available on the population will be gathered. At the same time, PDSA cycle evaluation will be initiated to modify the program to fit the needs of the population and the entities involved.

The focus of DY4 and DY5 will be to continue the expanded hours as initiated in DY3 and to measure the change for the target population in terms of use of the ED. Target changes for this outcome were developed from similar program outcomes in other locations.

Outcome Measure Valuation:

Outcome valuation follows the same process as for the program metrics. Cost avoidance of EMS transport, ED visits and in-patient stays for the county indigent program if the established targets are met, to be replaced by the lower cost Care Coordination at the FQHC. The total cost avoidance value anticipated for the related category 1 project 2967606-01 1.2 is $2,195,200. This value is distributed among the initiatives and outcome measures using the RHP formulation

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to achieve an estimated maximum payment of $2,100,000. $1,855,899 of the total maximum payment is distributed to the category 1 project 2967606-01 1.2. The remaining $249,101 of the maximum payment is distributed evenly among the 3 outcome measure improvement targets (IT-1.1, and IT-9.2).

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2967606-01 3.11	*IT 9.2*	*Reduce ED Use*	
Fort Bend County			**2967606-01**
Related Category 1 or 2 Projects:	**2967606-01 1.2**		
Starting Point/Baseline:	*TBD*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning **-** engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Documentation of activities and plans Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $5,330 **Process Milestone 2** [P-3]: Develop and test data systems Data Source: Documentation of systems and results of tests Process Milestone 2 Estimated Incentive Payment: $5,330	**Process Milestone 3** [P-2]: Establish baseline rates – of ED use by target population encountered and referred. Data Source: EHR, ePCR Process Milestone 3 Estimated Incentive Payment: $8,517 **Process Milestone 4** [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities. Data Source: PDSA data and actions Process Milestone 3 Estimated Incentive Payment: $8,516 **Process Milestone 5** [P-5]: Disseminate findings, including lessons learned and best practices, to stakeholders Data Source: Reports provided Process Milestone 3 Estimated Incentive Payment: $8,516	**Outcome Improvement Target 1** [IT-9.2]: ED Appropriate Utilization (Reduce ED use in target population after establishment of expanded clinic hours) Baseline/Goal: DY 3 ED use for target population / Improvement Target:25% reduction from baseline Data Source: ePCR, EHR Outcome Improvement Target 1 Estimated Incentive Payment*:* $27,919	**Outcome Improvement Target 1** [IT-9.2]: ED Appropriate Utilization (Reduce ED use in target population after establishment of expanded clinic hours) Baseline/Goal: DY 3 ED use for target population / Improvement Target:30% reduction from baseline Data Source: ePCR, EHR Outcome Improvement Target 2 Estimated Incentive Payment*:* $60,421
Year 2 Estimated Outcome Amount: $10,660	Year 3 Estimated Outcome Amount: $25,549	Year 4 Estimated Outcome Amount: $27,919	Year 5 Estimated Outcome Amount: $60,421
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $124,549			

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Gulf Bend

Pass 2

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Title of Outcome Measure (Improvement Target):
OD-2 Potentially Preventable Admissions, IT-2.4 Behavioral Health/Substance Abuse Admission Rate

Unique RHP outcome identification number: 1352544-07.3.1/Pass 2
Performing provider/TPI: Gulf Bend Center/135254407

Outcome Measure Description:
The related Category 3 outcome improvement measure chosen for the Gulf Bend Person-Centered Behavioral Health Medical Home project is OD-2 Potentially Preventable Admissions, specifically IT-2.4 Behavioral Health/Substance Abuse Admission Rate including the following:

1. One for BH/SA as the principal diagnosis
2. A second category in which a significant BH/SA secondary diagnosis is present (e.g. reduction in admission rate with a primary diagnosis of asthma/diabetes/COPD with a secondary diagnosis of mood/affective disorders.

Through this project Gulf Bend expects to decrease admissions due to asthma, depression, and diabetes with an underlying or co-existing mental health disorder by 10% by the end of DY 5.

Outcome Improvement Targets for each year:

Rationale:
Process milestones P-1 through P-3 were chosen so we can establish a detailed project plan including identifying current capacity and needed resources and baseline information in which to effectively manage and monitor the project. Gulf Bend expects to see a decrease in the admission rates as described above bydeveloping and implementing the Person-Centered Behavioral Health Medical Home. Targeting at risk populations with co-morbid diseases of mental illness and chronic disease who currently go untreated or under treated and who routinely access more intensive and costly services such as emergency departments, inpatient hospitals or jails and through this outcome measure we expect to see the success of a reduction in hospital admissions with a primary diagnosis of chronic disease and a secondary diagnosis of behavioral health.

Outcome Measure Valuation:
Due to the high number of admissions to the local hospitals due to co-occurring mood/affective disorders and chronic co-morbid disease, Gulf Bend feels that an initial decrease for all three admissions by 20% by the end of DY 5 is a great starting point. This could lead to an overall savings of $3,249,179 in just one year. These numbers may seem low, but this is because the integration of primary care and behavioral health services is new to the area. It will take time for patients to take full advantage of the integrated services offered by Gulf Bend.

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<table>
<tr><td>1352544-07.3.1</td><td>IT-2.4</td><td colspan="2">OD-2 Potentially Preventable Admissions</td></tr>
<tr><td colspan="3">Gulf Bend</td><td>1352544-07</td></tr>
<tr><td>Related Category 1 or 2 Projects:</td><td colspan="3">1352544-07.2.1</td></tr>
<tr><td>Starting Point/Baseline:</td><td colspan="3">Behavioral Health Admission rate with co-occurring chronic disease</td></tr>
<tr><th>Year 2
(10/1/2012 – 9/30/2013)</th><th>Year 3
(10/1/2013 – 9/30/2014)</th><th>Year 4
(10/1/2014 – 9/30/2015)</th><th>Year 5
(10/1/2015 – 9/30/2016)</th></tr>
<tr><td>Process Milestone 1 P-1 Project planning- engage stakeholders, identify current capacity and need resources, determine timelines and document implementation plans
Baseline/Goal: 54 admissions due to COPD, and 48 admissions due to diabetes with roughly 29% of each patient population having a co-occurring mental illness or behavioral health illness
Data Source: Encounter data, claims, hospital records

Process Milestone 1 Estimated Incentive Payment: 25,000

Process Milestone 2 P-2 Establish baseline rates
Data Source: Encounter data, claims, hospital records

Process Milestone 2 Estimated Incentive Payment: $25,000</td><td>Process Milestone 3 P-3 Develop and test data systems
Data Source: Information from discussions/interviews to understand current systems and then establish most effective systems for the project

Process Milestone 3 Estimated Incentive Payment (maximum amount): $100,000</td><td>Outcome Improvement Target 1
IT-2.4
Reduction in hospital admissions with primary diagnosis of chronic disease and secondary diagnosis of behavioral health by 10%
Data Source: Hospital EHR records, discharge data

Outcome Improvement Target 1 Estimated Incentive Payment: $125,000</td><td>Outcome Improvement Target 2
IT-2.4
Reduction in hospital admissions with primary diagnosis of chronic disease and secondary diagnosis of behavioral health by 20%
Data Source: Hospital EHR records, discharge data

Outcome Improvement Target 2 Estimated Incentive Payment: $125,000</td></tr>
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<table>
<tr><td>1352544-07.3.1</td><td>IT-2.4</td><td colspan="2">OD-2 Potentially Preventable Admissions</td></tr>
<tr><td colspan="3">Gulf Bend</td><td>1352544-07</td></tr>
<tr><td>Related Category 1 or 2 Projects:</td><td colspan="3">1352544-07.2.1</td></tr>
<tr><td>Starting Point/Baseline:</td><td colspan="3">Behavioral Health Admission rate with co-occurring chronic disease</td></tr>
<tr><td>Year 2
(10/1/2012 – 9/30/2013)</td><td>Year 3
(10/1/2013 – 9/30/2014)</td><td>Year 4
(10/1/2014 – 9/30/2015)</td><td>Year 5
(10/1/2015 – 9/30/2016)</td></tr>
<tr><td>Year 2 Estimated Outcome Amount: $50,000</td><td>Year 3 Estimated Outcome Amount: $100,000</td><td>Year 4 Estimated Outcome Amount: $100,000</td><td>Year 5 Estimated Outcome Amount: $200,000</td></tr>
<tr><td colspan="4">TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5):$ 450,000</td></tr>
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Gulf Coast Medical Center

Pass 1

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Title of Outcome Measure (Improvement Target): IT-1.18 Follow up after Hospitalization for Mental Illness-NFQ 0576

Unique RHP Outcome Identification Number: 178815001.3.1

Outcome Measure Description:

IT-1.18

- Rate 1: An outpatient visit, intensive outpatient encounter or partial hospitalization with a mental health practitioner within 30 days after discharge.
- Rate 2: An outpatient visit, intensive outpatient encounter or partial hospitalization with a mental health practitioner within 7 days after discharge.

Process Milestones:

- DY 2: P-1; P-2; P-3
- DY 3: P-5

Outcome Improvement Target(s) for each Year:

- DY 4
  - IT-1.18 Increase in percentage of patients with follow up care after hospitalization for Mental Illness

  Rate 1: An outpatient visit, intensive outpatient encounter or partial hospitalization with a mental health practitioner within 30 days after discharge.

  Rate 2: An outpatient visit, intensive outpatient encounter or partial hospitalization with a mental health practitioner within 7 days after discharge.
- DY 5
  - IT-1.18 Increase in percentage of patients with follow up care after hospitalization for Mental Illness

  Rate 1: An outpatient visit, intensive outpatient encounter or partial hospitalization with a mental health practitioner within 30 days after discharge.

  Rate 2: An outpatient visit, intensive outpatient encounter or partial hospitalization with a mental health practitioner within 7 days after discharge.

Rationale:

Process Milestone P-1, P-2 and P-3 were chosen to establish a foundation for the establishment of an inpatient adult psychiatric unit and consideration for an outpatient center for follow up care. The focus was to ensure that an initial timely response to a potential need for psychiatric care was addressed. Delay in treatment in the care of an individual with mental illness may result in adverse outcomes. During DY 2 a baseline will be established and DY 3, 4, and 5 has a percentage increase annually to complete admission process from time of referral to arrival on unit.

Improvement targets were placed in DY 3, DY 4 and DY 5 based upon the timeframe allowed to put in place the proper education/training and process implementation. Although all

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the overall goal is to ensure that individuals within the county, and surrounding counties ~~and the military~~ have expedited access to mental health care and receive quality inpatient care for the treatment of mental disorders it is of utmost importance that when patients move to the next continuum (discharge) treatment continues on an outpatient basis to ensure compliance with the treatment plan thus preventing readmissions. Patients in the project will need to be followed over time. Based upon the need to ensure compliance on an outpatient basis regarding the treatment plan established for the patient while hospitalized, follow up after hospitalization for mental illness is a targeted improvement outcome.

<u>Outcome Measure Valuation:</u>

Areas considered when allocating funds for this project included the importance of ensuring individuals within Wharton County and the surrounding rural areas ~~as well as the military~~ the care needed with regard to mental disorders. A 28 bed inpatient adult psychiatric unit would allow individual's timely access to care for mental disorders whereas currently delay in care is experienced frequently as bed availability is limited and waiting lists for beds are being utilized. In addition, upon discharge from an inpatient psychiatric follow up care by a mental health practitioner is of utmost importance to ensure that the patient remains compliant with his/her treatment plan to ensure a positive outcome with their care and prevent readmissions.

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<table>
<tr><td>178815001.3.1</td><td>IT 1.18</td><td colspan="2">Follow up after Hospitalization for Mental Illness NGQ 0576</td></tr>
<tr><td colspan="3">Gulf Coast Medical Center</td><td>178815001</td></tr>
<tr><td>Related Category 1 or 2 Projects:</td><td colspan="3">178815001.1.1</td></tr>
<tr><td>Starting Point/Baseline:</td><td colspan="3">Data Not Available</td></tr>
<tr><th>Year 2
(10/1/2012 – 9/30/2013)</th><th>Year 3
(10/1/2013 – 9/30/2014)</th><th>Year 4
(10/1/2014 – 9/30/2015)</th><th>Year 5
(10/1/2015 – 9/30/2016)</th></tr>
<tr><td>Process Milestone 1 [P-1]: Project planning –engage stakeholders, identify current capacity and needed resources, determine timeliness and document implementation plan.
Data Source: Potential management company documentation, AIA architect

Process Milestone 1 Estimated Incentive Payment (maximum amount): $56,716.67

Process Milestone 2 [P-2]: Establish baselines.
Data Source: Claims, EHR

Process Milestone 2 Estimated Incentive Payment: $56,716.67

Process Milestone 3 [P-3]: Develop and test systems.
Data Source: Data systems

Milestone 3 Estimated Incentive Payment: $56,716.67</td><td>Process Milestone 4 [P-5] Disseminate findings including lessons learned and best practices to stakeholders.
Data Source: Documented findings.

Process Milestone 4 Estimated Incentive Payment: $68,785.50

Outcome Improvement Target 1 [IT-1.18]:Follow up After Hospitalization for Mental Illness
Improvement Target: Establish baseline rate for follow up with mental health practitioner within 30 days (rate 1) and within 7 days (rate2) after hospitalization
Data Source: Reports and hospital generated data

Outcome Improvement Target 2 Estimated Incentive Payment: $68,785.50</td><td>Outcome Improvement Target 2 [IT 1.18]:Follow up After Hospitalization for Mental Illness
Baseline/Goal: DY 3
Improvement Target: Improve follow up rate/s with mental health practitioner within 30 days (rate 1) and within 7 days (rate2) after hospitalization by 5%
Data Source: Reports and hospital generated data.

Outcome Improvement Target 2 Estimated Incentive Payment: $214,611</td><td>Outcome Improvement Target 3 [IT 1.18]:Follow up After Hospitalization for Mental Illness
Baseline/Goal: DY 3
Improvement Target: Improve follow up rate/s with mental health practitioner within 30 days (rate 1) and within 7 days (rate2) after hospitalization by 10%.
Data Source: Reports and hospital generated data.

Outcome Improvement Target 3 Estimated Incentive Payment: $300,885</td></tr>
<tr><td>Year 2 Estimated Outcome Amount: $170,150</td><td>Year 3 Estimated Outcome Amount: $137,571</td><td>Year 4 Estimated Outcome Amount: $214,611</td><td>Year 5 Estimated Outcome Amount: $300,885</td></tr>
<tr><td colspan="4">TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5):$823,217</td></tr>
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Title of Outcome Measure (Improvement Target): IT-1.20 Timeliness of Inpatient Admission for Mental Illness

Unique RHP Outcome Identification Number: 178815001.3.2

Outcome Measure Description:

IT-1.20

- Timely admission to Inpatient Psychiatric Unit—based upon systems and processes instituted at the time of the establishment of the adult inpatient psychiatric timely respond to referrals for inpatient treatment will be measured and targets set to improve response rates.

Process Milestones:

- DY 2: P-1; P-2, P-3
- DY 3: P-3

Outcome Improvement Target(s) for each Year:

- DY 4
  - Improve rate for DY 4 as compared to baseline rate established in DY 2. Increase admission rate to an average daily census –TBD.
- DY 5
  - Improve rate for DY 5 as compared to baseline rate established in DY 2. Increase patient rate to an average daily census-TBD.

Rationale:

Process Milestone P-1, P-2 and P-3 were chosen to establish a foundation for the establishment of an inpatient adult psychiatric unit and consideration for an outpatient center for follow up care. The focus was to ensure that an initial timely response to a potential need for psychiatric care was addressed. Delay in treatment in the care of an individual with mental illness may result in adverse outcomes. During DY 2 a baseline will be established and DY 3, 4, and 5 has a percentage increase annually to complete admission process from time of referral to arrival on unit.

Improvement targets were placed in DY 3, DY 4 and DY 5 based upon the timeframe allowed to put in place the proper education/training and process implementation. Although all the overall goal is to ensure that individuals within the county, surrounding counties and the military have expedited access to mental health care and receive quality inpatient care for the treatment of mental disorders it is of utmost importance that when patients move to the next continuum (discharge) treatment continues on an outpatient basis to ensure compliance with the treatment plan thus preventing readmissions. Patients in the project will need to be followed over time. Based upon the need to ensure compliance on an outpatient basis regarding the treatment plan established for the patient while hospitalized, follow up after hospitalization for mental illness is a targeted improvement outcome.

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Outcome Measure Valuation:

Areas considered when allocating funds for this project included the importance of ensuring individuals within Wharton County and the surrounding rural areas ~~as well as the military~~ the care needed with regard to mental disorders. A 28 bed inpatient adult psychiatric unit would allow individual's timely access to care for mental disorders whereas currently delay in care is experienced frequently as bed availability is limited and waiting lists for beds are being utilized. In addition, upon discharge from an inpatient psychiatric follow up care by a mental health practitioner is of utmost importance to ensure that the patient remains compliant with his/her treatment plan to ensure a positive outcome with their care and prevent readmissions.

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178815001.3.2	*IT 1.20*	*Other: Timeliness of Inpatient Admission for Mental Illness (referral/ admission to Unit)*	
Gulf Coast Medical Center			*178815001*
Related Category 1 or 2 Projects:	*178815001.1.1*		
Starting Point/Baseline:	*Data Not Available*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning –engage stakeholders, identify current capacity and needed resources, determine timeliness and document implementation plan. Data Source: Potential management company documentation, AIA architect Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $54,738 **Process Milestone 2** [P-2]: Establish baselines. Data Source: Claims, EHR Process Milestone 2 Estimated Incentive Payment: $54,738 **Process Milestone 3** [P-3]: Develop and test systems. Data Source: Data systems Milestone 3 Estimated Incentive Payment: $54,738	**Process Milestone 4** [P-5]: Disseminate findings including lessons learned and best practices to stakeholders. Data Source: Documented findings. Estimated Incentive Payment: $20,000 **Outcome Improvement Target 1** [IT-1.20]: Timely Admission to Inpatient Psychiatric Unit Baseline/Goal: DY 2 baseline/Improvement Target: Improve rate for DY 3 as compared to baseline rate established in DY2. Data Source: Reports and hospital generated data Outcome Improvement Target 1 Estimated Incentive Payment*:* $150,000	**Outcome Improvement Target 2** [IT 1.20]: Timely Admission to Inpatient Psychiatric Unit Baseline/Goal: DY 2 Improvement Target: Improve rate for DY 4 as compared to baseline rate established in DY2. Increase patient admission rate to an average daily census --TBD. Data Source: Reports and hospital generated data Outcome Improvement Target 2 Incentive Payment*:* $200,000	**Outcome Improvement Target 3** [IT 1.20]: Timely Admission to Inpatient Psychiatric Unit Baseline/Goal: DY 2 Improvement Target: Improve rate for DY 5 as compared to baseline rate established in DY2. Increase patient admission rate to an average daily census -TBD. Data Source: Reports and hospital generated data. Outcome Improvement Target 3 Estimated Incentive Payment: $300,000
Year 2 Estimated Outcome Amount: $164,214	Year 3 Estimated Outcome Amount: $170,000	Year 4 Estimated Outcome Amount: $200,000	Year 5 Estimated Outcome Amount: $300,000
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:**$834,214			

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Harris County Hospital District Ben Taub General Hospital

Pass 1

DRAFT

Title of Outcome Measure (Improvement Target): IT- 6.1 Percent improvement over baseline of patient satisfaction (1) are getting timely care, appointments, and information

Unique RHP outcome identification number(s): 133355104.3.1

Outcome Measure Description:

IT- 6.1 will measure improvement in satisfaction scores over time relating to timeliness of care at the Gulfgate same day access clinic, specifically measuring the mean score for the Press Ganey survey question- "Ease of scheduling appointments."

Currently, Harris Health System health centers are designated NCQA Primary Care Medical Homes with increasingly limited capacity. Health center providers are currently 95% empaneled. Moreover, physicians in Harris Health centers carry a panel of 2,250 patients, which is higher than the industry standard of approximately 1,500 patients. Full panels lead to decreased access to primary care appointments at health centers. These health centers are approaching maximum capacity for empaneled patients. From March 2012-September 2012, the Patient Appointment Center was unable to schedule 68,247 unduplicated patients for primary care. For the Gulfgate Health Center, there were 792 unduplicated patients for which there were no Family Practice appointments available in the month of September 2012 alone. As a result, patient satisfaction scores reported by Press Ganey can be greatly improved. From November 2011-October 2012 at Gulfgate Health Center, the mean score for "Ease of scheduling appointments" was 68.0.

Same day access clinic operations will differ from current health centers, resulting in a need for a customized survey. The baseline patient satisfaction score at Gulfgate same day access clinic will be established in DY3 after a new, custom survey is developed and implemented through Press Ganey for same day access clinic usage.

Process Milestones:

- DY2: P-1; P-5
- DY3: P-2; P-4

Outcome Improvement Target(s) for each year:

- DY4:
  - IT- 6.1 Percent improvement over baseline of patient satisfaction (1) are getting timely care, appointments, and information
    - Increase "Ease of scheduling appointments" score by 1% above baseline
- DY5
  - IT- 6.1 Percent improvement over baseline of patient satisfaction (1) are getting timely care, appointments, and information
    - Increase "Ease of scheduling appointments" score by 2% above baseline

Rationale:

P-1 was chosen to ensure that all necessary stakeholders are consulted to develop strategies and processes necessary to reach patient satisfaction goals. Moreover, a new, customized patient satisfaction survey will be developed for same day access clinics in partnership with Press Ganey. P-5 will also be approached in DY2. We plan to share finding and lessons from project planning with internal and external stakeholders. In DY3, P-2 will produce a baseline "Ease of scheduling appointments" score at the new clinic based on available

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performance. In DY3, we will also conduct PDSA cycles for P-4 to ensure that strategies and processes for identified interventions are effective.

IT-6.1 will be measured beginning in DY4 to allow for time and resources needed to purchase lease space, hire staff, and operate the same day access clinic for patient care and successful survey calculation. Improvement targets were chosen with the expectation to reach patient satisfaction goals gradually to coincide with improvements in operations at the clinic.

Outcome Measure Valuation: This project addresses one of the main objectives of the 1115 Waiver; increasing access to primary care for the underserved population in this area of Harris County. The value of the project is based on the clinic's capacity to provide primary care services, including laboratory point-of-care testing, along with timely referrals for specialty care, imaging and other needed services within the Harris Health System network. The clinic can ultimately care for the episodic primary care needs of over ten thousand patients annually, and refer new patients with chronic disease management needs to one of the NCQA certified medical home clinics that are operated by Harris Health. In addition, the availability of same day primary care appointments will result in fewer emergency room visits for public and private hospitals located in the service area. Early detection, treatment and education regarding wellness and prevention will also help to prevent future downstream inpatient admissions.

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133355104.3.1	*IT-6.1*	*Percent improvement over baseline of patient satisfaction (1) are getting timely care, appointments, and information*	
Harris Health System			*133355104*
Related Category 1 or 2 Projects:	*133355104.1.1*		
Starting Point/Baseline:	*To be established in DY3*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: EHR; Business Intelligence Process Milestone 1 Estimated Incentive Payment *(maximum amount): $*419,558 **Process Milestone 2** [P-5]: Disseminate findings, including lessons learned and best practices, to stakeholders Data Source: EHR; Business Intelligence; reports Process Milestone 2 Estimated Incentive Payment: $ 419,558	**Process Milestone 3** [P-2]: Establish baseline patient satisfaction score for "Ease of scheduling appointments" at Gulfgate same day access clinic Data Source: Press Ganey Process Milestone 3 Estimated Incentive Payment: $ 486,323 **Process Milestone 4** [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve intervention activities Data Source: Report documentation Process Milestone 4 Estimated Incentive Payment *(maximum amount):* $ 486,322	**Outcome Improvement Target 1** [IT-6.1]: Percent improvement over baseline of patient satisfaction (1) are getting timely care, appointments, and information Improvement Target: Increase "Ease of scheduling appointments" score by 1% above baseline Data Source: Press Ganey Outcome Improvement Target 1 Estimated Incentive Payment*:* $1,560,756	**Outcome Improvement Target 2** [IT-6.1]: Percent improvement over baseline of patient satisfaction (1) are getting timely care, appointments, and information Improvement Target: Increase "Ease of scheduling appointments" score by 2% above baseline Data Source: Press Ganey Outcome Improvement Target 2 Estimated Incentive Payment*:* $3,732,243
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $839,116	Year 3 Estimated Outcome Amount: $972,645	Year 4 Estimated Outcome Amount: $1,560,756	Year 5 Estimated Outcome Amount: $3,732,243
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $7,104,760			

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Title of Outcome Measure (Improvement Target): IT- 6.1 Percent improvement over baseline of patient satisfaction (1) are getting timely care, appointments, and information

Unique RHP outcome identification number(s): 133355104.3.2

Outcome Measure Description:

IT- 6.1 will measure improvement in satisfaction scores over time relating to timeliness of care at the People's same day access clinic, specifically measuring the mean score for the Press Ganey survey question- "Ease of scheduling appointments."

Currently, Harris Health System health centers are designated NCQA Primary Care Medical Homes with increasingly limited capacity. Health center providers are currently 95% empaneled. Moreover, physicians in Harris Health health centers carry a panel of 2,250 patients, which is higher than the industry standard of approximately 1,500 patients. Full panels lead to decreased access to primary care appointments at health centers. These health centers are approaching maximum capacity for empaneled patients. From March 2012-September 2012, the Patient Appointment Center was unable to schedule 68,247 unduplicated patients for primary care. For the People's health center, there were 465 unduplicated patients for which there were no Family Practice appointments available in the month of September 2012 alone. As a result, patient satisfaction scores reported by Press Ganey can be greatly improved. From November 2011-October 2012 at People's Health Center, the mean score for "Ease of scheduling appointments" was 68.9.

Same day access clinic operations will differ from current health centers, resulting in a need for a customized survey. The baseline patient satisfaction score at People's same day access clinic will be established in DY3 after a new, custom survey is developed and implemented through Press Ganey for same day access clinic usage.

Process Milestones:

- DY2: P-1; P-5
- DY3: P-2; P-4

Outcome Improvement Target(s) for each year:

- DY4:
  - IT- 6.1 Percent improvement over baseline of patient satisfaction (1) are getting timely care, appointments, and information
    - Increase "Ease of scheduling appointments" score by 1% above baseline
- DY5
  - IT- 6.1 Percent improvement over baseline of patient satisfaction (1) are getting timely care, appointments, and information
    - Increase "Ease of scheduling appointments" score by 2% above baseline

Rationale:

P-1 was chosen to ensure that all necessary stakeholders are consulted to develop strategies and processes necessary to reach patient satisfaction goals. Moreover, a new, customized patient satisfaction survey will be developed for same day access clinics in partnership with Press Ganey. P-5 will also be approached in DY2. We plan to share finding and lessons from project planning with internal and external stakeholders. In DY3, P-2 will produce a baseline "Ease of scheduling appointments" score at the new clinic based on available

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performance. In DY3, we will also conduct PDSA cycles for P-4 to ensure that strategies and processes for identified interventions are effective.

IT-6.1 will be measured beginning in DY4 to allow for time and resources needed to purchase lease space, hire staff, and operate the same day access clinic for patient care and successful survey calculation. Improvement targets were chosen with the expectation to reach patient satisfaction goals gradually to coincide with improvements in operations at the clinic.

Outcome Measure Valuation: This project addresses one of the main objectives of the 1115 Waiver; increasing access to primary care for the underserved population in this area of Harris County. The value of the project is based on the clinic's capacity to provide primary care services, including laboratory point-of-care testing, along with timely referrals for specialty care, imaging and other needed services within the Harris Health System network. The clinic can ultimately care for the episodic primary care needs of over ten thousand patients annually, and refer new patients with chronic disease management needs to one of the NCQA certified medical home clinics that are operated by Harris Health. In addition, the availability of same day primary care appointments will result in fewer emergency room visits for public and private hospitals located in the service area. Early detection, treatment and education regarding wellness and prevention will also help to prevent future downstream inpatient admissions.

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133355104.3.2	*3.IT-6.1*	*Percent improvement over baseline of patient satisfaction (1) are getting timely care, appointments, and information*	
Harris Health System			*133355104*
Related Category 1 or 2 Projects:	*133355104.1.2*		
Starting Point/Baseline:	*To be established in DY3*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: EHR; Business Intelligence Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $ 419,558 **Process Milestone 2** [P-5]: Disseminate findings, including lessons learned and best practices, to stakeholders Data Source: EHR; Business Intelligence; reports Process Milestone 2 Estimated Incentive Payment: $419,558	**Process Milestone 3** [P-2]: Establish baseline patient satisfaction score for "Ease of scheduling appointments" at People's same day access clinic Data Source: Press Ganey Process Milestone 3 Estimated Incentive Payment: $486,323 **Process Milestone 4** [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve intervention activities Data Source: Report documentation Process Milestone 4 Estimated Incentive Payment *(maximum amount):* $486,322	**Outcome Improvement Target 1** [IT-6.1]: Percent improvement over baseline of patient satisfaction (1) are getting timely care, appointments, and information Improvement Target: Increase "Ease of scheduling appointments" score by 1% above baseline Data Source: Press Ganey Outcome Improvement Target 1 Estimated Incentive Payment*:* $1,560,756	**Outcome Improvement Target 2** [IT-6.1]: Percent improvement over baseline of patient satisfaction (1) are getting timely care, appointments, and information Improvement Target: Increase "Ease of scheduling appointments" score by 2% above baseline Data Source: Press Ganey Outcome Improvement Target 2 Estimated Incentive Payment*:* $3,732,243
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $839,116	Year 3 Estimated Outcome Amount: $972,645	Year 4 Estimated Outcome Amount: $1,560,756	Year 5 Estimated Outcome Amount: $3,732,243
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $7,104,760			

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Title of Outcome Measure (Improvement Target): IT-6.1 Percent improvement over baseline of patient satisfaction (1) are getting timely care, appointments, and information

Unique RHP outcome identification number(s): 133355104.3.3

Outcome Measure Description:

IT- 6.1 will measure percent improvement over baseline of patient satisfaction scores over time relating to timeliness of care, specifically measuring the mean score for the Press Ganey survey question – "Ease of scheduling appointments".

The expansion of primary care capacity in the existing Health Centers will increase capacity for primary care visits within the Harris Health System, which will enhance access and improve the patient experience in obtaining services. Patient satisfaction scores for timely access to care for the Health Centers have historically been below expectations. The expansion of primary care capacity in the existing Health Centers will offer additional access, affording patients the opportunity to seek care in the right setting. The current score for Ease of scheduling appointment for the Health Centers is 71.3%. The additional providers will add capacity for appointments, which will increase appointment availability for both new and return patients. The enhanced access to care will result in improved patient satisfaction scores as related to Ease of scheduling appointments.

Process Milestones:

- DY2: P-1
- DY3: P-2

Outcome Improvement Target(s) for each year:

- DY4:
  - IT- 6.1 Percent improvement over baseline of patient satisfaction score of (1) getting timely care, appointments, and information
    - Increase Getting Timely Care, Appointments, and Information survey dimension score by 1% above baseline
- DY5:
  - IT- 6.1 Percent improvement over baseline of patient satisfaction score of (1) getting timely care, appointments, and information
    - Increase Getting Timely Care, Appointments, and Information survey dimension score by 2% above baseline

Rationale:

P-1 was chosen to ensure that all necessary stakeholders are involved and addressed to develop the strategies necessary to improve Access to Care patient satisfaction scores.

Improvement targets were chosen based on the time and resources needed to hire and train physicians and support staff. The improved patient access may begin in DY3, Ease of scheduling appointments patient satisfaction score improvements will be measured in DY4 and DY5. Improvement target 1 aims to increase patient satisfaction in relation to Ease of scheduling appointments by 1% above baseline, while improvement target 2 aims to increase patient satisfaction in relation to Ease of scheduling appointments by 2% above baseline.

Outcome Measure Valuation:

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This project addresses one of the main objectives of the 1115 Waiver; increasing access to primary care for the underserved population in Harris County. The value of the project is based on the expansion of services in Harris Health System's NCQA certified medical home clinics, substantially increasing our capacity to provide primary care services, including laboratory testing, imaging, and other ancillary services, along with prescription medications and timely referrals for specialty care and other needed services within the Harris Health System network. The increase in provider staffing throughout the existing medical home network can ultimately care for the primary care needs of an additional twenty-three thousand patients annually, including the coordination of chronic disease education and management for patients needing those services. In addition, the availability of incremental primary care appointments will result in fewer emergency room visits for public and private hospitals located in the service area. Early detection, treatment and education regarding wellness and prevention will also help to prevent future downstream inpatient admissions.

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133355104.3.3	*IT-6.1*	*IT-6.1 Percent improvement over baseline of patient satisfaction scores*	
Harris Health System			*133355104*
Related Category 1 or 2 Projects:	*133355104.1.3*		
Starting Point/Baseline:	*Patient Satisfaction Score for Ease of scheduling appointments for the Health Centers is 71.3%.*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: EHR; billing system Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $1,666,789	**Process Milestone 2** [P-2]: Establish baseline Patient Satisfaction Score of (1) getting timely care, appointments, and information at Health Centers Data Source: Press Ganey Patient Satisfaction Survey Process Milestone 2 Estimated Incentive Payment: $1,932,026	**Outcome Improvement Target 1** [IT-6.1]: Percent improvement over baseline of patient satisfaction score of (1) getting timely care, appointments, and information at Health Centers Improvement Target: Increase Getting Timely Care, Appointments, and Information survey dimension score by 1% above baseline Data Source: Press Ganey Patient Satisfaction Survey Outcome Improvement Target 1 Estimated Incentive Payment: $3,100,227	**Outcome Improvement Target 2** [IT-6.1]: Percent improvement over baseline of patient satisfaction score of (1) getting timely care, appointments, and information at Health Centers Improvement Target: Increase Getting Timely Care, Appointments, and Information survey dimension score by 2% above baseline Data Source: Press Ganey Patient Satisfaction Survey Outcome Improvement Target 2 Estimated Incentive Payment: $7,413,587
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $1,666,789	Year 3 Estimated Outcome Amount: $1,932,026	Year 4 Estimated Outcome Amount: $3,100,227	Year 5 Estimated Outcome Amount: $7,413,587
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $14,112,629			

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Title of Outcome Measure (Improvement Target): IT- 1.10 Diabetes care: HbA1c poor control (>9.0%)

Unique RHP outcome identification number(s): 133355104.3.4

Outcome Measure Description:

IT1.10 will measure improvement in the percentage of patients 18-75 years of age with poorly controlled diabetes. Poorly controlled will be defined as patients with diabetes (type 1 or 2) who had hemoglobin A1c (HbA1c) control >9.0%.

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: P-1; P-5
- DY3: P-2; P-4

Outcome Improvement Target(s) for each year:

- DY4:
  - IT- 1.10 Diabetes care: HbA1c poor control (>9.0%)
    - Decrease the percentage of patients with poorly controlled diabetes by 0.5% below baseline
- DY5
  - IT- 1.10 Diabetes care: HbA1c poor control (>9.0%)
    - Decrease the percentage of patients with poorly controlled diabetes by 1.0% below baseline

Rationale:

P-1 was chosen to ensure that all necessary stakeholders are consulted to develop strategies and processes necessary to reach patient satisfaction goals. P-5 will also be approached in DY2. We plan to share finding and lessons from project planning with internal and external stakeholders. In DY3, P-2 will produce a baseline HbA1c poor control (>9.0%) at the new West and Northwest 1 area health centers based on available data. In DY3, we will also conduct PDCA cycles for P-4 to ensure that strategies and processes for identified interventions are effective.

IT-1.10 will be measured beginning in DY4 to allow for time and resources needed to purchase lease space, hire staff, and operate the West and Northwest 1 area health centers for patient care and successful data calculation. Improvement targets were chosen with the expectation to decrease the percentage of patients with poorly controlled diabetes gradually to coincide with improvements in operations at the clinic.

Outcome Measure Valuation: This project addresses one of the main objectives of the 1115 Waiver; increasing access to primary care for the underserved population in this area of Harris County. The value of the project is based on the clinic's capacity to provide a medical home for primary care

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services, including laboratory point-of-care testing, some imaging, other ancillary services and prescription medications along with timely referrals for specialty care and other needed services within the Harris Health System network. The clinic can ultimately care for the comprehensive primary care needs of over five thousand patients annually, including the coordination of chronic disease education and management for patients needing those services. In addition, the availability of timely primary care appointments will result in fewer emergency room visits for public and private hospitals located in the service area. Early detection, treatment and education regarding wellness and prevention will also help to prevent future downstream inpatient admissions.

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133355104.3.4	*3.IT-1.10*	*Percent improvement over baseline of diabetes care: HbA1c poor control (>9.0%)*	
Harris Health System			*133355104*
Related Category 1 or 2 Projects:	*133355104.1.4*		
Starting Point/Baseline:	*To be established in DY3*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: EHR; Business Intelligence Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $413,673 **Process Milestone 2** [P-5]: Disseminate findings, including lessons learned and best practices, to stakeholders Data Source: EHR; Business Intelligence; reports Process Milestone 2 Estimated Incentive Payment: $413,672	**Process Milestone 3** [P-2]: Establish baseline for percentage of patients with poorly controlled HbA1c (>9.0%) at West and Northwest 1 area health centers Data Source: EHR; Business Intelligence Process Milestone 3 Estimated Incentive Payment: $1,030,161 **Process Milestone 4** [P-4]: Conduct Plan Do Check Act (PDCA) cycles to improve intervention activities Data Source: Report documentation Process Milestone 4 Estimated Incentive Payment *(maximum amount):* $1,030,161	**Outcome Improvement Target 1** [IT-1.10]: Diabetes care: HbA1c poor control (>9.0%) Improvement Target: Decrease percentage of patients with poorly controlled diabetes by 0.5% below baseline Data Source: EHR Outcome Improvement Target 1 Estimated Incentive Payment*:* $3,090,483	**Outcome Improvement Target 2** [IT-1.10]: Diabetes care: HbA1c poor control (>9.0%) Improvement Target: Decrease percentage of patients with poorly controlled diabetes by 1.0% below baseline Data Source: EHR Outcome Improvement Target 2 Estimated Incentive Payment*:* $6,799,062
Year 2 Estimated Outcome Amount: $827,345	Year 3 Estimated Outcome Amount: $959,001	Year 4 Estimated Outcome Amount: $1,538,862	Year 5 Estimated Outcome Amount: $3,679,887
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $7,005,095			

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Title of Outcome Measure (Improvement Target): IT- 1.10 Diabetes care: HbA1c poor control (>9.0%)

Unique RHP outcome identification number(s): 133355104.3.5

Outcome Measure Description:

IT1.10 will measure improvement in the percentage of patients 18-75 years of age with poorly controlled diabetes. Poorly controlled will be defined as patients with diabetes (type 1 or 2) who had hemoglobin A1c (HbA1c) control >9.0%.

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: P-1; P-5
- DY3: P-2; P-4

Outcome Improvement Target(s) for each year:

- DY4:
  - IT- 1.10 Diabetes care: HbA1c poor control (>9.0%)
    - Decrease the percentage of patients with poorly controlled diabetes by 0.5% below baseline
- DY5
  - IT- 1.10 Diabetes care: HbA1c poor control (>9.0%)
    - Decrease the percentage of patients with poorly controlled diabetes by 1.0% below baseline

Rationale:

P-1 was chosen to ensure that all necessary stakeholders are consulted to develop strategies and processes necessary to reach patient satisfaction goals. P-5 will also be approached in DY2. We plan to share finding and lessons from project planning with internal and external stakeholders. In DY3, P-2 will produce a baseline HbA1c poor control (>9.0%) at the new Northwest 2 ~~and Northwest 3~~ area health centers based on available data. In DY3, we will also conduct PDCA cycles for P-4 to ensure that strategies and processes for identified interventions are effective.

IT-1.10 will be measured beginning in DY4 to allow for time and resources needed to purchase lease space, hire staff, and operate the Northwest 2 ~~and Northwest 3~~ area health centers for patient care and successful data calculation. Improvement targets were chosen with the expectation to decrease the percentage of patients with poorly controlled diabetes gradually to coincide with improvements in operations at the clinic.

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Outcome Measure Valuation: This project addresses one of the main objectives of the 1115 Waiver; increasing access to primary care for the underserved population in this area of Harris County. The value of the project is based on the clinic's capacity to provide a medical home for primary care services, including laboratory point-of-care testing, some imaging, other ancillary services and prescription medications along with timely referrals for specialty care and other needed services within the Harris Health System network. Each clinic can ultimately care for the comprehensive primary care needs of over three thousand patients annually, including the coordination of chronic disease education and management for patients needing those services. In addition, the availability of timely primary care appointments will result in fewer emergency room visits for public and private hospitals located in the service area. Early detection, treatment and education regarding wellness and prevention will also help to prevent future downstream inpatient admissions.

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133355104.3.5	*3.IT-1.10*	*Percent improvement over baseline of diabetes care: HbA1c poor control (>9.0%)*	
Harris Health System			*133355104*
Related Category 1 or 2 Projects:	*133355104.1.5*		
Starting Point/Baseline:	*To be established in DY3*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: EHR; Business Intelligence Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $492,388 **Process Milestone 2** [P-5]: Disseminate findings, including lessons learned and best practices, to stakeholders Data Source: EHR; Business Intelligence; reports Process Milestone 2 Estimated Incentive Payment: $492,389	**Process Milestone 3** [P-2]: Establish baseline for percentage of patients with poorly controlled HbA1c (>9.0%) at Northwest 2 ~~and Northwest 3~~ area health centers Data Source: EHR; Business Intelligence Process Milestone 3 Estimated Incentive Payment: $570,743 **Process Milestone 4** [P-4]: Conduct Plan Do Check Act (PDCA) cycles to improve intervention activities Data Source: Report documentation Process Milestone 4 Estimated Incentive Payment *(maximum amount):* $570,742	**Outcome Improvement Target 1** [IT-1.10]: Diabetes care: HbA1c poor control (>9.0%) Improvement Target: Decrease percentage of patients with poorly controlled diabetes by 0.5% below baseline Data Source: EHR Outcome Improvement Target 1 Estimated Incentive Payment*:* $1,831,686	**Outcome Improvement Target 2** [IT-1.10]: Diabetes care: HbA1c poor control (>9.0%) Improvement Target: Decrease percentage of patients with poorly controlled diabetes by 1.0% below baseline Data Source: EHR Outcome Improvement Target 2 Estimated Incentive Payment*:* $4,380,119
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $984,777	Year 3 Estimated Outcome Amount: $1,141,485	Year 4 Estimated Outcome Amount: $1,831,686	Year 5 Estimated Outcome Amount: $4,380,119
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $8,338,067			

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Title of Outcome Measure (Improvement Target): IT- 6.1 Percent improvement over baseline of patient satisfaction (1) are getting timely care, appointments, and information

Unique RHP outcome identification number(s): 133355104.3.6

Outcome Measure Description:

IT- 6.1 will measure improvement in satisfaction scores over time relating to timeliness of care at the Southwest, Medical Center, and Northeast same day access clinics, specifically measuring the mean score for the Press Ganey survey question- "Ease of scheduling appointments."

Currently, Harris Health System health centers are designated NCQA Primary Care Medical Homes with increasingly limited capacity. Health center providers are currently 95% empaneled. Moreover, physicians in Harris Health System health centers carry a panel of 2,250 patients, which is higher than the industry standard of approximately 1,500 patients. Full panels lead to decreased access to primary care appointments at health centers. These health centers are approaching maximum capacity for empaneled patients. From March 2012-September 2012, the Patient Appointment Center was unable to schedule 68,247 unduplicated patients for primary care.

Same day access clinic operations will differ from current health centers, resulting in a need for a customized survey. The baseline patient satisfaction score at Southwest, Medical Center, and Northeast same day access clinics will be established in DY3 after a new, custom survey is developed and implemented through Press Ganey for same day access clinic usage.

Process Milestones:

- DY2: P-1; P-5
- DY3: P-2; P-4

Outcome Improvement Target(s) for each year:

- DY4:
  - IT- 6.1 Percent improvement over baseline of patient satisfaction (1) are getting timely care, appointments, and information
    - Increase "Ease of scheduling appointments" score by 1% above baseline
- DY5
  - IT- 6.1 Percent improvement over baseline of patient satisfaction (1) are getting timely care, appointments, and information
    - Increase "Ease of scheduling appointments" score by 2% above baseline

Rationale:

P-1 was chosen to ensure that all necessary stakeholders are consulted to develop strategies and processes necessary to reach patient satisfaction goals. Moreover, a new, customized patient satisfaction survey will be developed for same day access clinics in partnership with Press Ganey. P-5 will also be approached in DY2. We plan to share finding and lessons from project planning with internal and external stakeholders. In DY3, P-2 will produce a baseline "Ease of scheduling appointments" score at the new same day access clinic based on available performance. In DY3, we will also conduct PDSA cycles for P-4 to ensure that strategies and processes for identified interventions are effective.

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IT-6.1 will be measured beginning in DY4 to allow for time and resources needed to purchase lease space, hire staff, and operate the same day access clinic for patient care and successful survey calculation. Improvement targets were chosen with the expectation to reach patient satisfaction goals gradually to coincide with improvements in operations at the clinic.

Outcome Measure Valuation: This project addresses one of the main objectives of the 1115 Waiver; increasing access to primary care for the underserved population in this area of Harris County. The value of the project is based on the clinics' capacity to provide primary care services, including laboratory point-of-care testing, along with timely referrals for specialty care, imaging and other needed services within the Harris Health System network. Each of the three clinics can ultimately care for the episodic primary care needs of over six thousand patients annually, and refer new patients with chronic disease management needs to one of the NCQA certified medical home clinics that are operated by Harris Health. In addition, the availability of same day primary care appointments will result in fewer emergency room visits for public and private hospitals located in the service area. Early detection, treatment and education regarding wellness and prevention will also help to prevent future downstream inpatient admissions.

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133355104.3.6	*3.IT-6.1*	*Percent improvement over baseline of patient satisfaction (1) are getting timely care, appointments, and information*	
Harris Health System			*133355104*
Related Category 1 or 2 Projects:	*133355104.1.6*		
Starting Point/Baseline:	*To be established in DY3*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: EHR; Business Intelligence Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $833,746 **Process Milestone 2** [P-5]: Disseminate findings, including lessons learned and best practices, to stakeholders Data Source: EHR; Business Intelligence; reports Process Milestone 2 Estimated Incentive Payment: $833,745	**Process Milestone 3** [P-2]: Establish baseline patient satisfaction score for "Ease of scheduling appointments" at Southwest, Medical Center, and Northeast same day access clinics Data Source: Press Ganey Process Milestone 3 Estimated Incentive Payment: $966,420 **Process Milestone 4** [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve intervention activities Data Source: Report documentation Process Milestone 4 Estimated Incentive Payment*:* $966,420	**Outcome Improvement Target 1** [IT-6.1]: Percent improvement over baseline of patient satisfaction (1) are getting timely care, appointments, and information Improvement Target: Increase "Ease of scheduling appointments" score by 1% above baseline Data Source: Press Ganey Outcome Improvement Target 1 Estimated Incentive Payment*:* $3,101,534	**Outcome Improvement Target 2** [IT-6.1]: Percent improvement over baseline of patient satisfaction (1) are getting timely care, appointments, and information Improvement Target: Increase "Ease of scheduling appointments" score by 2% above baseline Data Source: Press Ganey Outcome Improvement Target 2 Estimated Incentive Payment*:* $7,416,712
Year 2 Estimated Outcome Amount: $1,667,491	Year 3 Estimated Outcome Amount: $1,932,840	Year 4 Estimated Outcome Amount: $3,101,534	Year 5 Estimated Outcome Amount: $7,416,712
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $14,118,577			

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Title of Outcome Measure (Improvement Target): IT-1.1 Third next available appointment

Unique RHP outcome identification number(s): 133355104.3.7
Outcome Measure Description:

OD-1 Primary Care and Chronic Disease Management
IT-1.1 Third next available appointment

Process Milestones:
- DY2:
  P-2 Establish Baseline
  P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans

Outcome Improvement Targets for each year:
- DY3: decrease wait time from specialty referral to specialty clinic visit 20% from baseline
- DY4: decrease wait time from specialty referral to specialty clinic visit 30% from baseline
- DY5: decrease wait time from specialty referral to specialty clinic visit 40% from baseline

Rationale:
This particular improvement target, IT-1.1 (Third next available appointment) was chosen because a goal of this project is to produce more efficiencies in primary care visits that lead to appropriate specialty clinic referrals. With this goal in mind, a primary goal of the project is to decrease the backlog for diabetes and rheumatology clinics, which will ultimately decrease the wait time for next available appointment. Process milestone P-1 was chosen for DY2 because of the nature of this project. In order to see improvement in outcomes for this project, it is essential to plan and engage physician and other clinical stakeholders. During this year, a baseline will also be established (P-2) to measure improvement in later years. Based on the outcome of baseline, we plan to decrease the wait time 20% in DY3, 30% in DY4, and 40% in DY5.

Outcome Measure Valuation:
This project will focus primarily on diabetes mellitus (DM)/pre-diabetes and rheumatologic conditions, making it possible for providers to efficiently order the most appropriate best practices algorithm driven laboratory workups for particular patients. The value of the project is based on cost savings and efficiencies through (1) increasing the capacity of clinics and consulting services by reducing the number of patient visits required to solve diagnostic problems, (2) reducing the need for emergency room visits and hospitalizations that result from delayed or inaccurate diagnoses in the clinics. (3) increasing the throughput and productivity of the specialists consulting services by eliminating unnecessary consults, and (4) improving quality of care by decreasing the waiting time and eliminating unnecessary repeated visits due to incomplete pre-consult testing; thus enhancing patients' satisfaction. In addition, these improvements will facilitate providing quality care for expected significant influx of patients due

to implementation of ACA and the 1115 Waver without a major increase in the number of providers and capital investment.

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133355104.3.7	*IT-1.1*	*Third next available appointment*	
Harris Health System			*133355104*
Related Category 1 or 2 Projects:	*133355104.1.7*		
Starting Point/Baseline:	*TBD*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-2]: Establish Baseline rates Data Source: Referral Center reports Process Milestone 1 Estimated Incentive Payment*:* $121,724 **Process Milestone 2** [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Project Plans Process Milestone 2 Estimated Incentive Payment: $121,724	**Outcome Improvement Target 1** [IT-1.1]: Third next available appointment Improvement Target: decrease wait time from specialty referral to specialty clinic visit 20% from baseline Data Source: Referral Center Reports Outcome Improvement Target 1 Estimated Incentive Payment*:* $282,187	**Outcome Improvement Target 1** [IT-1.1]: Third next available appointment Improvement Target: decrease wait time from specialty referral to specialty clinic visit 30% from baseline Data Source: Referral Center Reports Outcome Improvement Target 2 Estimated Incentive Payment*:* $452,812	**Outcome Improvement Target 1** [IT-1.1]: Third next available appointment Improvement Target: decrease wait time from specialty referral to specialty clinic visit 40% from baseline Data Source: Referral Center Reports Outcome Improvement Target 3 Estimated Incentive Payment*:* $1,082.812
Year 2 Estimated Outcome Amount: $243,448	Year 3 Estimated Outcome Amount: $282,187	Year 4 Estimated Outcome Amount: $452,812	Year 5 Estimated Outcome Amount: $1,082,812
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $2,061,259			

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Title of Outcome Measure (Improvement Target): IT-1.14 Diabetes care: Microalbumin/Nephropathy- NQF 0062 (non-standalone)

Unique RHP outcome identification number(s): 133355104.3.8

Outcome Measure Description:

OD-1 Primary Care and Chronic Disease Management
IT-1.14 Diabetes care: Microalbumin/Nephropathy- NQF 0062 (non-standalone)

Process Milestones:

- DY2: P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
- DY3: P-2 Establish Baseline

Outcome Improvement Targets for each year:

- DY4: TBD based on established baseline in DY3
- DY5: TBD based on established baseline in DY4

Rationale:

This particular improvement target, IT-1.14 (Diabetes care: Microalbumin/Nephropathy- NQF 0062) was chosen because a goal of this project is to produce more efficiencies in primary care visits that lead to appropriate specialty clinic referrals. There will be a focused algorithm on the diabetic population through this project. This is a large need in Harris County and the region. In creation of this algorithm, we plan to improve the percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had a nephropathy screening test or evidence of nephropathy. This is an important measure in improving the population health of our diabetic population served. The improvement targets for this outcome measure will be determined based on the baseline that will be established in DY2. In order to see improvement in outcomes for this project, it is essential to plan and engage physician and other clinical stakeholders.

Outcome Measure Valuation:

This project will focus primarily on diabetes mellitus (DM)/pre-diabetes and rheumatologic conditions, making it possible for providers to efficiently order the most appropriate best practices algorithm driven laboratory workups for particular patients. The value of the project is based on cost savings and efficiencies through (1) increasing the capacity of clinics and consulting services by reducing the number of patient visits required to solve diagnostic problems, (2) reducing the need for emergency room visits and hospitalizations that result from delayed or inaccurate diagnoses in the clinics. (3) increasing the throughput and productivity of the specialists consulting services by eliminating unnecessary consults, and (4) improving quality of care by decreasing the waiting time and eliminating unnecessary repeated visits due to incomplete pre-consult testing; thus enhancing patients' satisfaction. In addition, these improvements will facilitate providing quality care for expected significant influx of patients due to implementation of ACA and the 1115 Waver without a major increase in the number of providers and capital investment.

133355104.3.8	*IT-1.14*	*Diabetes care: Microalbumin/Nephropathy- NQF 0062*	
Harris Health System			*133355104*
Related Category 1 or 2 Projects:	*133355104.1.7*		
Starting Point/Baseline:	*TBD*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Project Plans Process Milestone 1 Estimated Incentive Payment: $243,448	**Process Milestone 1** [P-2]: Establish Baseline rates Data Source: EHR Process Milestone 2 Estimated Incentive Payment*:* $282,188	**Outcome Improvement Target 1** [IT-1.14]: Diabetes care: Microalbumin/Nephropathy- NQF 0062 Improvement Target: TBD Data Source: EHR Outcome Improvement Target 2 Estimated Incentive Payment*:* $452,812	**Outcome Improvement Target 1** [IT-1.14]: Diabetes care: Microalbumin/Nephropathy- NQF 0062 Improvement Target: TBD Data Source: EHR Outcome Improvement Target 3 Estimated Incentive Payment*:* $1,082,812
Year 2 Estimated Outcome Amount: $243,448	Year 3 Estimated Outcome Amount: $282,187	Year 4 Estimated Outcome Amount: $452,812	Year 5 Estimated Outcome Amount: $1,082,812
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $2,061,259			

Title of Outcome Measure (Improvement Target): IT-6.1(3) Percent improvement over baseline of patient satisfaction scores: patient's rating of doctor access to specialist (Standalone measure)

Unique RHP outcome identification number(s): 133355104.3.9

Outcome Measure Description:

OD-6 Patient Satisfaction
IT-6.1(3) Percent improvement over baseline of patient satisfaction scores: patient's rating of doctor access to specialist (standalone measure)

Process Milestones:

- DY2: P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
- DY3: P-2 Establish Baseline

Outcome Improvement Targets for each year:

- DY4: 3% increase above baseline
- DY5: 5% increase above baseline

Rationale:

This particular improvement target, IT-6.1(3) (Percent improvement over baseline of patient satisfaction scores: patient's rating of doctor access to specialist) was chosen because while Harris Health System produces more efficiencies in primary care visits that lead to appropriate specialty clinic referrals, we do not want to ignore the importance of satisfied customers. In an effort to decrease wait time to specialty clinic visits, we hope to better serve our patient population and improve our satisfaction scores. Process milestone P-1 was chosen for DY2 because of the nature of this project. In order to see improvement in outcomes for this project, it is essential to plan and engage physician and other clinical stakeholders. During DY3, a baseline will be established (P-2) to measure improvement in later years. Based on the outcome of baseline, we plan to increase patient satisfaction scores 3% in DY4 and 5% in DY5. We chose these goals based on historic patient satisfaction data for other areas within the system.

Outcome Measure Valuation:

This project will focus primarily on diabetes mellitus (DM)/pre-diabetes and rheumatologic conditions, making it possible for providers to efficiently order the most appropriate best practices algorithm driven laboratory workups for particular patients. The value of the project is based on cost savings and efficiencies through (1) increasing the capacity of clinics and consulting services by reducing the number of patient visits required to solve diagnostic problems, (2) reducing the need for emergency room visits and hospitalizations that result from delayed or inaccurate diagnoses in the clinics. (3) increasing the throughput and productivity of the specialists consulting services by eliminating unnecessary consults, and (4) improving quality of care by decreasing the waiting time and eliminating unnecessary repeated visits due to

incomplete pre-consult testing; thus enhancing patients' satisfaction. In addition, these improvements will facilitate providing quality care for expected significant influx of patients due to implementation of ACA and the 1115 Waver without a major increase in the number of providers and capital investment.

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133355104.3.9	*IT-6.1(3)*	*Percent improvement over baseline of patient satisfaction scores: patient's rating of doctor access to specialist*	
Harris Health System			*133355104*
Related Category 1 or 2 Projects:	*133355104.1.7*		
Starting Point/Baseline:	*TBD*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Project Plans Process Milestone 1 Estimated Incentive Payment: $243,448	**Process Milestone 1** [P-2]: Establish Baseline rates Data Source: Patient Satisfaction Survey Process Milestone 2 Estimated Incentive Payment*:* $282,188	**Outcome Improvement Target 1** [IT-6.1(3)]: Percent improvement over baseline of patient satisfaction scores: patient's rating of doctor access to specialist Improvement Target: 3% increase above baseline Data Source: Patient Satisfaction Survey Outcome Improvement Target 2 Estimated Incentive Payment*:* $452,812	**Outcome Improvement Target 1** [IT-6.1(3)]: Percent improvement over baseline of patient satisfaction scores: patient's rating of doctor access to specialist Improvement Target: 5% increase above baseline Data Source: Patient Satisfaction Survey Outcome Improvement Target 3 Estimated Incentive Payment*:* $1,082,812
Year 2 Estimated Outcome Amount: $243,448	Year 3 Estimated Outcome Amount: $282,187	Year 4 Estimated Outcome Amount: $452,812	Year 5 Estimated Outcome Amount: $1,082,812
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $2,061,259			

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Title of Outcome Measure (Improvement Target): IT- 6.1 Percent improvement over baseline of patient satisfaction scores related to whether patients (1) are getting timely care, appointments, and information

Unique RHP Outcome ID: 133355104.3.10

Outcome Measure Description:

IT- 6.1 will measure improvement in overall satisfaction scores over time at FQHCs, specifically measuring the mean score relating to timeliness of care, as a result of expanded access.

The baseline score will be set in DY2, before providers are added. The baseline will be established using patient satisfaction survey data from each FQHC, with each FQHC's score to be tracked and trended separately. At Harris Health System, timeliness of care scores is negatively affected by access and capacity. From March 2012-September 2012, the Patient Appointment Center was unable to schedule 68,247 unduplicated patients for primary care. As a result, the mean patient satisfaction score for Moving Through Your Visit for the last 12 months (9/2011-9/2012) was 70.2 for all primary care health centers at Harris Health System, as reported through the survey administered by Press Ganey. Expanded capacity and optimized referrals to FQHCs can improve patient satisfaction regarding timely care.

Process Milestones:

- DY2: P-1; P-2
- DY3: P-4; P-5

Outcome Improvement Target(s) for each year:

- DY4:
  - IT- 6.1 Percent improvement over baseline of patient satisfaction (1) is getting timely care, appointments, and information (measured separately for each FQHC).
    - Each FQHC that has added providers in DY3 will improve satisfaction scores overall by 1% above baseline
- DY5
  - IT- 6.1 Percent improvement over baseline of patient satisfaction (1) is getting timely care, appointments, and information (measured separately for each FQHC).
    - Each FQHC that has added providers in DY 3 will improve satisfaction scores overall by 2% above baseline, and each FQHC that has added providers in DY4 will improve satisfaction scores overall by 1% above baseline.

Rationale:

P-1 was chosen to ensure that all necessary stakeholders are consulted to develop strategies and processes necessary to reach patient satisfaction goals and collect data from each FQHC. In DY2, P-2 will produce a baseline score for timeliness of care at FQHCs. In DY3, we will also conduct PDSA cycles for P-4 to ensure that strategies and processes for identified interventions are effective. P-5 will also be approached in DY2. We plan to share findings and lessons from project planning with internal and external stakeholders.

IT-6.1 will be measured beginning in DY4 to allow for time and resources needed to hire providers and staff, begin seeing patients, and successfully collect significant survey data. Improvement targets were chosen with the expectation to reach patient satisfaction goals gradually to coincide with improvements in operations at the FQHCs.

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Outcome Measure Valuation: This project addresses one of the main objectives of the 1115 Waiver; increasing access to primary care for the underserved/uninsured population in Harris County. It will expand capacity for primary care medical homes and connect patients to care in a timely fashion that might not otherwise be possible. A referral system will be developed for patients who seek an appointment at the Harris Health System for whom the demand cannot be met in a timely manner, as well as for patients who seek care for primary care treatable conditions in the Harris Health Emergency Centers. The value of the project is based on the incremental capacity to provide primary care services at the community FQHCs, along with timely referrals for specialty care and other needed services within the Harris Health System network. This expansion can ultimately care for the primary care needs of over eight thousand patients annually. In addition, the availability of incremental primary care appointments will result in fewer emergency room visits for public and private hospitals located in the service area. Early detection, treatment and education regarding wellness and prevention will also help to prevent future downstream inpatient admissions.

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133355104.3.10	*3.IT-6.1*	*Percent improvement over baseline of patient satisfaction (1) are getting timely care, appointments, and information*	
Harris Health System			*133355104*
Related Category 1 or 2 Projects:	*133355104.1.8*		
Starting Point/Baseline:	*To be established in DY3*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: EHR; billing system Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $575,686	**Process Milestone 2** [P-2]: Establish baseline Patient Satisfaction Score of (1) getting timely care, appointments, and information at each FQHC Data Source: Press Ganey Patient Satisfaction Survey Process Milestone 2 Estimated Incentive Payment: $667,295	**Outcome Improvement Target 1** [IT-6.1]: Percent improvement over baseline of patient satisfaction scores for whether patients (1) are getting timely care, appointments, and information Improvement Target: Increase satisfaction scores overall by 1% above baseline (for FQHCs that added providers in DY 3) Data Source: FQHCs patient satisfaction surveys Outcome Improvement Target 1 Estimated Incentive Payment*:* $1,070,775	**Outcome Improvement Target 2** [IT-6.1]: Percent improvement over baseline of patient satisfaction (1) are getting timely care, appointments, and information Improvement Target: Increase satisfaction scores overall by 2% above baseline (for FQHCs that added providers in DY 3) and increase satisfaction scores for 1% overall for FQHCs that added providers in DY 4) Data Source: FQHCs patient satisfaction surveys Outcome Improvement Target 2 Estimated Incentive Payment*:* $2,560,550
Year 2 Estimated Outcome Amount: $575,686	Year 3 Estimated Outcome Amount: $667,295	Year 4 Estimated Outcome Amount: $1,070,775	Year 5 Estimated Outcome Amount: $2,560,550
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $4,874,306			

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Title of outcome measure (improvement target): IT-6.1 (1) - Percent improvement over baseline of patient satisfaction scores: patients are getting timely care, appointments, and information

Unique RHP outcome identification number: 133355104.3.11 / Pass 1

Outcome Measure Description:

Process Milestones

- DY2: P-1
- DY3: P-2

Outcome Improvement Targets: IT-6.1(1)

- DY3 Target: 1% improvement over baseline
- DY4 Target: 1.5% improvement over baseline
- DY5 Target: 2% improvement over baseline

Will be determined based on patient satisfaction scores for timely care, appointments, and information from Press-Ganey survey results. These surveys are currently being gathered by Press-Ganey and will incorporate the new services upon implementation of pediatric and adolescent behavioral health services.

Rationale:

The goal of this project is to increase psychiatry and behavioral therapy staffing at existing pediatric locations within Harris Health System. Expanding pediatric and adolescent behavioral health services has the potential to help decrease the future need for inpatient behavioral health beds by addressing issues at earlier stages in life. Untreated behavioral health needs may lead to school failure, behavioral conflicts, and substance abuse; the longer the issues are left untreated, the more difficult and costly it is to provide effective treatment. The increase in provider staffing throughout the existing pediatric services network can ultimately meet the behavioral care needs of an additional eight thousand patients annually.

We have selected process milestone, P-1, for DY2 in order to begin expansion of pediatric and adolescent behavioral health services at Harris Health System. This process milestone will allow us to plan for outcome reporting of patient satisfaction per our chosen outcome measure. We have selected process milestone P-2 for DY2 to establish the baseline for our outcome improvement targets to be measured in DY4 and DY5. We will begin reporting on improvement target IT-6.1(1) in DY3. By DY5 we want to increase patient satisfaction by 2% across all targeted sites. We selected 2% because many of the existing sites have higher than average patient satisfaction scores within the Harris Health System.

Outcome Measure Valuation:

The goal of this project is to increase psychiatry and behavioral therapy staffing at existing pediatric locations within Harris Health System. Expanding pediatric and adolescent behavioral health services has the potential to help decrease the future need for inpatient behavioral health beds by addressing issues at earlier stages in life. Untreated behavioral health needs may lead to school failure, behavioral conflicts, and substance abuse; the longer the issues are left untreated, the more difficult and costly it is to provide effective treatment. The increase in provider staffing throughout the existing pediatric services network can ultimately meet the behavioral care needs of an additional eight thousand patients annually.

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<table>
<tr><td>133355104.3.11</td><td>3.IT-6.1(1)</td><td colspan="2">Percent improvement over baseline of patient satisfaction scores: patients are getting timely care, appointments, and information</td></tr>
<tr><td colspan="3">Harris Health System</td><td>133355104</td></tr>
<tr><td>Related Category 1 or 2 Projects:</td><td colspan="3">133355104.1.9</td></tr>
<tr><td>Starting Point/Baseline:</td><td colspan="3">TBD</td></tr>
<tr><td>Year 2
(10/1/2012 – 9/30/2013)</td><td>Year 3
(10/1/2013 – 9/30/2014)</td><td>Year 4
(10/1/2014 – 9/30/2015)</td><td>Year 5
(10/1/2015 – 9/30/2016)</td></tr>
<tr><td>Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
Data Source: EHR reports

Process Milestone 1 Estimated Incentive Payment (maximum amount): $265,373.50

Process Milestone 2 [P-2]: Establish baseline rates
Data Source: Press-Ganey Survey Reports

Process Milestone 1 Estimated Incentive Payment: $265,373.50</td><td>Outcome Improvement Target 1 [IT-6.1(1)]: Percent improvement over baseline of patient satisfaction scores: patients are getting timely care, appointments, and information
Improvement Target: 1%
Data Source: Press-Ganey Survey

Outcome Improvement Target 2 Estimated Incentive Payment: $615,205</td><td>Outcome Improvement Target 2 [IT-6.1(1)]: Percent improvement over baseline of patient satisfaction scores: patients are getting timely care, appointments, and information
Improvement Target: 1.5%
Data Source: Press-Ganey Survey

Outcome Improvement Target 2 Estimated Incentive Payment: $987,189</td><td>Outcome Improvement Target 3 [IT-6.1(1)]: Percent improvement over baseline of patient satisfaction scores: patients are getting timely care, appointments, and information
Improvement Target: 2%
Data Source: Press-Ganey Survey

Outcome Improvement Target 3 Estimated Incentive Payment: $2,360,670</td></tr>
<tr><td>Year 2 Estimated Outcome Amount: $530,747</td><td>Year 3 Estimated Outcome Amount: $615,205</td><td>Year 4 Estimated Outcome Amount: $987,189</td><td>Year 5 Estimated Outcome Amount: $2,360,670</td></tr>
<tr><td colspan="4">TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5): $4,493,811</td></tr>
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Title of Outcome Measure (Improvement Target): IT- 1.20 Other outcome target: Percent of patients diagnosed with major depression that are adherent to prescribed medication treatment plan

Unique RHP outcome identification number(s): 133355104.3.12

Outcome Measure Description:

IT- 1.20 will be defined as adults age 18 and older with a diagnosis of major depression who show evidence of prescription medication adherence.

Process Milestones:

- DY2: P-1
- DY3: P-2, P-4

Outcome Improvement Target(s) for each year:

- DY4:
  - IT- 1.20 Other outcome target: Percent of patients diagnosed with major depression that are adherent to prescribed medication treatment plan
    - Adherence will be 15% of the identified patient population
- DY5:
  - IT- 1.20 Other outcome target: Percent of patients diagnosed with major depression that are adherent to prescribed medication treatment plan
    - Adherence will be 20% of the identified patient population

Rationale:

The outcome measures of adherence are important specific to the patient engagement in their disease process and the ability to effect mental health distress and behaviors exhibited as a result of major depression. Adherence to medications is a common issue in the United States and accounts for as much as 50% in chronic disease populations[275] and there is approximately only 30% adherence for patients diagnosed with major depression.[276]

Lack of adherence to medication regimes can be indicative of financial limitations that decrease access to necessary medications. Such barriers can be addressed by the mental health professional and the social worker in the community health center. Adherence to medications can be impacted by cultural beliefs and family dynamics that will be identified as part of this initiative and addressed in mental health sessions. Non-adherence can be related to medication side effects, guilt, and insufficient time allowed for the medication to be effective[2] ; all of which can be explained by increasing access to mental health providers and professionals.

Process improvement milestones of P -1 and P-2 were selected as a means to permit time for engagement of stakeholders to discuss, collaborate, and implement a comprehensive approach to promote medication adherence for patients diagnosed with major depression The

[275] Peterson AM, Takiya L, Finley R. (2003).Meta-analysis of trials of interventions to improve medication adherence. *American Journal Health Syst Pharm. Apr 1*;60(7):657-65. PMID: 12701547.

[276] Bucci, K., K, Possidente, C., L., Talbot., K., A. (2003). Strategies to improve medication adherence in patients with depression. *American Journal Health Syst Pharm. Apr 60* . Available from http://www.hawaii.edu/hivandaids/Strategies_to_Improve_Medication_Adherence_in_Patients_with_Depression.pdf

provision of planning to secure supplies, and stakeholder involvement in the types of services to be offered is essential, to promote the necessary collaboration required as part of an enhanced psychiatric and mental health access to services. Project planning will also include the necessary education of providers, existing staff, recruited staff, and also development of patient materials in the healthcare language of patient choice, and at the 5th grade literacy level, specifically for Harris Health patient population. Additionally, the ability to secure key performance indicators required as part of the project and the reporting required to evaluate the outcomes delineated in DY4 and DY5 is paramount to tracking and monitoring quality, access, and cost of care. Improvement targets were placed in DY4 and DY5 in order to collect data and improve upon the established baseline determined in DY3.

Outcome Measure Valuation:

The goal of this project is to increase psychiatry and behavioral therapy staffing at current medical home primary care clinics, in existing underutilized space. All of the targeted health centers offer behavioral services; however the hours and appointment availability are limited. Service hours and appointment capacity will be expanded within each of the clinics. Enhanced access to mental health services and the ability to track and monitor medication adherence will promote a decrease in acute care and emergency center visit utilization, as well as potentially decrease the need for additional inpatient psychiatric beds, thereby lowering the overall cost of care. The increase in provider staffing throughout the existing primary care services network can ultimately meet the behavioral care needs of an additional seven thousand patients annually.

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133355104.3.12	*IT-1.20*	*Percent of patients diagnosed with major depression that are adherent to prescribed medication treatment plan*	
	Harris Health System		*133355104*
Related Category 1 or 2 Projects:	*133355104.1.10*		
Starting Point/Baseline:	To be established in DY2		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Project planning documentation/report Process Milestone 1 Estimated Incentive Payment: $622,680	**Process Milestone 2** [P-2]: Establish baseline rate for patients identified as being diagnosed with major depression. Data Source: EHR Process Milestone 2 Estimated Incentive Payment (maximum amount): $$360,884 **Process Milestone 3** [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Goal: Documentation of PDSA Data source: EHR, utilization reports, pharmacy utilization reports Process Milestone 3 Estimated Incentive Payment: $360,884	**Outcome Improvement Target 1** [IT-1.20]: Other outcome target: Percent of patients diagnosed with major depression that are adherent to prescribed medication treatment plan Improvement Target: Adherence will be 15% of the identified patient population Data Source: EHR, pharmacy utilization reports Outcome Improvement Target 1 Estimated Incentive Payment: $1,158,186	**Outcome Improvement Target 2** [IT-1.20]: Other outcome target: Percent of patients diagnosed with major depression that are adherent to prescribed medication treatment plan Improvement Target: Adherence will be 20% of the identified patient population Data Source: EHR, pharmacy utilization reports Outcome Improvement Target 2 Estimated Incentive Payment: $2,769,575
Year 2 Estimated Outcome Amount: $622,680	Year 3 Estimated Outcome Amount: $721,768	Year 4 Estimated Outcome Amount: $1,158,186	Year 5 Estimated Outcome Amount: $2,769,575
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $ 5,272,209			

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<u>Outcome Measure (Improvement Target):</u> IT-3.2 Congestive Heart Failure 30 Day Readmission Rate

<u>Unique RHP Outcome ID:</u> 133355104.3.13 (133355104.1.11)

<u>Outcome Measure Description:</u>

IT-3.2 Congestive Heart Failure 30 Day Readmission Rate will measure the rate of readmissions, for any cause, within 30 days of discharge from the index HF admission. If an index admission has more than 1 readmission, only first is counted as a readmission.

The implementation of a chronic disease registry will permit the timely identification of patients at risk for acute care utilization relative to chronic disease and the respective patient's ability to appropriately self-manage their disease process. The disease registry will be utilized to identity patients with chronic disease to include the ambulatory sensitive conditions of COPD, Asthma, Diabetes, heart Failure and hypertension. The outcome measurement is specifically pertinent to self-management of the heart failure disease process to educate and manage patients to decrease readmissions for heart failure (IT-3.2); within 30 days of the index admission.

A disease registry stratifies the patients according to geographic location to promote the development of accessible programs to foster education, classes, telephonic outreach and case management services specific to the chronic disease diagnosed. The disease registry tracks utilization which will promote transparency of information sharing relative to appropriate and inappropriate utilization, and facilitates provider education respective to evidence based practice for the treatment of chronic disease. The disease registry additionally displays the gaps in service availability via the monitoring of patterns of utilization locations and the hours of service accessed.

Process Milestones:

- DY2: P-1; P-2
- DY3: P-4

Outcome Improvement Target(s) for each year:

- DY4:
  - IT-3.2 Congestive Heart Failure 30 Day Readmission Rate
    - Decrease the congestive heart failure 30 day readmission rate by 3% of baseline
- DY5:
  - IT-3.2 Congestive Heart Failure 30 Day Readmission Rate
    - Decrease the congestive heart failure 30 day readmission rate by 5% of baseline

<u>Rationale:</u>

Process improvement milestones of P -1 and P-2 were selected as a means to permit time for engagement of stakeholders to secure comprehensive registry system to provide the definitive functionality required. Additionally the ability to secure key performance indicators required electronically as part of the initiative, and the capacity for reporting will require cohesive planning, implementation and testing prior to go-live. Improvement targets were placed in DY3-

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5 in order to collect data and improve upon the established baseline determined in DY2. The baseline will dictate an appropriate improvement target goal.

Outcome Measure Valuation:

The purpose of the implementation of a disease registry is to provide the ability to identify patients at risk based on chronic disease states and associated utilization patterns that will facilitate the ability to identify gaps in service and deficits in patient understanding and self-management of their disease. Patients with chronic illness will have improved health, via education and case management, the cost per patient is decreased due to decreased acute care and emergency visit utilization, and the patient's quality of life is improved. Harris Health internal data for the most recent year has 47,000 patients with one or more of the top 5 diagnoses of chronic disease – heart failure, hypertension, obesity, depression, and chronic respiratory. With a disease registry allowing us to establish clear incidence and prevalence data, the cost saving opportunity related to the potential improved management of these conditions is substantial.

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133355104.3.13	*3.IT-3.2*	*Congestive Heart Failure 30 Day Readmission Rate*	
Harris Health System			*133355104*
Related Category 1 or 2 Projects:	*133355104.1.11*		
Starting Point/Baseline:	*To be established in DY2.*		
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Project planning documentation/report **Process Milestone 1** Estimated Incentive Payment *(maximum amount):* $283,848.50 **Process Milestone 2** [P-2]: Establish baseline rate for Congestive Heart Failure 30 Day Readmission Data Source: EHR Process Milestone 2 Estimated Incentive Payment: $283,848.50	**Process Milestone 3** [P-4]: Conduct PDSA cycles to improve data collection and intervention activities Data source: EHR, utilization reports Milestone 3 Estimated Incentive Payment: $658,034	**Outcome Improvement Target 1** [IT-3.2]: Congestive Heart Failure 30 Day Readmission Rate Improvement Target: 3% of baseline Data Source: EHR Outcome Improvement Target 1 Estimated Incentive Payment*:* $1,055,916	**Outcome Improvement Target 2** [IT-3.2]: Congestive Heart Failure 30 Day Readmission Rate Improvement Target: 5 % of baseline Data Source: EHR Outcome Improvement Target 2 Estimated Incentive Payment*:* $2,525,016
Year 2 Estimated Outcome Amount: $567,697	Year 3 Estimated Outcome Amount: $658,034	Year 4 Estimated Outcome Amount: $1,055,916	Year 5 Estimated Outcome Amount: $2,525,016
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $4,806,663			

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Title of Outcome Measure (Improvement Target): IT-4.2 Central line-associated bloodstream infections (CLABSI) rates

Unique RHP outcome ID: 133355104.3.14

Outcome Measure Description:
IT- 4.2 will measure the number of cases of CLABSI as designated by IQR criteria. Reduction of Central line associated bloodstream infection rates was chosen as an outcome measure as it requires process improvements from an interdisciplinary team of providers and innovators. Sustained improvements can be reached by redesigning our process around insertion and care of devices.

Process Milestones:

- DY2: P-1
- DY3: P-2; P-4

Outcome Improvement Target(s) for each year:

- DY4:
  - IT- 4.2 Central line-associated bloodstream infections (CLABSI) rates
    - Decrease the number of cases of CLABSI as designated by IQR criteria by 20%
- DY5:
  - IT- 4.2 Central line-associated bloodstream infections (CLABSI) rates
    - Decrease the number of cases of CLABSI as designated by IQR criteria by 50%

Rationale:

Process milestones –P-1 through P-3 develops the infrastructure of quality improvement, clinical effectiveness , systems engineering and other expertise to build the foundation for all subsequent processes. A baseline rate (P-2) for Central line-associated bloodstream infections (CLABSI) at Harris Health System will also be established in DY2 for performance purposes.

Improvement targets were placed in DY4 and 5 based on implementation of practices with rapid testing cycles for sustainable change in multiple clinical units and hospitals.

Outcome Measure Valuation:
The goal of the center is to define high impact opportunities in patient safety, clinical effectiveness of evidence based best practices, population health, care coordination and unmet patient needs in Medicaid and uninsured patients. The center design team will partner with healthcare providers, patients and other stakeholders to develop innovation strategies and plans, and pilot the implementation. As noted earlier, centers of healthcare innovation at other prominent healthcare organizations are excellent references. The success of these programs demonstrates high reliability organizations in patient safety, clinical effectiveness, cost of care and integration of nontraditional community resources to improve health. These centers have reduced patient harm, improved mortality, reduced patient admissions, readmissions and emergency room visits, improved patient satisfaction and reduced disparities in healthcare delivery.

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133355104.3.14	*3.IT-4.2*	*Central line-associated bloodstream infections (CLABSI) rates*	
Harris Health System			*133355104*
Related Category 1 or 2 Projects:	*133355104.1.12*		
Starting Point/Baseline:	*To be determined in DY2.*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Planning documentation Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $526,047.50 **Process Milestone 2** [P-2]: Establish baseline rates at Harris Health System- Central line-associated bloodstream infections (CLABSI) rates Data Source: EHR Process Milestone 2 Estimated Incentive Payment: $526,047.50	**Process Milestone 3** [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Data Source: PDSA documentation Process Milestone 3 Estimated Incentive Payment: $1,219,515	**Outcome Improvement Target 1** [IT-4.2]: Central line-associated bloodstream infections (CLABSI) rates Improvement Target: Decrease the number of cases of CLABSI as designated by IQR criteria at Harris Health System by 20% of baseline Data Source: EHR, Claims, IQR/NHSN data Outcome Improvement Target 1 Estimated Incentive Payment*:* $1,956,897	**Outcome Improvement Target 2** [IT-4.2]: Central line-associated bloodstream infections (CLABSI) rates Improvement Target: Decrease the number of cases of CLABSI as designated by IQR criteria at Harris Health System by 30% of baseline Data Source: EHR, Claims, IQR/NHSN data Outcome Improvement Target 2 Estimated Incentive Payment*:* $4,679,536
Year 2 Estimated Outcome Amount: $1,052,095	Year 3 Estimated Outcome Amount: $1,219,515	Year 4 Estimated Outcome Amount: $1,956,897	Year 5 Estimated Outcome Amount: $4,679,536
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $8,908,043			

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Title of Outcome Measure (Improvement Target): IT-5.1- Improved cost savings: Demonstrate cost savings in care delivery

Unique RHP outcome identification number: 133355104.3.15

Outcome Measure Description:

OD-5 Cost of Care – IT-5.1 Improved cost savings: Demonstrate cost savings in care delivery

Central fill will decrease costs through efficiencies gained with central fill automation (robotics, conveyor system, sorting and packing technology) thus decreasing labor costs. Therefore, we will measure the decreasing average labor cost per prescription as the percentage of total prescriptions processed through automation increases.

a) We will implement cost accounting systems to measure intervention impacts by monitoring average labor cost per prescription.
b) We will establish a method to measure cost containment by using the total salaries and benefits (as the numerator) and total number of ambulatory prescriptions filled (as the denominator) as stated on the monthly operating statements.
c) We will use the current state from the month preceding implementation as our baseline for cost. We currently have no automation.
d) We will measure cost containment by comparing the project's average labor cost per prescription and the percentage of prescriptions filled at the central fill site to the baseline at yearly intervals.

This cost savings is based on the current volume of 2.5M total prescriptions per year**.**

Process Milestones:

- **DY2**: P-2 Establish a baseline rate

Improvement Milestones:

- **DY3-DY5**: IT-5.1 Improved cost savings: Demonstrate cost savings in care delivery (stand-alone)

Outcome Improvement Targets:

- **DY3:** Cost savings: 7% decrease in average labor cost per prescription when processing 40% of the total Harris Health ambulatory volume at the central fill facility by the end of the year.
- **DY4**: Cost savings: 19% decrease in in average labor cost per prescription over established baseline by processing 50% of the total Harris Health ambulatory volume at the central fill facility.
- **DY5**: Cost savings: 31% decrease in in average labor cost per prescription over established baseline by processing 60% of the total Harris Health ambulatory volume at the central fill facility.

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Rationale:

Our process milestone P-2 is to establish a baseline cost based on current state before implementation of central fill.

Outcome Improvements will be analyzed by the Cost Benefit Analysis comparing the average labor cost per prescription at the goal percentage rates compared to baseline average labor cost per prescription.

Considering that there is no current automation at Harris Health Department of Pharmacy for prescription processing, the baseline rate will be the average labor cost per prescription when 0% of prescriptions are filled at the central fill facility. The data source will be the monthly operating statement from the month prior to go-live.

In DY3 cost savings result from a 7% decrease the average labor cost per prescription using the total salaries and benefits/total number of Harris Health prescriptions as found on the monthly operating statement compared to baseline. The cost savings are a result of automation efficiencies.

In DY4, cost savings result from a 19% decrease from baseline in the average labor cost per prescription using the total salaries and benefits/total number of Harris Health prescriptions as found on the monthly operating statement compared to baseline. The cost savings are a result of automation efficiencies.

In DY5, cost savings result from a 31% decrease from baseline in the average labor cost per prescription using the total salaries and benefits/total number of Harris Health prescriptions as found on the monthly operating statement compared to baseline. The cost savings are a result of automation efficiencies.

Outcome Measure Valuation:

This project is a supporting pillar for one of the main objectives of the 1115 Waiver; increasing access to primary care for the underserved population in Harris County. The value of the project is based on cost avoidance, projecting savings associated with reducing the costs incurred in filling 2.5 million current patient prescriptions on an annual basis. Based on the increase in primary care volumes addressed in several other Harris Health System Waiver projects, further growth in volume to over 3.0 million prescriptions is projected. Despite this increase in prescription volume, processing costs are projected to decrease in total with the addition of the central fill function. The prompt availability of needed prescriptions for our underserved patients, particularly those with chronic disease that can be managed effectively with appropriate pharmaceuticals, will result in fewer emergency room visits for public and private hospitals located in the service area, and will also help to prevent future downstream inpatient admission

133355104.3.15	*IT-5.1*	*Improved cost savings: Demonstrate cost savings in care delivery (stand alone)*	
Harris Health			*133355104*
Related Category 1 or 2 Projects::	*133355104.2.1*		
Starting Point/Baseline:	*0% of total prescription volume filled by automation*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-2]: Establish a baseline for cost Metric 1 [P-2.1]: Average labor cost per prescription Goal: Provide documentation of the updated baseline average cost/Rx Data Source: Operating statements from the month immediately preceding implementation of Central Fill project Milestone 1 Estimated Incentive Payment (*maximum amount)*: $806,743	**Outcome Improvement Target 1** [IT-5.1]: Improved cost savings: Demonstrate cost savings in care delivery Type of analysis: Cost Benefit Analysis using average labor cost per prescription calculated by total salaries and benefits divided by total # prescriptions Improvement Target: Decrease average labor cost per prescription 7% from established baseline (based on 2.5M annual prescription volume) Data source: Monthly operating statements – Total Salaries & Benefits and Prescription Statistics Outcome Improvement Target 1 Estimated Incentive Payment*:* $935,120	**Outcome Improvement Target 2** [IT-5.1]: Improved cost savings: Demonstrate cost savings in care delivery Type of analysis: Cost Benefit Analysis using average labor cost per prescription calculated by total salaries and benefits divided by total # prescriptions Improvement Target: Decrease average labor cost per prescription 19% from baseline (based on 2.5M annual prescription volume) Data source: Monthly operating statements – Total Salaries & Benefits and Prescription Statistics Outcome Improvement Target 2 Estimated Incentive Payment*:* $1,500,542	**Outcome Improvement Target 3** [IT-5.1]: Improved cost savings: Demonstrate cost savings in care delivery Type of analysis: Cost Benefit Analysis using average labor cost per prescription calculated by total salaries and benefits divided by total # prescriptions Improvement Target: Decrease average labor cost per prescription 31% from baseline (based on 2.5M annual prescription volume) Data source: Monthly operating statements – Total Salaries & Benefits and Prescription Statistics Outcome Improvement Target 3 Estimated Incentive Payment*:* $3,588,253
Year 2 Estimated Outcome Amount: $806,743	Year 3 Estimated Outcome Amount: $935,120	Year 4 Estimated Outcome Amount: $1,500,542	Year 5 Estimated Outcome Amount: $3,588,253
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $6,830,658			

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Title of Outcome Measure (Improvement Target): IT-9.4 Reduce ER Utilization for Frequent User Cohort

Unique RHP Outcome Identification Number: 133355104.3.16

Outcome Measure Description:

IT-9.4 will measure the reduction in ER utilization for the identified frequent user cohort.

This project will identify the highest utilizers of emergency room services in the Harris health System, and implement personalized navigation and management plans in order to decrease the annual rate of usage for these patients. The value of the project is based on cost savings associated with a substantial reduction in the utilization of emergency services, as well as helping to prevent future downstream inpatient admissions that frequently occur in this population. While the initial focus will begin with the top 100 patients, as the program expands we will drill further into the emergency room population and enroll more patients, as appropriate.

Process Milestones:

- DY2: P-1
- DY3: P-2

Outcome Improvement Targets:

- DY4: Reduce utilization rate by 10% compared to baseline
- DY5: Reduce utilization rate by 20% compared to baseline

Rationale:

Because this is a new service, process milestones P-1 and P-2 were selected in order to plan for the program and establish baseline metrics. Outcome IT-9.4 was selected to measure overall utilization of ER resources by the most frequent users. Decreases in ER resource utilization will reflect the success of the navigation program. The goals reflect that not all patients may engage fully in the navigation program. [277]

In 2010, over 40% of Harris County ER visits by Harris County residents were primary care related, these include visits for conditions that are non-urgent, primary care treatable, and primary care preventable. The average cost to treat these patients in the ER versus a primary care setting was approximately $800 per visit for all age groups. Connecting patients who frequent the ER with consistent, coordinated primary and specialty care access will improve clinical outcomes, which will decrease the need to access emergent services.

Outcome Measure Valuation:

[277] Gawande A. The Hot Spotters: Can we lower medical costs by giving the neediest patients better care? *The New Yorker.* 2011. http://www.newyorker.com/reporting/2011/01/24/110124fa_fact_gawande. Accessed October 25, 2012.

This project will identify the highest utilizers of emergency room services in the Harris health System, and implement personalized navigation and management plans in order to decrease the annual rate of usage for these patients. The value of the project is based on cost savings associated with a substantial reduction in the utilization of emergency services, as well as helping to prevent future downstream inpatient admissions that frequently occur in this population. While the initial focus will begin with the top 100 patients, as the program expands we will drill further into the emergency room population and enroll more patients, as appropriate.

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133355104.3.16	*IT-9.4*	*Reduce ER Utilization for Frequent User Cohort*	
Harris Health System			*133355104*
Related Category 2 Projects:	*133355104.2.2*		
Starting Point/Baseline:	*To be established in DY3.*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Complete project plan Data Source: Project plan document. Process Milestone 1 Estimated Incentive Payment: $368,321	**Process Milestone 2** [P-2]: Establish baseline EC utilization rate for top 100 frequent ER users Data Source: EHR Process Milestone 2 Estimated Incentive Payment: $426,933	**Outcome Improvement Target 1** [IT-9.4]: Reduce ER utilization rate for frequent user cohort Improvement Target: Reduce utilization rate by 10% compared to baseline Data Source: EHR Outcome Improvement Target 1 Estimated Incentive Payment: $685,078	**Outcome Improvement Target 2** [IT-9.4]: Reduce EC utilization rate for frequent user cohort Improvement Target: Reduce utilization rate by 20% compared to baseline Data Source: EHR Outcome Improvement Target 2 Estimated Incentive Payment: $1,638,229
Year 2 Estimated Outcome Amount: $368,321	Year 3 Estimated Outcome Amount: $426,933	Year 4 Estimated Outcome Amount: $685,078	Year 5 Estimated Outcome Amount: $1,638,229
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $3,118,561			

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Title of Outcome Measure (Improvement Target): IT-9.4 Reduced EC Utilization for ESI Level 5 Patients

Unique RHP Outcome Identification Number: 133355104.3.17

Outcome Measure Description:

Because this is a new service, process milestones P-1 and P-2 were selected in order to plan for the program and establish baseline metrics. Outcome IT-9.4 was selected to measure overall utilization of EC resources. Because the volume of patients who present to the EC cannot be controlled by the hospital system, we will measure the percentage of eligible patients who are referred to more appropriate care settings.

Process Milestones:

- DY2: P-1
- DY3: P-2

Outcome Improvement Targets:

- DY4 and DY5: IT-9.4 – Reduced EC Utilization with year over year improvements

Rationale:

In 2010, over 40% of Harris County ER visits by Harris County residents were primary care related, these include visits for conditions that are non-urgent, primary care treatable, and primary care preventable. The average cost to treat these patients in the ER versus a primary care setting was approximately $800 per visit for all age groups. Referring patients with primary care treatable conditions to proximate same day clinics can help to reduce costs of care for the affected individual patients, freeing resources and improving efficiency for patients who need emergent care.

Outcome Measure Valuation:

This project will improve patient throughput times for patients appropriately utilizing emergency room services, and improve the overall efficiency of the healthcare system by helping patients with non-urgent conditions receive appropriate care in a more cost effective setting. The value of the project is based on cost savings associated with a reduction in the utilization of emergency services by non-urgent patients. Referring patients with primary care treatable conditions to proximate walk-in clinics can also help to reduce costs of care for the affected individual patients, freeing resources and improving efficiency for patients who need emergent care.

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133355104.3.17	*IT-9.4*	*Reduced EC Utilization for ESI Level 5 Patients*	
Harris Health System			*133355104*
Related Category 2 Projects:	*133355104.2.3*		
Starting Point/Baseline:	*To be established in DY3.*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Complete project plan Data Source: Project plan document. Process Milestone 1 Estimated Incentive Payment: $288,935	**Process Milestone 2** [P-2]: Establish baseline EC utilization rate for ESI level 5 patients Data Source: EHR Process Milestone 2 Estimated Incentive Payment: $334,913	**Outcome Improvement Target 1** [IT-9.4]: Reduce EC utilization rate for ESI level 5 patients Improvement Target: Reduce utilization rate by 5% compared to baseline Data Source: EHR Outcome Improvement Target 1 Estimated Incentive Payment: $537,419	**Outcome Improvement Target 2** [IT-9.4]: Reduce EC utilization rate for ESI level 5 patients Improvement Target: Reduce utilization rate by 10% compared to baseline Data Source: EHR Outcome Improvement Target 2 Estimated Incentive Payment: $1,285,132
Year 2 Estimated Outcome Amount: $288,935	Year 3 Estimated Outcome Amount: $334,913	Year 4 Estimated Outcome Amount: $537,419	Year 5 Estimated Outcome Amount: $1,285,132
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $ 2,446,399			

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Harris County Hospital District Ben Taub General Hospital

Pass 2

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<u>Title of Outcome Measure (Improvement Target):</u> IT-10.1 Quality of Life

<u>Unique RHP Outcome ID:</u> 133355104.3.18 / Pass 2

<u>Outcome Measure Description:</u>

The outcome measure used for this program to measure improvement in quality of life is the Short Form Health Survey (SF-36). This is an outcome domain OD-10 Quality of Life/Functional Status Measure that is specifically IT-10.1 Quality of Life. The performing provider will be the physical or occupational therapist providing services.

This outcome measure was selected because it is able to be used on individuals from a wide range of age groups and treatment groups with a variety of diseases and conditions. In addition, this outcome measure is available in over 140 translations. This tool is evidence based and validated for a wide range of diagnostic groups that are routinely seen in outpatient services.

The SF-36 is a multipurpose, 36-item survey that measures eight domains of health: physical functioning, role limitations due to physical health, bodily pain, general health perceptions, vitality, social functioning, role limitations due to emotional problems, and mental health. It yields scale scores for each of these eight health domains, and two summary measures of physical and mental health: the Physical Component Summary (PCS) and Mental Component Summary (MCS). Patients will complete the Short Form Health Survey (SF-36) upon initial evaluation and upon discharge from Physical or Occupational Therapy to measure the patient's perceived quality of life before and after therapy intervention. With this outcome measure, improvement in quality of life will be demonstrated by an increased score at discharge from the score at initial evaluation. The scores will vary from patient to patient, but an average score is above a 50. The determined outcome improvement target for each year and patient will be to improve the score to greater than 50 at discharge from physical and occupational therapy.

Process Milestones:

- DY2: P-4
- DY3: P-2
- DY4: P-5

Outcome Improvement Target(s) for each year:

- DY4:
    - IT-10.1 Quality of Life
    - Improve quality of life (QOL) scores to greater than 50 at discharge from therapy for at least 10% of the patients seen in DY4
- DY5:
    - IT-10.1 Quality of Life
    - Improve quality of life (QOL) scores to greater than 50 at discharge from therapy for at least 20% of the patients seen in DY5

<u>Rationale:</u>

Milestones P-2 and P-4 were chosen to determine the baseline Quality of Life data for the population served and design a method to organize data and determine appropriate interventions to improve Quality of Life in order to determine the outcome improvement targets for the specific population served in years 3, 4, and 5. Milestone P-5 was chosen to ensure that the baseline data, lessons learned, and best practices be disseminate to the stakeholders and specialty providers to improve Quality of Life with improved access to care.

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The average QOL score is above a 50; therefore, Improvement Targets in DY4 and DY5 aim to improve QOL scores to greater than 50 at discharge from therapy for at least 10% of the patients seen in DY4 and 20% of patients seen in DY5.

Outcome Measure Valuation:

This project will increase the capacity to provide outpatient physical and occupational therapy services to the underserved areas of Harris County, primarily low-income, uninsured and Medicaid populations. The expanded Outpatient Physical Therapy and Occupational Therapy (PT and OT) services will be targeted to populations who are at risk for impairments in activities of daily living resulting from a lack of access to specialty care. The project will improve access by providing an additional 23 PT and OT providers to the Rehabilitation Services department and by adding additional outpatient therapy treatment space near the referring clinics, facilitating an increase in the number of patients seen per month by specialty Physical and Occupational Therapy services of 1,320 patients. The project will result in improved quality of life by persons served, measured by a standard health survey.

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133355104.3.18	*3.IT-10.1*	*Quality of Life*	
Harris Health System			*133355104*
Related Category 1 or 2 Projects:	*133355104.1.13*		
Starting Point/Baseline:	*To be established in DY2.*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-2]: Establish baseline scores for quality of life using SF-36 Data Source: EHR and SF-36 scores from initial evaluation and discharge. Process Milestone 1 Estimated Incentive Payment *(maximum amount):*$ 214,155 **Process Milestone 2** [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Data Source: EHR and SF-36 scores from initial evaluation and discharge. Process Milestone 2 Estimated Incentive Payment:$ 214,155	**Process Milestone 3** [P-5]: Disseminate findings, including lessons learned and best practices, to stakeholders Data Source: EHR, baseline data and PDSA Process Milestone 3 Estimated Incentive Payment: $496,467	**Outcome Improvement Target 1** [IT 10.1]: Quality of life; Patient self-reported scores on the SF-36 Improvement Target: Improve quality of life (QOL) scores to greater than 50 at discharge from therapy for at least 10% of the patients seen in DY4 Data Source: EHR and SF-36 scores from initial evaluation and discharge. Outcome Improvement Target 1 Estimated Incentive Payment*:* $796,657	**Outcome Improvement Target 2** [IT 10.1]: Quality of life; Patient self-reported scores on the SF-36 Improvement Target: Improve quality of life (QOL) scores to greater than 50 at discharge from therapy for at least 20% of the patients seen in DY5 Data Source: EHR and SF-36 scores from initial evaluation and discharge. Outcome Improvement Target 2 Estimated Incentive Payment*:* $1,905,049
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $428,310	Year 3 Estimated Outcome Amount: $496,467	Year 4 Estimated Outcome Amount: $796,657	Year 5 Estimated Outcome Amount: $1,905,049
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $3,626,484			

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Title of Outcome Measure (Improvement Target): IT- 6.1 Percent improvement over baseline of patient satisfaction (1) are getting timely care, appointments, and information

Unique RHP outcome identification number(s): 133355104.3.19 / Pass 2

Outcome Measure Description:

IT- 6.1 will measure improvement in satisfaction scores over time relating to timeliness of care at the Casa de Amigos (Casa) same day access clinic, specifically measuring the mean score for the Press Ganey survey question- "Ease of scheduling appointments."

Currently, Harris Health System health centers are designated NCQA Primary Care Medical Homes with increasingly limited capacity. Health center providers are currently 95% empaneled. Moreover, physicians in Harris Health System health centers carry a panel of 2,250 patients, which is higher than the industry standard of approximately 1,500 patients. Full panels lead to decreased access to primary care appointments at health centers. These health centers are approaching maximum capacity for empaneled patients. From March 2012-September 2012, the Patient Appointment Center was unable to schedule 68,247 unduplicated patients for primary care. For Casa de Amigos Health Center, there were 107 unduplicated patients for which there were no Family Practice appointments available in the month of September 2012 alone. As a result, patient satisfaction scores reported by Press Ganey can be greatly improved. From November 2011-October 2012 at Casa de Amigos Health Center, the mean score for "Ease of scheduling appointments" was 74.7.

Same day access clinic operations will differ from current health centers, resulting in a need for a customized survey. The baseline patient satisfaction score at Casa same day access clinic will be established in DY3 after a new, custom survey is developed and implemented through Press Ganey for same day access clinic usage.

Process Milestones:

- DY2: P-1; P-5
- DY3: P-2; P-4

Outcome Improvement Target(s) for each year:

- DY4:
  - IT- 6.1 Percent improvement over baseline of patient satisfaction (1) are getting timely care, appointments, and information
    - Increase "Ease of scheduling appointments" score by 1% above baseline
- DY5
  - IT- 6.1 Percent improvement over baseline of patient satisfaction (1) are getting timely care, appointments, and information
    - Increase "Ease of scheduling appointments" score by 2% above baseline

Rationale:

P-1 was chosen to ensure that all necessary stakeholders are consulted to develop strategies and processes necessary to reach patient satisfaction goals. Moreover, a new, customized patient satisfaction survey will be developed for same day access clinics in partnership with Press Ganey. P-5 will also be approached in DY2. We plan to share finding and lessons from project planning with internal and external stakeholders. In DY3, P-2 will produce a baseline "Ease of scheduling appointments" score at the new same day access clinic based on

available performance. In DY3, we will also conduct PDSA cycles for P-4 to ensure that strategies and processes for identified interventions are effective.

IT-6.1 will be measured beginning in DY4 to allow for time and resources needed to purchase lease space, hire staff, and operate the same day access clinic for patient care and successful survey calculation. Improvement targets were chosen with the expectation to reach patient satisfaction goals gradually to coincide with improvements in operations at the clinic.

Outcome Measure Valuation:

This project addresses one of the main objectives of the 1115 Waiver; increasing access to primary care for the underserved population in this area of Harris County. The value of the project is based on the clinic's capacity to provide primary care services, including laboratory point-of-care testing, along with timely referrals for specialty care, imaging and other needed services within the Harris Health System network. The clinic can ultimately care for the episodic primary care needs of over ten thousand patients annually, and refer new patients with chronic disease management needs to one of the NCQA certified medical home clinics that are operated by Harris Health. In addition, the availability of same day primary care appointments will result in fewer emergency room visits for public and private hospitals located in the service area. Early detection, treatment and education regarding wellness and prevention will also help to prevent future downstream inpatient admissions.

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133355104.3.19	*3.IT-6.1*	*Percent improvement over baseline of patient satisfaction (1) are getting timely care, appointments, and information*	
Harris Health System			*133355104*
Related Category 1 or 2 Projects:	*133355104.1.14*		
Starting Point/Baseline:	*To be established in DY3*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: EHR; Business Intelligence Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $419,558 **Process Milestone 2** [P-5]: Disseminate findings, including lessons learned and best practices, to stakeholders Data Source: EHR; Business Intelligence; reports Process Milestone 2 Estimated Incentive Payment: $419,558	**Process Milestone 3** [P-2]: Establish baseline patient satisfaction score for "Ease of scheduling appointments" at Casa de Amigos same day access clinic Data Source: Press Ganey Process Milestone 3 Estimated Incentive Payment: $486,323 **Process Milestone 4** [P-4]: Conduct Plan Do Study Act (PDCA) cycles to improve intervention activities Data Source: Report documentation Process Milestone 4 Estimated Incentive Payment*: $*486,323	**Outcome Improvement Target 1** [IT-6.1]: Percent improvement over baseline of patient satisfaction (1) are getting timely care, appointments, and information Improvement Target: Increase "Ease of scheduling appointments" score by 1% above baseline Data Source: Press Ganey Outcome Improvement Target 1 Estimated Incentive Payment*:* $1,560,756	**Outcome Improvement Target 2** [IT-6.1]: Percent improvement over baseline of patient satisfaction (1) are getting timely care, appointments, and information Improvement Target: Increase "Ease of scheduling appointments" score by 2% above baseline Data Source: Press Ganey Outcome Improvement Target 2 Estimated Incentive Payment*:* $3,732,243
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $839,116	Year 3 Estimated Outcome Amount: $972,645	Year 4 Estimated Outcome Amount: $1,560,756	Year 5 Estimated Outcome Amount: $3,732,243
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $7,104,761			

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Title of Outcome Measure (Improvement Target): IT-7.8 Chronic Disease Patients Accessing Dental Services: Percentage of patients with chronic disease conditions accessing dental services following referral by their medical provider. (Standalone measure)

Unique RHP outcome identification number: 133355104.3.20 / Pass 2

Performing Provider name/TPI: Harris Health System / TPI 133355104

Outcome Measure Description:

Process Milestones
- DY2: P-1
- DY3: P-2

Outcome Improvement Milestones and Targets:
- DY4:
  - IT-7.8 Chronic Disease Patients Accessing Dental Services: Percentage of patients with diabetes accessing dental services following referral by their medical provider. Target: 5% increase over baseline
- DY5:
  - IT-7.8 Chronic Disease Patients Accessing Dental Services: Percentage of patients with diabetes accessing dental services following referral by their medical provider. Target: 7% increase over baseline

Rationale

In DY2, we will focus on process milestone P-1 chosen to ensure that all necessary stakeholders are consulted to develop strategies and processes necessary to reach patient satisfaction goals. P-5 will also be completed in DY2 as we share findings and lessons from project planning with internal and external stakeholders. In DY3, we will establish the baseline rate to be used for measuring and reporting purposes in DY4 and DY5. During DY4 and DY5, we will begin to measure improvement targets. Our goal is to increase the percentage of patients with diabetes who access our dental services following a referral. We chose a low target because the demand is greater than the access.

Outcome Measure Valuation:

There is limited access for oral health, particularly for the low-income, uninsured, and Medicaid populations. Oral health is vital in disease prevention. Bad oral health care increases the risk of heart disease, diabetes and stroke. By adding and expanding dental services to seven sites, we will be increasing access to oral health services for the underserved in Harris County, and thereby helping to reduce disparities. The expanded services in Harris Health clinics can ultimately address the routine dental care needs of over ten thousand patients, or 25,000 additional visits, annually. Treating cavities and other oral health problems will assist in providing healthcare cost savings by preventing or mitigating the effects of other chronic diseases, with a specific focus on the diabetic population.

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133355104.3.20	*IT-7.8*	*Chronic Disease Patients Accessing Dental Services: Percentage of patients with chronic disease conditions accessing dental services following referral by their medical provider.*	
Harris Health System			*133355104*
Related Category 1 or 2 Projects:	*133355104.1.15*		
Starting Point/Baseline:	*TBD*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning **-** engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: EHR; Business Intelligence Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $ 764,898	**Process Milestone 2** [P-2]: Establish baseline rates of unduplicated patients with diabetes accessing dental services at new primary care sites following referral by their medical provider. Data Source: EMR Process Milestone 2 Estimated Incentive Payment: $886,617	**Outcome Improvement Target 1** [IT-7.8] Chronic Disease Patients Accessing Dental Services: Percentage of patients with diabetes accessing dental services following referral by their medical provider. Improvement Target: 5% increase over baseline Data Source: EMR Outcome Improvement Target 1 Estimated Incentive Payment*:* $1,422,711	**Outcome Improvement Target 2** [IT-7.8] Chronic Disease Patients Accessing Dental Services: Percentage of patients with diabetes accessing dental services following referral by their medical provider. Improvement Target: 7% increase over baseline Data Source: EMR Outcome Improvement Target 2: Estimated Incentive Payment*:* $3,402,135
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $ 764,898	Year 3 Estimated Outcome Amount: $886,617	Year 4 Estimated Outcome Amount: $1,422,711	Year 5 Estimated Outcome Amount: $3,402,135
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $6,476,361			

Harris County Hospital District Ben Taub General Hospital

Pass 3

DRAFT

Title of Outcome Measure (Improvement Target): IT-6.1 (1) Percent improvement over baseline of patient satisfaction scores: Patients are getting timely care, appointments, and information

Unique RHP outcome identification number: 133355104.3.21 / Pass 3

Outcome Measure Description:

OD-6; IT-6.1(1)

- **Process Milestones selected:**
  - DY2: (P-2) Establish baseline rates – The current house call program does not collect patient satisfaction rates. Harris Health will use patient satisfaction will be measured in DY2 to establish a baseline for improvement.
- **Improvement targets selected:**
  - DY3: (IT-6.1(1)) Improvement Target: 5% improvement above baseline
  - DY4: (IT-6.1(1)) Improvement Target: 10% improvement above baseline
  - DY5: (IT-6.1(1)) Improvement Target: 15% improvement above baseline

Rationale:

It would be no challenge to save money by reducing services, and therefore reducing satisfaction. Therefore while saving money it is critical to assess satisfaction to insure that the patients are not "suffering" from these interventions.

Outcome Measure Valuation:

This project will expand the House Calls Program in order to improve access, maximize independence, and realize cost savings by providing comprehensive, coordinated, multidisciplinary primary care at home to a population of patients that are homebound or have difficulties getting to clinic visits. The geographical challenges of the region will be addressed by a logistics approach using regional cohorting, and the house calls model will create patient-centered, coordinated primary care delivery that improves patient satisfaction and health outcomes, reduces unnecessary services, and builds on the accomplishments of our existing health care system. The present house calls team is very modest, delivering care to 180 housebound patients. By the end of the demonstration period, the four interdisciplinary teams including physicians, nurse practitioners, social workers, pharmacists, therapists, and integrated call center and support team are expecting to manage close 2,000 patients in their homes and make approximately 10,000 house calls in the year. The expected impact will be several thousand fewer ambulance rides, 2,000 fewer EC visits, 670 fewer admissions, resulting in millions of dollars in cost avoidance and realized savings.

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133355104.3.21	*IT-6.1(1)*	*Percent improvement over baseline of patient satisfaction score: are getting timely care, appointments, and information*	
Harris Health System			*133355104*
Related Category 1 or 2 Projects:	*133355104.1.16*		
Starting Point/Baseline:	*TBD*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-2]: Establish Baseline Data Source: Patient Satisfaction survey Process Milestone 1 Estimated Incentive Payment: $1,504,357	**Outcome Improvement Target 1** [IT-6.1(1)]: Percent improvement over baseline of patient satisfaction score: are getting timely care, appointments, and information Improvement Target: 5% improvement above baseline Data Source: Patient Satisfaction Survey Outcome Improvement Target 1 Estimated Incentive Payment: $427,054	**Outcome Improvement Target 2** [IT-6.1(1)]: Percent improvement over baseline of patient satisfaction score: are getting timely care, appointments, and information Improvement Target: 6% improvement above baseline Data Source: Patient Satisfaction Survey Outcome Improvement Target 2 Estimated Incentive Payment: $666,578	**Outcome Improvement Target 3** [IT-6.1(1)]: Percent improvement over baseline of patient satisfaction score: are getting timely care, appointments, and information Improvement Target: 7% improvement above baseline Data Source: Patient Satisfaction Survey Outcome Improvement Target 3 Estimated Incentive Payment: $1,586,826
Year 2 Estimated Outcome Amount: $1,504,357	Year 3 Estimated Outcome Amount: $427,054	Year 4 Estimated Outcome Amount: $666,578	Year 5 Estimated Outcome Amount: $1,586,826
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $4,184,815			

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Title of Outcome Measure (Improvement Target): IT-7.2 Cavities: Percentage of children with untreated dental caries (Standalone measure)

Unique RHP outcome identification number(s): 133355104.3.22/ Pass 3
Performing Provider name/TPI: Harris Health System/133355104

Outcome Measure Description:

Process Milestones:

- DY2:
  - P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
- DY3:
  - P-2 Establish baseline rates of unduplicated patients with untreated dental cavities within the Harris Health System pediatric dental clinics

Improvement Milestones and Targets:

- DY4:
  - IT-7.2 Cavities: Percentage of children with untreated dental caries
    Target: 3% decrease of baseline
- DY5:
  - IT-7.2 Cavities: Percentage of children with untreated dental caries
    Target: 4% decrease of baseline

Rationale:

In DY2, we will focus on process milestone P-1 to allow Harris Health to plan for the implantation of pediatric dental clinics. In DY3, we will establish the baseline rate to be used for measuring and reporting purposes in DY4 and DY5. During DY4 and DY5, we will begin to measure improvement targets. Our goal is to decrease the percentage of children seen within our pediatric dental clinics with untreated dental caries by providing preventive dental treatments. We chose a low target because literature indicates that low-income children are less likely to receive preventative dental services.

Outcome Measure Valuation:

The goal is to increase the number of children accessing dental services. Currently, Harris Health System only offers adult oral health care at some of our centers. Oral health services are essential in preventing gum disease and cavities, which have been linked to other diseases such as diabetes and heart stroke. Access to oral health services is especially important for children and adolescents, since dental problems may affect quality of life and ability to succeed. Children from lower-income families often do not receive timely treatment for tooth decay, and they are more likely to suffer from chronic conditions (National Center for Chronic Disease Prevention and Health Promotion). Treating cavities and other oral health problems at an early age has potential cost savings by preventing other chronic diseases that may come later in life.

133355104.3.22	*IT-7.2*	*Cavities: Percentage of children with untreated dental caries*	
Harris Health System			*133355104*
Related Category 1 or 2 Projects:	*133355104.1.17*		
Starting Point/Baseline:	*TBD*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data source: Planning Documentation Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $1,457,950	**Process Milestone 2** [P-2]: Establish baseline rates of unduplicated patients with untreated dental cavities within the Harris Health System pediatric dental clinics Data Source: EMR, Billing Claims Process Milestone 2 Estimated Incentive Payment: $369,114	**Outcome Improvement Target 1** [IT-7.2] Cavities: Percentage of children with untreated dental caries Improvement Target: 3% decrease of baseline Data Source: EMR, Billing Claims Outcome Improvement Target 1 Estimated Incentive Payment*:* $571,602	**Outcome Improvement Target 2** [IT-7.2] Cavities: Percentage of children with untreated dental caries Improvement Target: 4% decrease of baseline Data Source: EMR, Billing Claims Outcome Improvement Target 2: Estimated Incentive Payment*:* $1,360,732
Year 2 Estimated Outcome Amount: $1,457,950	Year 3 Estimated Outcome Amount: $369,114	Year 4 Estimated Outcome Amount: $571,602	Year 5 Estimated Outcome Amount: $1,360,732
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $3,759,398			

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Title of Outcome Measure (Improvement Target): IT-7.4 Topical Fluoride application (Non-Standalone measure)

Unique RHP outcome identification number(s): 133355104.3.23/ Pass 3

Performing Provider name/TPI: Harris Health System/133355104

Outcome Measure Description:

Process Milestones:

- DY2:
  - P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
- DY3:
  - P-2 Establish baseline rates of children receiving fluoride application within the Harris Health System pediatric dental clinics

Improvement Milestones and Targets:

- DY4:
  - IT-7.4 Topical Fluoride application
    Target: 5% increase from baseline
- DY5:
  - IT-7.4 Topical Fluoride application
    Target: 10% increase from baseline

Rationale:

In DY2, we will focus on process milestone P-1 to allow Harris Health to plan for the implantation of pediatric dental clinics. In DY3, we will establish the baseline rate to be used for measuring and reporting purposes in DY4 and DY5. During DY4 and DY5, we will begin to measure improvement targets. Our goal is to increase the number of fluoride applications to prevent more costly adverse effects. We chose a low target because literature indicates that low-income children are less likely to receive preventative dental services.

Outcome Measure Valuation:

The goal is to increase the number of children accessing dental services. Currently, Harris Health System only offers adult oral health care at some of our centers. Oral health services are essential in preventing gum disease and cavities, which have been linked to other diseases such as diabetes and heart stroke. Access to oral health services is especially important for children and adolescents, since dental problems may affect quality of life and ability to succeed. Children from lower-income families often do not receive timely treatment for tooth decay, and they are more likely to suffer from chronic conditions (National Center for Chronic Disease Prevention and Health Promotion). Treating cavities and other oral health problems at an early age has potential cost savings by preventing other chronic diseases that may come later in life.

DRAFT

133355104.3.23	*IT-7.4*	*Topical Fluoride application*	
Harris Health System			*133355104*
Related Category 1 or 2 Projects:	*133355104.1.17*		
Starting Point/Baseline:	*TBD*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Planning Documentation Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $1,457,950	**Process Milestone 2** [P-2]: Establish baseline rates of children receiving fluoride application within the Harris Health System pediatric dental clinics Data Source: EMR, Billing Claims Process Milestone 2 Estimated Incentive Payment: $369,114	**Outcome Improvement Target 1** [IT-7.4] Topical Fluoride application: Percentage of children, age 6mos-20 years, who received a fluoride varnish application during the measurement period. Improvement Target: 5% increase from baseline Data Source: EMR, Billing Claims Outcome Improvement Target 1 Estimated Incentive Payment*:* $571,602	**Outcome Improvement Target 1** [IT-7.4] Topical Fluoride application: Percentage of children, age 0-20 years, who received a fluoride varnish application during the measurement period. Improvement Target: 10% increase from baseline Data Source: EMR, Billing Claims Outcome Improvement Target 2: Estimated Incentive Payment*:* $1,360,732
Year 2 Estimated Outcome Amount: $1,457,950	Year 3 Estimated Outcome Amount: $369,114	Year 4 Estimated Outcome Amount: $571,602	Year 5 Estimated Outcome Amount: $1,360,732
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $3,759,398			

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Title of Outcome Measure (Improvement Target): IT- 8.2 Percentage of Low Birth-Weight Births

Unique RHP outcome identification number(s): 133355104.3.24 / Pass 3

Outcome Measure Description:

IT- 8.2 will be defined as babies born weighing <2,500 grams at birth and will measure the percentage of low birth-weight births among those patients who have completed the OB Navigation program by the time of delivery at a Harris Health System hospital.

Harris County's low birth weight rate (8.8 %) for the same year is higher than the Healthy People 2020 goal of 7.8% and higher than the 2010 national average of 8.15%. Moreover, the percentage of low birth-weight births at the Harris Health System (LBJ General Hospital and Ben Taub General Hospital combined) for 2011 was 9.9%. Low birth-weight rate is also a Healthy People 2020 objective.

IT-8.2 will measure the percentage of low birth-weight births among those patients who have completed the OB Navigation program (received the intervention) by the time of delivery at a Harris Health System hospital. The definition of "program completion" will be determined during the DY2 planning period. While we know that the 2011 percentage was 9.9%, we will collect more recent baseline data during DY3 for the low birth-weight percentage. The DY3 baseline will be used for performance measurement.

Process Milestones:

- DY2: P-1; P-3; P-5
- DY3: P-2; P-3

Outcome Improvement Target(s) for each year:

- DY4:
  - IT- 8.2 Percentage of Low Birth-Weight Births
    - Of those patients who received the intervention, decrease the percentage of babies born weighing <2,500 grams at birth to less than DY2 baseline
- DY5:
  - IT- 8.2 Percentage of Low Birth-Weight Births
    - Of those patients who received the intervention, decrease the percentage of babies born weighing <2,500 grams at birth to a rate to be determined

Rationale:

Process milestones –P-1 through P-3 were chosen due to the lack of accurate reports and resources currently available to measure and monitor timeliness of prenatal and postnatal care within the Harris Health System. In order to report accurate data and establish baselines, P-1 and P-3 must be approached in DY2-DY3. In DY3 we will establish baseline percentage with P-2. P-5 will be approached in DY2, after the initial gap analysis is completed. Lessons learned will be shared with the Region and stakeholders.

Improvement targets were placed in DY4 and 5 based on the timeframe allowed to put in place the proper resources and processes needed to collect data. The mprovement target goal will be to achieve a low birth-weight percentage below the baseline percentage to be determined in in DY3. The performance during DY4, whether high or low, will dictate an appropriate improvement target goal for DY5. It is also important to note that the outcome measure being addressed may be affected by social determinants other than prenatal encounters with navigators

and providers. For instance, psychosocial, mental health, demography trends, and behavioral issues will affect the incidence of low birth-weight births. In addition, the long timeframe needed to realize perinatal outcomes results for full-term pregnancies was considered when determined improvement targets. Patients in the project will be encountered at the beginning of pregnancy and will need to be followed over time.

Outcome Measure Valuation:

The goal of this project is to utilize community health workers, case managers, social workers, and nurses as a comprehensive patient navigation team that will provide enhanced care coordination, community outreach, social support and culturally competent care to high-risk obstetrics patients throughout their pregnancy. The estimated number of high risk cases at Harris Health on an annual basis is over 2,000. All of those cases will be targeted by this program, with a goal to decrease the percentage of low birth-weight births among patients who complete the program and deliver at Harris Health System. Of those patients who receive patient navigation services, he goal is to decrease the percentage of babies born weighing <2,500 grams at birth to less than DY2 baseline.

DRAFT

133355104.3.24	*3.IT-8.2*	*Percentage of Low Birth-Weight Births*	
Harris Health System			*133355104*
Related Category 1 or 2 Projects:	*133355104.2.4*		
Starting Point/Baseline:	*Accurate Report Not Available*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: EHR reports Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $592,658 **Process Milestone 2** [P-5]: Disseminate findings, including lessons learned and best practices, to stakeholders Data Source: EHR; Business Intelligence; reports Process Milestone 2 Estimated Incentive Payment: $592,658 **Process Milestone 3** [P-3]: Develop and test data systems Data Source: EHR; Business Intelligence Process Milestone 3 Estimated Incentive Payment: $592,658	**Process Milestone 4** [P-3]: Develop and test data systems Data Source: EHR; Business Intelligence Process Milestone 4 Estimated Incentive Payment: $386,954 **Process Milestone 5** [P-2]: Establish baseline rate- total percentage of babies born weighing <2,500 grams at birth at Harris Health System hospitals Data Source: EHR; Business Intelligence Process Milestone 5 Estimated Incentive Payment: $386,954	**Outcome Improvement Target 1** [IT-8.2]: Percentage of Low Birth-Weight Births Improvement Target: Of those patients who received the intervention, decrease the percentage of babies born weighing <2,500 grams to less than DY3 baseline percentage Data Source: EHR; Business Intelligence Outcome Improvement Target 1 Estimated Incentive Payment*:* $1,235,128	**Outcome Improvement Target 2** [IT-8.2]: Percentage of Low Birth-Weight Births Improvement Target: Of those patients who received the intervention, decrease the percentage of babies born weighing <2,500 grams- TBD Data Source: EHR; Business Intelligence Outcome Improvement Target 2 Estimated Incentive Payment*:* $2,940,292
Year 2 Estimated Outcome Amount: $1,777,974	Year 3 Estimated Outcome Amount: $773,908	Year 4 Estimated Outcome Amount: $1,235,128	Year 5 Estimated Outcome Amount: $2,940,292
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $6,727,302			

DRAFT

<u>Title of Outcome Measure (Improvement Target):</u> IT-1.20 Management of International Normalized Ratio (INR) for patients receiving anticoagulation monitoring

<u>Unique Project Identification number</u>: 133355104.3.25/ Pass 3

<u>Performing Provider Name/TPI#:</u> Harris Health System/133355104

Outcome Measure Description

IT-1.20 will measure the percentage of patients with at least 2 consecutive INRs within goal range (goal is specific for each patient). We will divide the number of patients with INR at goal for 2 consecutive visits by the total number of patients with monitored INR to establish the baseline percentages within the Harris Health System.

Process Milestones:

- DY2: P-2

Outcome Improvement Target(s) for each year:

- DY3:
  - IT-1.20 will measure the percentage of patients with at least 2 consecutive INRs within goal range (goal is specific for each patient).
    - 35% of all patients seen at Harris Health will have at least 2 consecutive INRs at goal by the end of DY3
- DY4:
  - IT-1.20 will measure the percentage of patients with at least 2 consecutive INRs within goal range (goal is specific for each patient).
    - 40% of all patients seen at Harris Health will have at least 2 consecutive INRs at goal by the end of DY3
- DY5:
  - IT-1.20 will measure the percentage of patients with at least 2 consecutive INRs within goal range (goal is specific for each patient).
    - 50% of all patients seen at Harris Health will have at least 2 consecutive INRs at goal by the end of DY3

<u>Rationale:</u>

Process milestone P-2 was chosen to determine the percentage of patients with at least 2 consecutive INRs within goal range (goal is specific for each patient). We will divide the number of patients with INRs at goal for 2 consecutive visits by the total number of patients being monitored to establish the baseline percentages within the Harris Health System. Reports run from EPIC® (our electronic medical record system) will allow us to capture the baseline data needed and this will be completed in DY2. Improvement targets were placed in DY3 thru DY5 and are on contingent on our ability to accurately establish the baseline rate in DY2. Improvement target goals will be determined after baseline percentage is set in DY2. The baseline percentage, whether high or low, will dictate an appropriate improvement target goal.

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Outcome Measure Valuation:

In recent years there has been an increasing shift in warfarin therapy management from standard care by a physician to dedicated anticoagulation clinic models. Pharmacist-managed anticoagulation clinics provide patients with expert care, frequent monitoring, and education to ensure optimal outcomes and increased patient safety. Education and patient involvement have been shown to increase compliance, leading to improved patient outcomes as a result of more frequent monitoring. This project significantly enhances our existing delivery system by increasing availability of persons qualified to manage acute and chronic care needs as related to anticoagulation management. This increase in availability not only allows for timely and more frequent patient follow up but also decreases the risk of potential complications which may require management in the acute care setting, resulting in a measurable reduction in the number of hospital admissions and emergency room visits secondary to the warfarin complications rate.

DRAFT

133355104.3.25	*IT-1.20*	*MANAGEMENT OF INTERNATIONAL NORMALIZED RATIO FOR PATIENTS RECEIVING ANTICOAGULATION MONITORING*	
Harris Health System			*133355104*
Related Category 1 or 2 Projects::	*133355104.2.5*		
Starting Point/Baseline:	*TBD*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P- 2] Establish baseline rates for percentage of patients seen by clinical pharmacists with at least 2 consecutive INRs Data Source: EHR Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $1,327,433	**Outcome Improvement Target 1** [IT-1.20]: Management of INR for patients receiving anticoagulation monitoring Improvement Target: 20% increase from baseline of the number of patients seen by clinical pharmacists with at least 2 consecutive INRs at goal. Data Source: EHR Outcome Improvement Target 1 Estimated Incentive Payment: $204,025	**Outcome Improvement Target 2** [IT-1.20]: Management of INR for patients receiving anticoagulation monitoring Improvement Target: 30% increase from baseline of the number of patients seen by clinical pharmacists with at least 2 consecutive INRs at goal. Data Source: EHR Outcome Improvement Target 2 Estimated Incentive Payment: $300,995	**Outcome Improvement Target 3** [IT-1.20]: Management of INR for patients receiving anticoagulation monitoring Improvement Target: 40% increase from baseline of the number of patients seen by clinical pharmacists with at least 2 consecutive INRs at goal. Data Source: EHR Outcome Improvement Target 3 Estimated Incentive Payment: $716,536
Year 2 Estimated Outcome Amount: (target): $1,327,433	Year 3 Estimated Outcome Amount: $204,025	Year 4 Estimated Outcome Amount: $300,995	Year 5 Estimated Outcome Amount: $716,536
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $ 2,548,989			

DRAFT

Title of Outcome Measure (Improvement Target): IT-2.13 Other Admissions Rate

Unique Project Identification number: 133355104.3.26/ Pass 3

Performing Provider Name/TPI#: Harris Health/133355104

Outcome Measure Description:

IT- 2.13 will be defined as other admissions rates and will measure the number of hospital admissions and emergency room visits secondary to warfarin complications at Harris Health System.

Process Milestones:

- DY2: P-2

Outcome Improvement Target(s) for each year:

- DY3:
  - IT- 2.13 Other admissions rate: hospital admissions and emergency room visits secondary to warfarin complications
    - 10% reduction from baseline in the number of hospital admissions and emergency room visits secondary to warfarin complications rate at the end of DY3
- DY4:
  - IT- 2.13 Other admissions rate: hospital admissions and emergency room visits secondary to warfarin complications
    - 20% reduction from baseline in the number of hospital admissions and emergency room visits secondary to warfarin complications rate at the end of DY4
- DY5:
  - T- 2.13 Other admissions rate: hospital admissions and emergency room visits secondary to warfarin complications
    - 40% reduction from baseline in the number of hospital admissions and emergency room visits secondary to warfarin complications rate at the end of DY5

Rationale:

Process milestone P-2 was chosen to determine baseline rates for hospital admissions and emergency room visits secondary to warfarin complications within the Harris Health System. Reports run in EPIC® (our electronic medical record system) will allow us to capture the baseline data needed and this will be completed in DY2. Improvement targets were placed in DY3 thru DY5 and are on contingent on our ability to accurately establish baseline rates in DY2. Improvement target goals will be determined after baseline rates are set in DY2. The baseline rates, whether high or low, will dictate an appropriate improvement target goal.

Outcome Measure Valuation:

In recent years there has been an increasing shift in warfarin therapy management from standard care by a physician to dedicated anticoagulation clinic models. Pharmacist-managed anticoagulation clinics provide patients with expert care, frequent monitoring, and education to ensure optimal outcomes and increased patient safety. Education and patient involvement have been shown to increase compliance, leading to improved patient outcomes as a result of more frequent monitoring. This project significantly enhances our existing delivery system by increasing availability of persons qualified to manage acute and chronic care needs as related to anticoagulation management. This increase in availability not only allows for timely and more frequent patient follow up but also decreases the risk of potential complications which may require management in the acute care setting, resulting in a measurable reduction in the number of hospital admissions and emergency room visits secondary to the warfarin complications rate.

DRAFT

133355104.3.26	*IT-2.13*	*OTHER ADMISSIONS RATE (Standalone measure)*	
Harris Health System			*133355104*
Related Category 1 or 2 Projects::	*133355104.2.5*		
Starting Point/Baseline:	*TBD*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P- 2]: Establish baseline rates for hospital admissions and emergency room visits secondary to warfarin complications Data Source: EHR Process Milestone 1 Estimated Incentive Payment *(maximum amount): $*1,327,433	**Outcome Improvement Target 1 [IT-2.13 Other Admissions Rate]** Improvement Target: 5% reduction from baseline in hospital admissions and emergency room visits secondary to warfarin complications Data Source: EHR, Claims Outcome Improvement Target 1 Estimated Incentive Payment: $204,025	**Outcome Improvement Target 2 [IT-2.13 Other Admissions Rate]** Improvement Target: 10% reduction from baseline in hospital admissions and emergency room visits secondary to warfarin complications Data Source: EHR, Claims Outcome Improvement Target 2 Estimated Incentive Payment: $300,995490	**Outcome Improvement Target 3 [IT-2.13 Other Admissions Rate]** Improvement Target: 15% reduction from baseline in hospital admissions and emergency room visits secondary to warfarin complications Data Source: EHR, Claims Outcome Improvement Target 3 Estimated Incentive Payment: $716,536
Year 2 Estimated Outcome Amount: (target): $1,327,433	Year 3 Estimated Outcome Amount: $204,025	Year 4 Estimated Outcome Amount: $300,995	Year 5 Estimated Outcome Amount: $716,536
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $ 2,548,989			

DRAFT

Title of Outcome Measure (Improvement Target): IT-6.1—Patient Satisfaction
(4) patient's involvement in shared decision making

Unique RHP outcome identification number(s) 133355104.3.27 / Pass 3

Outcome Measure Description:
IT-6.1 Percent Improvement over Baseline of Patient Satisfaction Scores related to involvement in shared decision making

Process Milestones:

- DY2:
  - P-7—Other activities not described: Determine baseline of Outpatient satisfaction scores related to shared decision making
  - P-4—Conduct Plan-Do-Study-Act cycles to improve data collection and intervention activities
- DY3:
  - P-4—Conduct Plan-Do-Study-Act cycles to improve data collection and intervention activities

Outcome Improvement Targets for each year:

- DY3:
  - IT-6.1: Percent Improvement over Baseline of Patient Satisfaction Scores—Increase patient satisfaction scores 5% over baseline for shared decision making
- DY4:
  - IT-6.1: Percent Improvement over Baseline of Patient Satisfaction Scores—Increase patient satisfaction scores 10% over baseline for shared decision making
- DY5:
  - IT-6.1: Percent Improvement over Baseline of Patient Satisfaction Scores—Increase patient satisfaction scores 15% over baseline for shared decision making

Rationale:
Process milestone P-7 was chosen to capture the degree to which providers and patients are engaged in the health promotion effort at baseline. Process milestone P-4 was chosen so that rapid ongoing improvements in the program's effectiveness and reach can be implemented and the outcome improvement targets can be reached throughout DY3-DY5.[18, 19]

The improvement target (IT-6.1) was chosen based on evidence that patient satisfaction surveys are an acceptable proxy of quality care provision in healthcare settings.[17] The improvement in patient satisfaction will compliment the Category 2 Improvement measure. It is believed the more patients who receive health promotion through their primary care provider and medical home, the more will view this aspect of care favorably and will express satisfaction in the shared decision making activities in which they engage with their providers around the issues of health promotion and healthy eating.

Outcome Measure Valuation:
The goal of the this project is to develop a program for promoting increased consumption of fruits and vegetables among primary care patients through an integrated approach that

includes multi-provider and multi-modal patient education and access to a clinic-based farmer's market. Providers in Harris Health System recognize the need to counsel patients on healthy lifestyle behavior, but are often hesitant because of the challenges patients face with compliance. This project will leverage the motivating power of the provider-patient relationship. It will equip providers with a tangible tool (prescription) to use in their counseling and will give patients a specific avenue for adoption of the recommended behavior. The goal will be to educate 1,000 patients monthly across 10 medical home sites on the health promoting benefits of fruit and vegetable intake. Evidence from studies like Dietary Approaches to Stop Hypertension have determined that diets high in fruits and vegetables can reduce blood pressure, stroke risk, and weight. It has also been shown to prevent some cancers, and diabetes. Given the high level of chronic disease in the Harris Health patient population, improved diet can have immediate positive impact on the health of our patients, and result in long-term savings in emergency and acute care costs.

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133355104.3.27	*IT-6.1(4)*	*Patient Satisfaction (4) patient's involvement in shared decision making*	
	Harris Health System		*1333355104*
Related Category 1 or 2 Projects:	*133355104.2.6*		
Starting Point/Baseline:	*Baseline to be determined in year 2*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-7]: Other activities not described—Establish baseline rate of patients receiving prescriptions for healthy eating Data Source: EHR report of number of prescriptions written Milestone 1 Estimated Incentive Payment (*maximum amount)*: $657,161 **Process Milestone 2** [P-4]: Conduct Plan-Do-Study-Act cycles to improve data collection and intervention activities Data Source: Document weekly program assessment and outcomes and ideas for improvement Milestone 2 Estimated Incentive Payment (*maximum amount)*: $657,162	**Process Milestone 3** [P-4]: Conduct Plan-Do-Study-Act cycles to improve data collection and intervention activities Data Source: Document weekly program assessment and outcomes and ideas for improvement Milestone 3 Estimated Incentive Payment (*maximum amount)*: $83,522 **Outcome Improvement Target 4** [IT-6.1]: Other outcome improvement target— Improvement Target: Increase patient satisfaction score 5% above baseline Data Source: Press Ganey administered patient satisfaction survey results Outcome Improvement Target 4 Estimate Incentive Payment: $83,522	**Outcome Improvement Target 4** [IT-6.1]: Other outcome improvement target— Improvement Target: Increase patient satisfaction score 10% above baseline Data Source: Press Ganey administered patient satisfaction survey results Outcome Improvement Target 4 Estimate Incentive Payment: $273,813	**Outcome Improvement Target 4** **[IT-6.1]:** Other outcome improvement target— Improvement Target: Increase patient satisfaction score 15% above baseline Data Source: Press Ganey administered patient satisfaction survey results Outcome Improvement Target 4 Estimate Incentive Payment: $651,828
Year 2 Estimated Outcome Amount: $1,314,323	Year 3 Estimated Outcome Amount: $167,044	Year 4 Estimated Outcome Amount: $273,813	Year 5 Estimated Outcome Amount: $651,828
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $2,407,008			

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<u>Title of Outcome Measure (Improvement Target):</u> IT-13.1 Pain assessment (NQF-1637)

<u>Unique RHP outcome identification number</u>: 133355104.3.28/ Pass 3

<u>Outcome Measure Description:</u>

IT-13.1 Pain assessment (NQF-1637) *(Non-standalone measure)*
Increase the percentage of palliative care patients who screened positive for pain and who received a clinical assessment of pain within 24 hours of screening.
Exclusion: patients with length of stay < 1 day in palliative care or patients who were not screened for pain. Patients who screen negative for pain are excluded from the denominator.

Process Milestones:

- DY2: P- 1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
- DY3: P- 2 Establish baseline rates

Outcome Improvement Targets for each year:

- DY 4:
  Increase by 3% the percentage of palliative care patients who screened positive for pain and who received a clinical assessment of pain within 24 hours of screening. Exclusion: patients with length of stay < 1 day in palliative care or patients who were not screened for pain. Patients who screen negative for pain are excluded from the denominator.

- DY 5: Increase by 5% the percentage of palliative care patients who screened positive for pain and who received a clinical assessment of pain within 24 hours of screening. Exclusion: patients with length of stay < 1 day in palliative care or patients who were not screened for pain. Patients who screen negative for pain are excluded from the denominator.

<u>Rationale:</u>

Research on care of patients with serious incurable illness and those nearing the end of life shows they experience high rates of pain (40-70% prevalence) and other physical, emotional, and spiritual causes of distress. Pain is under-recognized by clinicians and undertreated, resulting in excess suffering from patients with serious illness. Pain screening and assessments are necessary in order to improve the patient centered outcome of pain, and its effects on global outcomes of function and quality of life.

<u>Outcome Measure Validation:</u>
The goal of this project is to expand our Palliative Care Program with an increase in mid-level practitioners, physicians and social workers to provide palliative care to patients who would otherwise not have access. This model has been shown to prevent emergency center visits, as well as hospital and ICU admissions. The cost of care for seriously ill and dying patients is frequently greater than the reimbursement for such care due to long length-of-stay and utilization of high-cost beds (ICU), drugs, and procedures, and the fixed payment design of reimbursement.

Currently we provide this type of care to less than 350 persons a year. We intend to increase the patient population served to a total of 2000 patients by the end of demonstration year (DY) 5. The research available regarding palliative care shows significant reductions in pharmacy, laboratory, and intensive care costs for care coordinated through a palliative program.

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133355104.3.28	*IT-13.1*	*Pain assessment (NQF-1637) (Non-standalone measure)*	
Harris Health System			133355104
Related Category 1 or 2 Projects:	*133355104.2.7*		
Starting Point/Baseline:	*60 Patients a Year Currently*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Project Reports and Documents Process Milestone 1 Estimated Incentive Payment*:* $ $ 1,289,426	**Process Milestone 2** [P-2]: Establish baseline rates Data source: EHR, palliative care database, provider reports Process Milestone 2 Estimated Incentive Payment: $ 140,552	**Outcome Improvement Target 1** [IT-13.1]: Pain assessment Improvement Target: Increase by 3% the percentage of palliative care patients who screened positive for pain and who received a clinical assessment of pain within 24 hours of screening. Data Source: EHR, palliative care database Outcome Improvement Target 1 Estimated Incentive Payment*:* $222,193	**Outcome Improvement Target 2** [IT-13.1]: Pain assessment Improvement Target: Increase by 5% the percentage of palliative care patients who screened positive for pain and who received a clinical assessment of pain within 24 hours of screening. Data Source: EHR, palliative care database Outcome Improvement Target 2 Estimated Incentive Payment*:* $528,942
Year 2 Estimated Outcome Amount: $ 1,289,426	Year 3 Estimated Outcome Amount: $ 140,552	Year 4 Estimated Outcome Amount: $ 222,193	Year 5 Estimated Outcome Amount: $528,942
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $ 2,181,113			

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Title of Outcome Measure (Improvement Target): IT-13.3 Proportion with more than one emergency room visit in the last days of life (NQF 0211)

Unique RHP outcome identification number: 133355104.3.29/ Pass 3

Outcome Measure Description:

IT-13.3 Proportion with more than one emergency room visit in the last days of life (NQF 0211)- Decrease the percentage of patients who died from cancer or another life-limiting illness with more than one emergency room visit in the last days of life. *(Standalone measure)*

Process Milestones:

- DY2: P- 2 Establish baseline rates
- DY3: P- 4 Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities

Outcome Improvement Targets for each year:

- DY4: IT-13.3 Decrease the percentage of patients who died from cancer with more than one emergency room visit in the last days of life by 3%.
- DY5: IT-13.3 Decrease the percentage of patients who died from cancer with more than one emergency room visit in the last days of life by 5%.

Rationale:

Generally, emergency centers are not organized to provide comfort and palliative care. Although, when operationalized as a claims-based measure, this does not take patient preferences into account, the idea is for the measure to be seen as an overall indication of practice style and/or available palliative resources. An individual patient experiencing this process of care has not necessarily received poor quality care, but unless there is a reason to think that the patients in one setting have a significantly greater proportion with differing preferences, aggregate rates of the measure can justifiably be compared across settings. In this way it is a reflection of the quality of end-of life care.

Outcome Measure Valuation:

The goal of this project is to expand our Palliative Care Program with an increase in mid-level practitioners, physicians and social workers to provide palliative care to patients who would otherwise not have access. This model has been shown to prevent emergency center visits, as well as hospital and ICU admissions. The cost of care for seriously ill and dying patients is frequently greater than the reimbursement for such care due to long length-of-stay and utilization of high-cost beds (ICU), drugs, and procedures, and the fixed payment design of reimbursement. Currently we provide this type of care to less than 350 persons a year. We intend to increase the patient population served to a total of 2000 patients by the end of demonstration year (DY) 5. The research available regarding palliative care shows significant reductions in pharmacy, laboratory, and intensive care costs for care coordinated through a palliative program.

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133355104.3.29	*IT-13.3*	*Proportion with more than one emergency room visit in the last days of life*	
Harris Health System			*133355104*
Related Category 1 or 2 Projects:	*133355104.2.7*		
Starting Point/Baseline:	*TBD*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-2] Establish baseline rates Data Source: EHR, palliative care database Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $ 1,289,426	**Process Milestone 2 [P-4]** Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Data Source: EHR, palliative care database Process Milestone 3 Estimated Incentive Payment: $134, 458140,552	**Outcome Improvement Target 1** [IT-13.3]: Proportion with more than one emergency room visit in the last days of life Improvement Target: Decrease the percentage of patients who died from cancer with more than one emergency room visit in the last days of life by 3%. Data Source: EHR, claims Outcome Improvement Target 1 Estimated Incentive Payment*:* $222,193	**Outcome Improvement Target 2** [IT-13.3]: Proportion with more than one emergency room visit in the last days of life Improvement Target: Decrease the percentage of patients who died from cancer with more than one emergency room visit in the last days of life by 5%. Data Source: EHR, claims Outcome Improvement Target 2 Estimated Incentive Payment*:* $528,942
Year 2 Estimated Outcome Amount: $ 1,289,426	Year 3 Estimated Outcome Amount: $ 140,552	Year 4 Estimated Outcome Amount: $ 222,193	Year 5 Estimated Outcome Amount: $528,942
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $ 2,181,113			

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Title of Outcome Measure (Improvement Target): IT-13.4 Proportion admitted to the ICU in the last 30 days of life (NQF 0213)

Unique RHP outcome identification number: 133355104.3.30/ Pass 3
Outcome Measure Description:

IT-13.4 Proportion admitted to the ICU in the last 30 days of life (NQF 0213) - Percentage of patients who died from cancer admitted to the ICU in the last 30 days of life. *(Standalone measure)*

Process Milestones:

- DY2: P- 2 Establish baseline rates
- DY3: P- 4 Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities

Outcome Improvement Targets for each year:

- DY4: IT-13.4 Decrease the percentage of patients who died from cancer or other life-limiting illness admitted to the ICU in the last 30 days of life by 3%.
- DY5: IT-13.4 Decrease the percentage of patients who died from cancer or other life-limiting illness admitted to the ICU in the last 30 days of life by 5%.

Rationale:
Using patient satisfaction with end-of-life care as a desired outcome, patient survey data reflect patients' desires to die at home and to not be connected to machines at the end-of-life. ICU use near the end of life may indicate a lack of discussion about advance directives. ICU care is expensive and uncomfortable, and generally not appropriate for the dying patient.

Outcome Measure Validation:
The goal of this project is to expand our Palliative Care Program with an increase in mid-level practitioners, physicians and social workers to provide palliative care to patients who would otherwise not have access. This model has been shown to prevent emergency center visits, as well as hospital and ICU admissions. The cost of care for seriously ill and dying patients is frequently greater than the reimbursement for such care due to long length-of-stay and utilization of high-cost beds (ICU), drugs, and procedures, and the fixed payment design of reimbursement. Currently we provide this type of care to less than 350 persons a year. We intend to increase the patient population served to a total of 2000 patients by the end of demonstration year (DY) 5. The research available regarding palliative care shows significant reductions in pharmacy, laboratory, and intensive care costs for care coordinated through a palliative program.

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133355104.3.30	*IT-13.4*	*Proportion admitted to the ICU in the last 30 days of life*	
Harris Health System			*133355104*
Related Category 1 or 2 Projects:	*133355104.2.7*		
Starting Point/Baseline:	*TBD*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-2] Establish baseline rates Data Source: EHR, palliative care database Process Milestone 1 Estimated Incentive Payment*:* $1,289,426	**Process Milestone 2 [P-4]** Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Data Source: EHR, palliative care database Process Milestone 3 Estimated Incentive Payment: $140,552	**Outcome Improvement Target 1** [IT-13.4]: Proportion admitted to the ICU in the last 30 days of life Improvement Target: Decrease the percentage of patients who died from cancer or other life-limiting illness admitted to the ICU in the last 30 days of life by 3%. Data Source: EHR, claims Outcome Improvement Target 1 Estimated Incentive Payment*:* $222,193	**Outcome Improvement Target 2** [IT-13.4]: Proportion admitted to the ICU in the last 30 days of life Improvement Target: Decrease the percentage of patients who died from cancer or other life-limiting illness admitted to the ICU in the last 30 days of life by 5%. Data Source: EHR, claims Outcome Improvement Target 2 Estimated Incentive Payment*:* $528,942
Year 2 Estimated Outcome Amount: $ 1,289,426	Year 3 Estimated Outcome Amount: $ 140,552	Year 4 Estimated Outcome Amount: $ 222,193	Year 5 Estimated Outcome Amount: $528,942
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $ 2,181,113			

DRAFT

Matagorda Regional Medical Center

Pass 1

DRAFT

Title of Outcome Measure (Improvement Target): IT-2.11 Ambulatory Care Sensitive Conditions Admissions Rate

Unique RHP outcome identification number(s): 130959304.3.1

Outcome Measure Description:
IT-2.11 will be defined as the number of acute care hospitalizations for ambulatory care sensitive conditions (grand mal status and other epileptic convulsions, chronic pulmonary diseases (COPD), asthma, heart failure and, pulmonary edema, hypertension, angina and diabetes) for patients in defined population 75 years of age and under.

Process Milestones:

- DY2: P-1; P-2; P-3
- DY3: P-2; P-3; P-4
- DY4: P-4; P-5
- DY5: P-4; P-5

Outcome Improvement Target(s) for each year:

- **DY4:**
  - IT-2.11 Ambulatory Care Sensitive Conditions Admissions Rate
    - Reduce admission rate for acute care hospitalizations for ambulatory care sensitive conditions for individuals under 75 years of age by 5% from DY2 base for those patients of the chronic disease specialty clinic.
- **DY5:**
  - IT-2.11 Ambulatory Care Sensitive Conditions Admissions Rate
    - Reduce admission rate for acute care hospitalizations for ambulatory care sensitive conditions for individuals under 75 years of age by 10% from DY2 base for those patients of the chronic clinic.

Rationale:

The analysis of admissions into the system for acute chronic conditions, the prevalence of chronic disease in the specified population, as well as the rate of uncontrolled chronic conditions is the baseline for the establishment of a chronic disease specialty clinic. To establish the chronic clinic we chose key process milestones of project planning, confirmation of disease rates, admission rates and subsequently the measurement of the performance of the chronic clinic will be accomplished. Process Milestones will all be completed in years 2 and 3. Beginning in year 3 and continuing through year 5, Plan Do Study Act (PDSA) cycles will be utilized for process improvement and refinement. The lessons learned and best practices will be shared across Region 3 as they are experienced to allow for improvement and/or intervention as needed.

Although slight improvement in controlling chronic diseases as well as reducing Ambulatory Care Sensitive Conditions Admissions is expected in Year 3, improvements in this health disparity is expected to be measurable in years 4 and 5. The original study documented a 30% reduction in admissions rate over a 6 year period[278] and supports the expectation of a 5% and 10% in DY4 and 5 respectively.

[278] http://www.qualitymeasures.ahrq.gov/content.aspx?id=27275

Outcome Measure Valuation:

The direct dollar association with achieving the outcomes of this project is mainly in the arena of cost avoidance. For each acute admission reduction for disease related issues, we estimate a savings of approximately $15,000 - $20,000 including the associated reduction in disease crises oriented emergency department visits. Therefore, by reducing 1 admission on 50% of the active clinic patients described as a process milestone, it is possible to avoid as much as $1,000,000 of unnecessary hospital related costs.

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130959304.3.1	*IT-2.11*	*Ambulatory Care Sensitive Conditions Admissions Rate*	
Matagorda Regional Medical Center			130959304
Related Category 1 or 2 Projects:	*130959304.1.1*		
Starting Point/Baseline:	DY2 Ambulatory Admissions Rate- Diabetes, Hypertension, COPD, Asthma		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Reports, Minutes Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $41,025 **Process Milestone 2** [P-2]: Establish baseline rates for admissions targeted and for chronic conditions prior to chronic clinic establishment – base year 10/1/12 through 9/30/13 Data Source: EHR, state and national reports Process Milestone 2 Estimated Incentive Payment: $41,025 **Process Milestone 3** [P-3]: Develop and test data systems to establish performance targets for providers, targeted clinical improvement and reduced admissions Data Source: EHR, HIET Process Milestone 3 Estimated Incentive Payment: $41,024	**Process Milestone 4**[P-4] Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Data Source: Internal Reports Process Milestone 4 Estimated Incentive Payment: $71,329 **Process Milestone 5** [P-5] Disseminate findings, including lessons learned and best practices, to stakeholders Data Source: EHR, Business Intelligence, reports Process Milestone 5 Estimated Incentive Payment: $71,330	**Outcome Improvement Target 1** IT-2.11 Ambulatory Care Sensitive Conditions Admissions Rate Improvement Target: Reduce admission rate for acute care hospitalizations for ambulatory care sensitive conditions for individuals under 75 years of age by 5% from 2013 base for those patients of the chronic clinic Data Source: EHR, State, National Reports Outcome Improvement Target 1 Estimated Incentive Payment*:* $76,306 **Process Milestone6** [P-4] Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Data Source: Internal Reports **Process Milestone6** Estimated Incentive Payment: $76,306 **Process Milestone 7** [P-5] Disseminate findings, including lessons learned and best practices, to stakeholders Data Source: EHR, Business Intelligence, reports	**Outcome Improvement Target 2** IT-2.11 Ambulatory Care Sensitive Conditions Admissions Rate Improvement Target: Reduce admission rate for acute care hospitalizations for ambulatory care sensitive conditions for individuals under 75 years of age by 10% from 2013 base for those patients of the chronic clinic. Data Source: EHR, State National Reports Outcome Improvement Target 2 Estimated Incentive Payment*:* $182,471 **Process Milestone 8** [P-4] Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Data Source: Internal Reports **Process Milestone** 8 Estimated Incentive Payment: $182,472 **Process Milestone 9**[P-5] Disseminate findings, including lessons learned and best practices, to stakeholders Data Source: EHR, Business Intelligence, reports

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130959304.3.1	*IT-2.11*	*Ambulatory Care Sensitive Conditions Admissions Rate*	
Matagorda Regional Medical Center			130959304
Related Category 1 or 2 Projects:	*130959304.1.1*		
Starting Point/Baseline:	DY2 Ambulatory Admissions Rate- Diabetes, Hypertension, COPD, Asthma		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
		Process Milestone 7 Estimated Incentive Payment: $76,306	**Process Milestone** 9 Estimated Incentive Payment: $182,471
Year 2 Estimated Outcome Amount: $123,074	Year 3 Estimated Outcome Amount: $142,659	Year 4 Estimated Outcome Amount: $228,918	Year 5 Estimated Outcome Amount: $547,414
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $1,042,065			

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Matagorda Regional Medical Center Pass 2

DRAFT

Title of Outcome Measure (Improvement Target): IT – 9.2 ED appropriate utilization

Unique RHP outcome identification number(s): 130959304.3.2 / Pass 3
Performing Provider Name/TPI: Matagorda Regional Medical Center/130959304

Outcome Measure Description:

- Reduce all ED visits (including ACSC)[279]
- Reduce pediatric Emergency Department visits (CHIPRA Core Measure)[280]
- Reduce Emergency Department visits for target conditions
    - Congestive Heart Failure
    - Diabetes
    - End Stage Renal Disease
    - Cardiovascular Disease /Hypertension
    - Behavioral Health/Substance Abuse
    - Chronic Obstructive Pulmonary Disease
    - Asthma

Process Milestones:

- DY2: P-1; P-2; P-3
- DY3: P-2; P-3; P-4
- DY4: P-4; P-5
- DY5: P-4; P-5

Outcome Improvement Target(s) for each year:

- **DY4:**
    - IT-9.2 ED appropriate utilization
        - Reduce all ED visits (including ACSC)[281]
        - Reduce pediatric Emergency Department visits (CHIPRA Core Measure)[282]
        - Reduce Emergency Department visits for target conditions
            - Congestive Heart Failure
            - Diabetes
            - End Stage Renal Disease
            - Cardiovascular Disease /Hypertension
            - Behavioral Health/Substance Abuse
            - Chronic Obstructive Pulmonary Disease
            - Asthma

- **DY5:**
    - IT-9.2 ED appropriate utilization

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[279] http://archive.ahrq.gov/data/safetynet/billappb.htm
[280] http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/CHIPRA-Initial-Core-Set-of-Childrens-Health-Care-Quality-Measures.html
[281] http://archive.ahrq.gov/data/safetynet/billappb.htm
[282] http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/CHIPRA-Initial-Core-Set-of-Childrens-Health-Care-Quality-Measures.html

- Reduce all ED visits (including ACSC)[283]
- Reduce pediatric Emergency Department visits (CHIPRA Core Measure)[284]
- Reduce Emergency Department visits for target conditions
    - Congestive Heart Failure
    - Diabetes
    - End Stage Renal Disease
    - Cardiovascular Disease /Hypertension
    - Behavioral Health/Substance Abuse
    - Chronic Obstructive Pulmonary Disease
    - Asthma

Rationale:

The analysis of visits to the hospital emergency department led to the rationale for establishing a patient care navigation program to reduce unnecessary utilization of one of the more expense pieces of the health care continuum. To establish the patient care navigation program we chose key process milestones of project planning, confirmation of utilization statistics, patient needs and available community resources. Process Milestones will all be completed in years 2 and 3. Beginning in year 3 and continuing through year 5, Plan Do Study Act (PDSA) cycles will be utilized for process improvement and refinement. The lessons learned and best practices will be shared across Region 3 as they are experienced to allow for improvement and/or intervention as needed.

Outcome Measure Valuation:

Matagorda Regional Medical Center has approximately 20,000 visits to the Emergency Department annually. Records reflect a potential of 40 – 50%[285] of the visits could have been treated in another venue. If the Patient Care Navigator Program is successful at reducing unnecessary ED visits by a conservative 10%, a savings of as much as $2,000,000[286] could be realized by the end of the project period (as compared to a standard physician office visit).

[283]http://archive.ahrq.gov/data/safetynet/billappb.htm
[284]http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/CHIPRA-Initial-Core-Set-of-Childrens-Health-Care-Quality-Measures.html
[285] MCHD ED Records 2012
[286] Cost of an average ED visit compared to an office visit. *Consumer Health Ratings, 2011*

130959304.3.2	*IT-9.2*	*ED Appropriate Utilization*	
Matagorda Regional Medical Center		130959304	
Related Category 1 or 2 Projects:	*130959304.2.1*		
Starting Point/Baseline:	DY2 Unnecessary visits to the ED		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Reports, Minutes Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $6,356 **Process Milestone 2** [P-2]:Establish baseline rates for admissions targeted and for chronic conditions prior to chronic clinic establishment – base year 10/1/12 through 9/30/13 Data Source: EHR, state and national reports Process Milestone 2 Estimated Incentive Payment: $6,355 **Process Milestone 3** [P-3]:Develop and test data systems to establish performance targets for providers,	**Process Milestone 4**[P-4] Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Data Source: Internal Reports Process Milestone 4 Estimated Incentive Payment: $11,293 **Process Milestone 5** [P-5] Disseminate findings, including lessons learned and best practices, to stakeholders Data Source: EHR, Business Intelligence, reports Process Milestone 5 Estimated Incentive Payment: $11,294	**Outcome Improvement Target 1** ○ IT-9.2 ED appropriate utilization • Reduce all ED visits (including ACSC)[287] • Reduce pediatric Emergency Department visits (CHIPRA Core Measure)[288] • Reduce Emergency Department visits for target conditions ○ Congestive Heart Failure ○ Diabetes ○ End Stage Renal Disease ○ Cardiovascular Disease /Hypertension ○ Behavioral Health/Substance Abuse ○ Chronic Obstructive Pulmonary Disease ○ Asthma Data Source: ED and navigation program records Outcome Improvement Target 1 Estimated Incentive Payment*:*	**Outcome Improvement Target 2** ○ IT-9.2 ED appropriate utilization • Reduce all ED visits (including ACSC)[289] • Reduce pediatric Emergency Department visits (CHIPRA Core Measure)[290] • Reduce Emergency Department visits for target conditions ○ Congestive Heart Failure ○ Diabetes ○ End Stage Renal Disease ○ Cardiovascular Disease /Hypertension ○ Behavioral Health/Substance Abuse ○ Chronic Obstructive Pulmonary Disease ○ Asthma Data Source: ED and navigation program records Outcome Improvement Target 2 Estimated Incentive Payment*:*

[287]http://archive.ahrq.gov/data/safetynet/billappb.htm
[288]http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/CHIPRA-Initial-Core-Set-of-Childrens-Health-Care-Quality-Measures.html
[289]http://archive.ahrq.gov/data/safetynet/billappb.htm
[290]http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/CHIPRA-Initial-Core-Set-of-Childrens-Health-Care-Quality-Measures.html

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130959304.3.2	*IT-9.2*	*ED Appropriate Utilization*	
Matagorda Regional Medical Center		130959304	
Related Category 1 or 2 Projects:	*130959304.2.1*		
Starting Point/Baseline:	DY2 Unnecessary visits to the ED		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
targeted clinical improvement and reduced admissions Data Source: EHR, HIET Process Milestone 3 Estimated Incentive Payment: $6,356		$12,221 **Process Milestone6** [P-4] Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Data Source: Internal Reports Process Milestone 6Estimated Incentive Payment: $12,221 **Process Milestone 7** [P-5] Disseminate findings, including lessons learned and best practices, to stakeholders Data Source: EHR, Business Intelligence, reports Process Milestone 7 Estimated Incentive Payment: $12,222	$29,121 **Process Milestone 8** [P-4] Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Data Source: Internal Reports Process Milestone 8 Estimated Incentive Payment: $29,121 **Process Milestone 9**[P-5] Disseminate findings, including lessons learned and best practices, to stakeholders Data Source: EHR, Business Intelligence, reports Process Milestone 9 Estimated Incentive Payment: $29,122
Year 2 Estimated Outcome Amount: $19,067	Year 3 Estimated Outcome Amount: $22,587	Year 4 Estimated Outcome Amount$36,664	Year 5 Estimated Outcome Amount: $87,364
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:**$165,682			

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Matagorda Regional Medical Center

Pass 3

DRAFT

Title of Outcome Measure (Improvement Target): IT-9.2 ED appropriate utilization

Unique RHP outcome identification number(s): 130959304.3.3/Pass 3
Performing Provider Name/TPI: Matagorda Regional Medical Center/130959304

Outcome Measure Description:

- Reduce all ED visits (including ACSC)[291]
- Reduce pediatric Emergency Department visits (CHIPRA Core Measure)[292]
- Reduce Emergency Department visits for target conditions
  - Congestive Heart Failure
  - Diabetes
  - End Stage Renal Disease
  - Cardiovascular Disease /Hypertension
  - Behavioral Health/Substance Abuse
  - Chronic Obstructive Pulmonary Disease
  - Asthma

Process Milestones:

- DY2: P-1; P-2; P-3
- DY3: P-2; P-3; P-4
- DY4: P-4; P-5
- DY5: P-4; P-5

Outcome Improvement Target(s) for each year:

- **DY4: (quantified improvement target TBD)**
  - IT-9.2 ED appropriate utilization
    - Reduce all ED visits (including ACSC)[293]
    - Reduce pediatric Emergency Department visits (CHIPRA Core Measure)[294]
    - Reduce Emergency Department visits for target conditions
      - Congestive Heart Failure
      - Diabetes
      - End Stage Renal Disease
      - Cardiovascular Disease /Hypertension
      - Behavioral Health/Substance Abuse
      - Chronic Obstructive Pulmonary Disease
      - Asthma

- **DY5: (quantified improvement target TBD)**

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[291] http://archive.ahrq.gov/data/safetynet/billappb.htm
[292] http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/CHIPRA-Initial-Core-Set-of-Childrens-Health-Care-Quality-Measures.html
[293] http://archive.ahrq.gov/data/safetynet/billappb.htm
[294] http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/CHIPRA-Initial-Core-Set-of-Childrens-Health-Care-Quality-Measures.html

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- IT-9.2 ED appropriate utilization
  - Reduce all ED visits (including ACSC)[295]
  - Reduce pediatric Emergency Department visits (CHIPRA Core Measure)[296]
  - Reduce Emergency Department visits for target conditions
    - Congestive Heart Failure
    - Diabetes
    - End Stage Renal Disease
    - Cardiovascular Disease /Hypertension
    - Behavioral Health/Substance Abuse
    - Chronic Obstructive Pulmonary Disease
    - Asthma

Rationale:

The analysis of visits to the hospital emergency department indicates unnecessary utilization of one of the most expense pieces of the health care continuum, the ED. To provide an alternative to care at the right time and right setting urgent care services will be expanded to evenings and weekends. An urgent care medical advice call center manned with RN professionals trained in pediatric as well as adult triage will promote the use of the expanded urgent care services. Key process milestones of project planning, identification of capacity utilization statistics from inception to Year 3, identification of patient needs, matching patient needs to resources and testing data systems and processes will be evaluated and completed in years 2 and 3. Beginning in year 3 and continuing through year 5, Plan Do Study Act (PDSA) cycles will be utilized for process improvement and refinement. The lessons learned and best practices will be shared across Region 3 as they are experienced to allow for improvement and/or intervention as needed.

Outcome Measure Valuation:

Matagorda Regional Medical Center has approximately 20,000 visits to the Emergency Department annually. Records reflect a potential of 40 – 50%[297] of the visits could have been treated in another venue. If the Patient Care Navigator Program is successful at reducing unnecessary ED visits by a conservative 15%, a savings of as much as $3,000,000[298] could be realized by the end of the project period (as compared to a standard physician office visit).

[295] http://archive.ahrq.gov/data/safetynet/billappb.htm
[296] http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/CHIPRA-Initial-Core-Set-of-Childrens-Health-Care-Quality-Measures.html
[297] MCHD ED Records 2012
[298] Cost of an average ED visit compared to an office visit. *Consumer Health Ratings, 2011*

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130959304.3.3	*IT – 9.2*	*ED appropriate utilization*	
Matagorda Regional Medical Center			130959304
Related Category 1 or 2 Projects:	*130959304.1.2*		
Starting Point/Baseline:	DY2 Unnecessary visits to the ED		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Reports, Minutes Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $20,305 **Process Milestone 2** [P-2]: Establish baseline rates for unnecessary ER visits and utilization rates of medical advise call center and expanded urgent care visits – base year 1/1/13-12/31/13 Data Source: EHR, state and national reports Process Milestone 2 Estimated Incentive Payment: $20,306 **Process Milestone 3** [P-3]: Develop and test data systems to establish performance targets for providers based on patient needs Data Source: HER, HIET	**Process Milestone 4**[P-3]: Evaluate rates for unnecessary ER visits and utilization rates of medical advise call center and expanded urgent care visits – year 2 1/1/14-12/31/14 Data Source: EHR, state and national reports Process Milestone 4 Estimated Incentive Payment: $18,249 **Process Milestone 5** [P-3]: Test data systems to establish performance targets for providers based on patient needs Data Source: HER, HIET Process Milestone 5 Estimated Incentive Payment: $18,249 **Process Milestone 6**[P-4] Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Data Source: Internal Reports **Process Milestone** 6 Estimated Incentive Payment: $18,249	**Outcome Improvement Target 1** (IT- 9.2): ED appropriate utilization Improvement Target: TBD Data Source: EMR Outcome Improvement Target 1 Estimated Incentive Payment*:* $39,885 **Process Milestone 8** **[**P-4**]** Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Data Source: Internal Reports **Process Milestone8** Estimated Incentive Payment: $39,885 **Process Milestone 9** **[**P-5**]** Disseminate findings, including lessons learned and best practices, to stakeholders Data Source: EHR, Business Intelligence, reports **Process Milestone** 9 Estimated Incentive Payment: $39,885	**Outcome Improvement Target 2** (IT- 9.2): ED appropriate utilization Improvement Target: TBD Data Source: EMR Outcome Improvement Target 2 Estimated Incentive Payment*:* $94,948 **Process Milestone 10** **[**P-4**]** Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Data Source: Internal Reports **Process Milestone** 8 Estimated Incentive Payment: $94,948 **Process Milestone 11[**P-5**]** Disseminate findings, including lessons learned and best practices, to stakeholders Data Source: EHR, Business Intelligence, reports **Process Milestone** 9 Estimated Incentive Payment: $94,948

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130959304.3.3	*IT – 9.2*	*ED appropriate utilization*	
Matagorda Regional Medical Center			130959304
Related Category 1 or 2 Projects:	*130959304.1.2*		
Starting Point/Baseline:	DY2 Unnecessary visits to the ED		
Year 2 (10/1/2012 – 9/30/2013)	**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 3 Estimated Incentive Payment: $20,306	**Process Milestone 7** [P-5] Disseminate findings, including lessons learned and best practices, to stakeholders Data Source: EHR, Business Intelligence, reports **Process 7** Estimated Incentive Payment: $18,249		
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $60,917	Year 3 Estimated Outcome Amount: $72,996	Year 4 Estimated Outcome Amount: $119,655	Year 5 Estimated Outcome Amount: $284,844
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)*: $538,412			

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Memorial Hermann Hospital

Pass 1

DRAFT

Title of Outcome Measure (Improvement Target): IT-6.1 Improvement in Patient Satisfaction

Unique RHP outcome identification number(s): 137805107.3.1

Outcome Measure Description:
To achieve improvement under this metric, Memorial Hermann will engage in project planning during DY 2. In DY 3, Memorial Hermann will apply the planning developed in DY 2 in order to determine baseline rates for future DYs. In DY 4, Memorial Hermann intends to improve its patient satisfaction scores by at least 10% over the baseline recorded in DY 3 for patients' rating of whether patients are getting timely care, appointments, and information. In DY 5, Memorial Hermann intends to improve its patient satisfaction scores by at least 10% over the DY 4 measurement in the same area.

Process Milestones:
- DY2:
  - P-1: Project planning—engage stakeholders, identify current capacity and needed resources, determine timelines, and document implementation plans
- DY3:
  - P-2: Establish baseline rates

Outcome Improvement Targets for each year:
- DY4:
  - IT-6.1: Percent improvement over baseline of patient satisfaction scores—5% improvement over baseline
- DY5:
  - IT-6.1: Percent improvement over baseline of patient satisfaction scores—10% improvement baseline

Rationale:
The greater Houston area faces several major healthcare challenges, including a lack of primary care capacity, which can result in negative utilization patterns such as ED overutilization. Improper utilization results in lower levels of patient satisfaction with the care received, since it is not the level of care or type of care most appropriate to the patient's condition. This challenge will be addressed by Memorial's Network Development project (137805107.1.1), and Memorial Hermann expects to see an improvement in patient satisfaction as a result of the associated Category 1 project—specifically, an improvement in patients' rating of whether patients are getting timely care, appointments, and information.

Outcome Measure Valuation:
The valuation of each Memorial Hermann project takes into account the transformational impact of the project, the population served by the project (both number of people and complexity of patient needs), the alignment of the project with community needs, the magnitude of costs avoided or reduced by the project, the degree of collaboration involved in the project, and the sustainability of the project.

137805107.3.1	*IT-6.1*	*Percent Improvement Over Baseline of Patient Satisfaction Scores*	
Memorial Hermann Hospital			*137805107*
Related Category 1 or 2 Projects:	*137805107.1.1*		
Starting Point/Baseline:	*TBD*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning—engage stakeholders, identify current capacity and needed resources, determine timelines, and document implementation plans. Data Source: Documentation of project planning. Process Milestone 1 Estimated Incentive Payment: $496,453	**Process Milestone 2** [P-2]: Establish baseline rates. Data Source: Patient survey. Process Milestone 3 Estimated Incentive Payment: $575,453	**Outcome Improvement Target 1** [IT-6.1]: Percent improvement over baseline of patient satisfaction scores. Improvement Target: 5% improvement over baseline. Data Source: Patient survey. Outcome Improvement Target 1 Estimated Incentive Payment: $923,402	**Outcome Improvement Target 2** [IT-6.1]: Percent improvement over baseline of patient satisfaction scores. Improvement Target: 10% improvement over baseline Data Source: Patient survey. Outcome Improvement Target 2 Estimated Incentive Payment: $2,208,134
Year 2 Estimated Outcome Amount: $496,453	Year 3 Estimated Outcome Amount: $575,453	Year 4 Estimated Outcome Amount: $923,402	Year 5 Estimated Outcome Amount: $2,208,134
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $4,203,442			

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Title of Outcome Measure (Improvement Target): IT-3.8: Behavioral Health/Substance Abuse (BH/SA) 30-day readmission rate

Unique RHP outcome identification number(s): 137805107.3.2

Outcome Measure Description:

To achieve improvement under this metric, Memorial Hermann will engage in project planning during DY 2. In DY 3, Memorial Hermann will apply the planning developed in DY 2 in order to determine baseline rates for future DYs. In DY 4, Memorial Hermann intends to reduce its Behavioral Health/Substance Abuse (BH/SA) 30-day readmission rate by at least 5% over the baseline recorded in DY 3. In DY 5, Memorial Hermann intends to improve its BH/SA 30-day readmission rate by at least 5% over baseline measurement.

Process Milestones:

- DY2:
  - P-1: Project planning—engage stakeholders, identify current capacity and needed resources, determine timelines, and document implementation plans
- DY3:
  - P-2: Establish baseline rates

Outcome Improvement Targets for each year:

- DY4:
  - IT-3.8: Behavioral Health/Substance Abuse (BH/SA) 30-day readmission rate—5% reduction over DY3
- DY5:
  - IT-3.8: Behavioral Health/Substance Abuse (BH/SA) 30-day readmission rate—10% reduction over baseline measurement

Rationale:

Mental health patients in the greater Houston area, particularly uninsured patients, face significant challenges in obtaining the mental health care services they need, which can result in negative utilization patterns including unnecessary inpatient admissions. These challenges will be addressed by Memorial Hermann's Health Crisis Clinic project (137805107.1.2), which will result in greater access to emergency mental health care appointments for these underserved patients. Memorial Hermann expects to see an improvement in the Behavioral Health/Substance Abuse (BH/SA) 30-day readmission rate as a result of the associated Category 1 project.

Outcome Measure Valuation:

The valuation of each Memorial Hermann project takes into account the transformational impact of the project, the population served by the project (both number of people and complexity of patient needs), the alignment of the project with community needs, the magnitude of costs avoided or reduced by the project, the degree of collaboration involved in the project, and the sustainability of the project.

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137805107.3.2	IT-3.8	*Behavioral Health/Substance Abuse (BH/SA) 30-Day Readmission Rate*	
Memorial Hermann Hospital			*137805107*
Related Category 1 or 2 Projects::	137805107.1.2		
Starting Point/Baseline:	*TBD*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning—engage stakeholders, identify current capacity and needed resources, determine timelines, and document implementation plans. Data Source: Documentation of project planning. Process Milestone 1 Estimated Incentive Payment: $472,585	**Process Milestone 2** [P-2]: Establish baseline rates. Data Source: EHR; claims. Process Milestone 3 Estimated Incentive Payment: *$547,787*	**Outcome Improvement Target 1** [IT-3.8]: Behavioral Health/Substance Abuse (BH/SA) 30-day readmission rate. Improvement Target: 5% improvement over baseline. Data Source: EHR; claims. Outcome Improvement Target 1 Estimated Incentive Payment: $879,007	**Outcome Improvement Target 2** [IT-3.8]: Behavioral Health/Substance Abuse (BH/SA) 30-day readmission rate. Improvement Target: 5% improvement over baseline Data Source: EHR; claims. Outcome Improvement Target 2 Estimated Incentive Payment: $2,101,974
Year 2 Estimated Outcome Amount: $472,585	Year 3 Estimated Outcome Amount: $547,787	Year 4 Estimated Outcome Amount: $879,007	Year 5 Estimated Outcome Amount: $2,101,974
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $4,001,353			

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Title of Outcome Measure (Improvement Target): OD-1 Primary Care and Chronic Disease Management

Unique RHP outcome identification number(s): 137805107.3.3

Outcome Measure Description:
IT-1.1 Third next available appointment (Non- standalone measure)
Reduce the average length of time in days between the day a patient makes a request for an appointment with a physician and the third available appointment for a new patient physical, routine exam, or return visit exam. The goals will be to decrease number of days to third next available appointment to zero days (same day) for Primary Care.

Process Milestones:

- DY2:
  - P-1: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
- DY3:
  - P-2: Establish baseline rates
  - P-3: Develop and test data systems

Outcome Improvement Targets for each year:

- DY4:
  - IT-1.1:
    Reduce by 1 day the average length of time in days between the day a patient makes a request for an appointment with a physician and the third available appointment for a new patient physical, routine exam, or return visit exam.
- DY5:
  - IT-1.1:
    Reduce the average length of time in days between the day a patient makes a request for an appointment with a physician and the third available appointment for a new patient physical, routine exam, or return visit exam to zero (0) days.

Rationale:
Access to primary care services can have an impact on healthcare outcomes, by providing early screening and treatment and patients are more likely to get these services when they are able to get appointments when first needed that accommodate their schedule. Since the goal of the project is to increase access to care and the third next available appointment is the healthcare industry's standard measure of access to care, we have chosen this outcome measure.

Outcome Measure Valuation:
The valuation of each Memorial project takes into account the transformational impact of the project, the population served by the project (both number of people and complexity of patient needs), the alignment of the project with community needs, the magnitude of costs avoided or reduced by the project, the degree of collaboration involved in the project, and the sustainability of the project.

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137805107.3.3	*3.IT-1.1*	*Third next available appointment (Non- standalone measure)*	
Memorial Hermann Hospital			*137805107*
Related Category 1 or 2 Projects:	***137805107.1.3***		
Starting Point/Baseline:	*To be determined during DY3.*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 2 (10/1/2012 – 9/30/2013)**
Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Project reports and documents Process Milestone 1 Estimated Incentive Payment: $274,365	**Process Milestone 2** [P-2]: Establish baseline rates Data Source: Provider reports Process Milestone 2 Estimated Incentive Payment: $ 158,967 **Process Milestone 3** [P-3]: Develop and test data systems Data Source: Project reports, EMR, claims Process Milestone 3 Estimated Incentive Payment: $ 158,966	**Outcome Improvement Target 1** [IT-1.1]: Reduce by 1 day the average length of time in days between the day a patient makes a request for an appointment with a physician and the third available appointment for a new patient physical, routine exam, or return visit exam. Data Source: Appointment management system Outcome Improvement Target 1 Estimated Incentive Payment: $508,774	**Outcome Improvement Target 2** [IT-1.1]: Reduce the average length of time in days between the day a patient makes a request for an appointment with a physician and the third available appointment for a new patient physical, routine exam, or return visit exam to zero (0) days. Data Source: Appointment management system Outcome Improvement Target 2 Estimated Incentive Payment: $316,309
Year 2 Estimated Outcome Amount: $274,365	Year 3 Estimated Outcome Amount: $317,933	Year 4 Estimated Outcome Amount: $508,774	Year 5 Estimated Outcome Amount: $1,204,600
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $2,305,672			

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Title of Outcome Measure (Improvement Target): OD-1 Primary Care and Chronic Disease Management

Unique RHP outcome identification number(s): 137805107.3.4
Outcome Measure Description:
IT-1.19 Antidepressant Medication Management - NQF 0105 (Standalone measure)

This measure has two components that assess the management of antidepressant medication in children ages 6 and over: A) the acute phase treatment period consisting at least 84 days (12 weeks) of continuous treatment with antidepressant medication during the 114-day period following the IPSD (inclusive), and B) the continuation phase treatment period consisting of at least 180 days (6 months) of continuous treatment with antidepressant medication (Table AMM-D) during the 231-day period following the IPSD (inclusive). For the acute phase, continuous treatment allows gaps in medication treatment up to a total of 30 days during the 114-day period. Gaps can include either washout period gaps to change medication or treatment gaps to refill the same medication. Regardless of the number of gaps, there may be no more than 30 gap days. Any combination of gaps (e.g., two washout gaps of 15 days each, or two washout gaps of 10 days each and one treatment gap of 10 days) will be counted. For the continuation phase, continuous treatment allows gaps in medication treatment up to a total of 51 days during the 231-day period. Gaps can include either washout period gaps to change medication or treatment gaps to refill the same medication. Regardless of the number of gaps, gap days may total no more than 51. Any combination of gaps (e.g., two washout gaps, each 25 days or two washout gaps of 10 days each and one treatment gap of 10 days) will be counted.

The denominator for this measures is based on discharges (of 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. All discharges for members who have more than one discharge on or between January 1 and December 1 of the measurement year will be included. If the discharge is followed by readmission or direct transfer to an acute facility for a mental health principal diagnosis (within the 30-day follow-up period), only the readmission discharge or the discharge from the facility to which the member was transferred will be counted. Although rehospitalization might not be for a selected mental health disorder, it is probably for a related condition.

Process Milestones:

- DY2:
  - P-1: Project planning—engage stakeholders, identify current capacity and needed resources, determine timelines, and document implementation plans.
- DY3:
  - P-2: Establish baseline rates
  - P-3: Develop and test data systems

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Outcome Improvement Targets for each year:

- DY4:

  IT-1.19 Increase by **3%** the percentage of discharges (of 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 who receive at least 84 days (12 weeks) of continuous treatment with antidepressant medication during the 114-day period following the IPSD (inclusive) and at least 180 days (6 months) of continuous treatment with antidepressant medication (Table AMM-D) during the 231-day period following the IPSD (inclusive).
- DY5:

  IT-1.19 Increase by **5%** the percentage of discharges (of 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 who receive at least 84 days (12 weeks) of continuous treatment with antidepressant medication during the 114-day period following the IPSD (inclusive) and at least 180 days (6 months) of continuous treatment with antidepressant medication (Table AMM-D) during the 231-day period following the IPSD (inclusive).

Rationale:

This outcome measure will be a direct reflection on whether the pediatric population in this service area is receiving appropriate management of anti-depressant medications . Greater access to primary care services can help ensure that pediatric patients receive appropriate medication management, reducing the need for additional acute care services and improving health outcomes.

Outcome Measure Valuation:

The valuation of each Memorial project takes into account the transformational impact of the project, the population served by the project (both number of people and complexity of patient needs), the alignment of the project with community needs, the magnitude of costs avoided or reduced by the project, the degree of collaboration involved in the project, and the sustainability of the project.

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137805107.3.4	*3.IT-1.19*	*Antidepressant Medication Management - NQF 0105 (Standalone measure)*	
Memorial Hermann Hospital			*137805107*
Related Category 1 or 2 Projects:	***137805107.1.3***		
Starting Point/Baseline:	*TBD*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Project reports and documents Process Milestone 1 Estimated Incentive Payment: $274,365	**Process Milestone 2 [P-2]:** Establish baseline rates Data Source: Provider reports Process Milestone 2 Estimated Incentive Payment: $158,967 **Process Milestone 3** [P-3]: Develop and test data systems Data Source: Project reports, EMR, claims Process Milestone 3 Estimated Incentive Payment: $158,966	**Outcome Improvement Target 1** [IT-1.19]: Increase by 35% the percentage of discharges (of 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 children age 18 or younger with a diagnosis of major depression or dysthymia and an initial PHQ-9 score greater than nine who receive at least 84 days (12 weeks) of continuous treatment with antidepressant medication during the 114-day period following the IPSD (inclusive)achieve remission at twelve months as demonstrated by a twelve month (+/-30 days) PHQ-9 score of less than five and at least 180 days (6 months) of continuous treatment with antidepressant medication (Table AMM-D) during the 231-day period following the IPSD (inclusive). Data Source: Electronic Clinical Data, Electronic Health Record, Paper Records Outcome Improvement Target 1 Estimated Incentive Payment: $508,774	**Outcome Improvement Target 2** [IT-1.19]: Increase by 5% the percentage of discharges (of 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 who receive at least 84 days (12 weeks) of continuous treatment with antidepressant medication during the 114-day period following the IPSD (inclusive) and at least 180 days (6 months) of continuous treatment with antidepressant medication (Table AMM-D) during the 231-day period following the IPSD (inclusive). Data Source Electronic Clinical Data, Electronic Health Record, Paper Records Outcome Improvement Target 2 Estimated Incentive Payment: $1,204,600

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137805107.3.4	*3.IT-1.19*	*Antidepressant Medication Management - NQF 0105 (Standalone measure)*	
Memorial Hermann Hospital			*137805107*
Related Category 1 or 2 Projects:	***137805107.1.3***		
Starting Point/Baseline:	*TBD*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Year 2 Estimated Outcome Amount: $274,365	Year 3 Estimated Outcome Amount: $317,933	Year 4 Estimated Outcome Amount: $508,774	Year 5 Estimated Outcome Amount: $1,204,600
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $2,305,672			

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Title of Outcome Measure (Improvement Target): OD-1 Primary Care and Chronic Disease Management

Unique RHP outcome identification number(s): 137805107.3.5

Outcome Measure Description:
IT-1.1 Third next available appointment (Non- standalone measure)
Reduce the average length of time in days between the day a patient makes a request for an appointment with a physician and the third available appointment for a new patient physical, routine exam, or return visit exam. The goals will be to decrease number of days to third next available appointment to zero days (same day) for Primary Care.

Process Milestones:

- DY2:
  - P-1: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
- DY3:
  - P-2: Establish baseline rates
  - P-3: Develop and test data systems

Outcome Improvement Targets for each year:

- DY4:
  - IT-1.1:
    Reduce by 1 day the average length of time in days between the day a patient makes a request for an appointment with a physician and the third available appointment for a new patient physical, routine exam, or return visit exam.
- DY5:
  - IT-1.1:
    Reduce the average length of time in days between the day a patient makes a request for an appointment with a physician and the third available appointment for a new patient physical, routine exam, or return visit exam to zero (0) days.

Rationale:
Access to primary care services can have an impact on healthcare outcomes, by providing early screening and treatment and patients are more likely to get these services when they are able to get appointments when first needed that accommodate their schedule. Since the goal of the project is to increase access to care and the third next available appointment is the healthcare industry's standard measure of access to care, we have chosen this outcome measure.

Outcome Measure Valuation:
The valuation of each Memorial project takes into account the transformational impact of the project, the population served by the project (both number of people and complexity of patient needs), the alignment of the project with community needs, the magnitude of costs avoided or reduced by the project, the degree of collaboration involved in the project, and the sustainability of the project.

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137805107.3.5	*3.IT-1.1*	*Third next available appointment (Non- standalone measure)*	
Memorial Hermann Hospital			*137805107*
Related Category 1 or 2 Projects:	***137805107.1.4***		
Starting Point/Baseline:	*To be determined during DY3.*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2012 – 9/30/2013)**
Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Project reports and documents Process Milestone 1 Estimated Incentive Payment: $ 241,068	**Process Milestone 2** [P-2]: Establish baseline rates Data Source: Provider reports Process Milestone 2 Estimated Incentive Payment: $ 139,715 **Process Milestone 3** [P-3]: Develop and test data systems Data Source: Project reports, EMR, claims Process Milestone 3 Estimated Incentive Payment: $ 139,715	**Outcome Improvement Target 1** [IT-1.1]: Reduce by 1 day the average length of time in days between the day a patient makes a request for an appointment with a physician and the third available appointment for a new patient physical, routine exam, or return visit exam. Data Source: Appointment management system Outcome Improvement Target 1 Estimated Incentive Payment: $ 448,387	**Outcome Improvement Target 2** [IT-1.1]: Reduce the average length of time in days between the day a patient makes a request for an appointment with a physician and the third available appointment for a new patient physical, routine exam, or return visit exam to zero (0) days. Data Source: Appointment management system Outcome Improvement Target 2 Estimated Incentive Payment: $ 1,072,230
Year 2 Estimated Outcome Amount: $ 241,068	Year 3 Estimated Outcome Amount: $ 279,430	Year 4 Estimated Outcome Amount: $ 448,387	Year 2 Estimated Outcome Amount: $ 1,072,230
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $ 2,041,115			

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Title of Outcome Measure (Improvement Target): OD-1 Primary Care and Chronic Disease Management

Unique RHP outcome identification number(s): 137805107.3.6

Outcome Measure Description:
IT-1.19 Antidepressant Medication Management - NQF 0105 (Standalone measure)

This measure has two components that assess the management of antidepressant medication in children ages 6 and over: A) the acute phase treatment period consisting at least 84 days (12 weeks) of continuous treatment with antidepressant medication during the 114-day period following the IPSD (inclusive), and B) the continuation phase treatment period consisting of at least 180 days (6 months) of continuous treatment with antidepressant medication (Table AMM-D) during the 231-day period following the IPSD (inclusive). For the acute phase, continuous treatment allows gaps in medication treatment up to a total of 30 days during the 114-day period. Gaps can include either washout period gaps to change medication or treatment gaps to refill the same medication. Regardless of the number of gaps, there may be no more than 30 gap days. Any combination of gaps (e.g., two washout gaps of 15 days each, or two washout gaps of 10 days each and one treatment gap of 10 days) will be counted. For the continuation phase, continuous treatment allows gaps in medication treatment up to a total of 51 days during the 231-day period. Gaps can include either washout period gaps to change medication or treatment gaps to refill the same medication. Regardless of the number of gaps, gap days may total no more than 51. Any combination of gaps (e.g., two washout gaps, each 25 days or two washout gaps of 10 days each and one treatment gap of 10 days) will be counted.

The denominator for this measures is based on discharges (of 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. All discharges for members who have more than one discharge on or between January 1 and December 1 of the measurement year will be included. If the discharge is followed by readmission or direct transfer to an acute facility for a mental health principal diagnosis (within the 30-day follow-up period), only the readmission discharge or the discharge from the facility to which the member was transferred will be counted. Although rehospitalization might not be for a selected mental health disorder, it is probably for a related condition.

Process Milestones:

- DY2:
  - P-1: Project planning—engage stakeholders, identify current capacity and needed resources, determine timelines, and document implementation plans.
- DY3:
  - P-2: Establish baseline rates
  - P-3: Develop and test data systems

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Outcome Improvement Targets for each year:

- DY4:

  IT-1.19 Increase by **3%** the percentage of discharges (of 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 who receive at least 84 days (12 weeks) of continuous treatment with antidepressant medication during the 114-day period following the IPSD (inclusive) and at least 180 days (6 months) of continuous treatment with antidepressant medication (Table AMM-D) during the 231-day period following the IPSD (inclusive).
- DY5:

  IT-1.19 Increase by **5%** the percentage of discharges (of 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 who receive at least 84 days (12 weeks) of continuous treatment with antidepressant medication during the 114-day period following the IPSD (inclusive) and at least 180 days (6 months) of continuous treatment with antidepressant medication (Table AMM-D) during the 231-day period following the IPSD (inclusive).

Rationale:

This outcome measure will be a direct reflection on whether the pediatric population in this service area is receiving appropriate management of anti-depressant medications . Greater access to primary care services can help ensure that pediatric patients receive appropriate medication management, reducing the need for additional acute care services and improving health outcomes.

Outcome Measure Valuation:

The valuation of each Memorial project takes into account the transformational impact of the project, the population served by the project (both number of people and complexity of patient needs), the alignment of the project with community needs, the magnitude of costs avoided or reduced by the project, the degree of collaboration involved in the project, and the sustainability of the project.

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137805107.3.6	*3.IT-1.19*	*Antidepressant Medication Management - NQF 0105 (Standalone measure)*	
Memorial Hermann Hospital			*137805107*
Related Category 1 or 2 Projects:	***137805107.1.4***		
Starting Point/Baseline:	*TBD*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Project reports and documents Process Milestone 1 Estimated Incentive Payment: $ 241,068	**Process Milestone 2 [P-2]:** Establish baseline rates Data Source: Provider reports Process Milestone 2 Estimated Incentive Payment: $ 139,715 Process Milestone 3 [P-3]: Develop and test data systems Data Source: Project reports, EMR, claims Process Milestone 3 Estimated Incentive Payment: $ 139,715	**Outcome Improvement Target 1** [IT-1.19]: Increase by 35% the percentage of discharges (of 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 children age 18 or younger with a diagnosis of major depression or dysthymia and an initial PHQ-9 score greater than nine who receive at least 84 days (12 weeks) of continuous treatment with antidepressant medication during the 114-day period following the IPSD (inclusive)achieve remission at twelve months as demonstrated by a twelve month (+/-30 days) PHQ-9 score of less than five and at least 180 days (6 months) of continuous treatment with antidepressant medication (Table AMM-D) during the 231-day period following the IPSD (inclusive). Data Source: Electronic Clinical Data, Electronic Health Record, Paper Records Outcome Improvement Target 1 Estimated Incentive Payment: $ 448,387	**Outcome Improvement Target 2** [IT-1.19]: Increase by 5% the percentage of discharges (of 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 who receive at least 84 days (12 weeks) of continuous treatment with antidepressant medication during the 114-day period following the IPSD (inclusive) and at least 180 days (6 months) of continuous treatment with antidepressant medication (Table AMM-D) during the 231-day period following the IPSD (inclusive). Data Source Electronic Clinical Data, Electronic Health Record, Paper Records Outcome Improvement Target 2 Estimated Incentive Payment: $ 1,072,230

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137805107.3.6	*3.IT-1.19*	*Antidepressant Medication Management - NQF 0105 (Standalone measure)*	
Memorial Hermann Hospital			*137805107*
Related Category 1 or 2 Projects:	***137805107.1.4***		
Starting Point/Baseline:	*TBD*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Year 2 Estimated Outcome Amount: $ 241,068	Year 3 Estimated Outcome Amount: $ 279,430	Year 4 Estimated Outcome Amount: $ 448,387	Year 5 Estimated Outcome Amount: $ 1,072,230
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $ 2,041,115			

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Title of Outcome Measure (Improvement Target): OD-1 Primary Care and Chronic Disease Management

Unique RHP outcome identification number(s): 137805107.3.7

Outcome Measure Description:
IT-1.1 Third next available appointment (Non- standalone measure)
Reduce the average length of time in days between the day a patient makes a request for an appointment with a physician and the third available appointment for a new patient physical, routine exam, or return visit exam. The goals will be to decrease number of days to third next available appointment to zero days (same day) for Primary Care.

Process Milestones:

- DY2:
  - P-1: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
- DY3:
  - P-2: Establish baseline rates
  - P-3: Develop and test data systems

Outcome Improvement Targets for each year:

- DY4:
  - IT-1.1:
    Reduce by 1 day the average length of time in days between the day a patient makes a request for an appointment with a physician and the third available appointment for a new patient physical, routine exam, or return visit exam.
- DY5:
  - IT-1.1:
    Reduce the average length of time in days between the day a patient makes a request for an appointment with a physician and the third available appointment for a new patient physical, routine exam, or return visit exam to zero (0) days.

Rationale:
Access to primary care services can have an impact on healthcare outcomes, by providing early screening and treatment and patients are more likely to get these services when they are able to get appointments when first needed that accommodate their schedule. Since the goal of the project is to increase access to care and the third next available appointment is the healthcare industry's standard measure of access to care, we have chosen this outcome measure.

Outcome Measure Valuation:
The valuation of each Memorial project takes into account the transformational impact of the project, the population served by the project (both number of people and complexity of patient needs), the alignment of the project with community needs, the magnitude of costs avoided or reduced by the project, the degree of collaboration involved in the project, and the sustainability of the project.

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<table>
<tr><td>137805107.3.7</td><td>3.IT-1.1</td><td colspan="2">Third next available appointment (Non- standalone measure)</td></tr>
<tr><td colspan="3">Memorial Hermann Hospital</td><td>137805107</td></tr>
<tr><td>Related Category 1 or 2 Projects:</td><td colspan="3">137805107.1.5</td></tr>
<tr><td>Starting Point/Baseline:</td><td colspan="3">To be determined during DY3.</td></tr>
<tr><th>Year 2
(10/1/2012 – 9/30/2013)</th><th>Year 3
(10/1/2013 – 9/30/2014)</th><th>Year 4
(10/1/2014 – 9/30/2015)</th><th>Year 5
(10/1/2015 – 9/30/2016)</th></tr>
<tr><td>Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans

Data Source: Project reports and documents

Process Milestone 1 Estimated Incentive Payment: $ 241,068</td><td>Process Milestone 2 [P-2]: Establish baseline rates
Data Source: Provider reports

Process Milestone 2 Estimated Incentive Payment: $ 139,715

Process Milestone 3 [P-3]: Develop and test data systems
Data Source: Project reports, EMR, claims

Process Milestone 3 Estimated Incentive Payment: $ 139,715</td><td>Outcome Improvement Target 1 [IT-1.1]: Reduce by 1 day the average length of time in days between the day a patient makes a request for an appointment with a physician and the third available appointment for a new patient physical, routine exam, or return visit exam.

Data Source: Appointment management system

Outcome Improvement Target 1 Estimated Incentive Payment: $ 448,387</td><td>Outcome Improvement Target 2 [IT-1.1]: Reduce the average length of time in days between the day a patient makes a request for an appointment with a physician and the third available appointment for a new patient physical, routine exam, or return visit exam to zero (0) days.

Data Source: Appointment management system

Outcome Improvement Target 2 Estimated Incentive Payment: $ 1,072,230</td></tr>
<tr><td>Year 2 Estimated Outcome Amount: $ 241,068</td><td>Year 3 Estimated Outcome Amount: $ 279,430</td><td>Year 4 Estimated Outcome Amount: $ 448,387</td><td>Year 2 Estimated Outcome Amount: $ 1,072,230</td></tr>
<tr><td colspan="4">TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $ 2,041,115</td></tr>
</table>

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Title of Outcome Measure (Improvement Target): OD-1 Primary Care and Chronic Disease Management

Unique RHP outcome identification number(s): 137805107.3.8

Outcome Measure Description:
IT-1.19 Antidepressant Medication Management - NQF 0105 (Standalone measure)

This measure has two components that assess the management of antidepressant medication in children ages 6 and over: A) the acute phase treatment period consisting at least 84 days (12 weeks) of continuous treatment with antidepressant medication during the 114-day period following the IPSD (inclusive), and B) the continuation phase treatment period consisting of at least 180 days (6 months) of continuous treatment with antidepressant medication (Table AMM-D) during the 231-day period following the IPSD (inclusive). For the acute phase, continuous treatment allows gaps in medication treatment up to a total of 30 days during the 114-day period. Gaps can include either washout period gaps to change medication or treatment gaps to refill the same medication. Regardless of the number of gaps, there may be no more than 30 gap days. Any combination of gaps (e.g., two washout gaps of 15 days each, or two washout gaps of 10 days each and one treatment gap of 10 days) will be counted. For the continuation phase, continuous treatment allows gaps in medication treatment up to a total of 51 days during the 231-day period. Gaps can include either washout period gaps to change medication or treatment gaps to refill the same medication. Regardless of the number of gaps, gap days may total no more than 51. Any combination of gaps (e.g., two washout gaps, each 25 days or two washout gaps of 10 days each and one treatment gap of 10 days) will be counted.

The denominator for this measures is based on discharges (of 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. All discharges for members who have more than one discharge on or between January 1 and December 1 of the measurement year will be included. If the discharge is followed by readmission or direct transfer to an acute facility for a mental health principal diagnosis (within the 30-day follow-up period), only the readmission discharge or the discharge from the facility to which the member was transferred will be counted. Although rehospitalization might not be for a selected mental health disorder, it is probably for a related condition.

Process Milestones:

- DY2:
  - P-1: Project planning—engage stakeholders, identify current capacity and needed resources, determine timelines, and document implementation plans.
- DY3:
  - P-2: Establish baseline rates
  - P-3: Develop and test data systems

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Outcome Improvement Targets for each year:

- DY4:

  IT-1.19 Increase by **3%** the percentage of discharges (of 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 who receive at least 84 days (12 weeks) of continuous treatment with antidepressant medication during the 114-day period following the IPSD (inclusive) and at least 180 days (6 months) of continuous treatment with antidepressant medication (Table AMM-D) during the 231-day period following the IPSD (inclusive).

- DY5:

  IT-1.19 Increase by **5%** the percentage of discharges (of 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 who receive at least 84 days (12 weeks) of continuous treatment with antidepressant medication during the 114-day period following the IPSD (inclusive) and at least 180 days (6 months) of continuous treatment with antidepressant medication (Table AMM-D) during the 231-day period following the IPSD (inclusive).

Rationale:

This outcome measure will be a direct reflection on whether the pediatric population in this service area is receiving appropriate management of anti-depressant medications . Greater access to primary care services can help ensure that pediatric patients receive appropriate medication management, reducing the need for additional acute care services and improving health outcomes.

Outcome Measure Valuation:

The valuation of each Memorial project takes into account the transformational impact of the project, the population served by the project (both number of people and complexity of patient needs), the alignment of the project with community needs, the magnitude of costs avoided or reduced by the project, the degree of collaboration involved in the project, and the sustainability of the project.

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137805107.3.8	*3.IT-1.19*	*Antidepressant Medication Management - NQF 0105 (Standalone measure)*	
Memorial Hermann Hospital			*137805107*
Related Category 1 or 2 Projects:	***137805107.1.5***		
Starting Point/Baseline:	*TBD*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Project reports and documents Process Milestone 1 Estimated Incentive Payment: $ 241,068,	**Process Milestone 2 [P-2]:** Establish baseline rates Data Source: Provider reports Process Milestone 2 Estimated Incentive Payment: $ 139,715 Process Milestone 3 [P-3]: Develop and test data systems Data Source: Project reports, EMR, claims Process Milestone 3 Estimated Incentive Payment: $ 139,715	**Outcome Improvement Target 1** [IT-1.19]: Increase by 35% the percentage of discharges (of 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 children age 18 or younger with a diagnosis of major depression or dysthymia and an initial PHQ-9 score greater than nine who receive at least 84 days (12 weeks) of continuous treatment with antidepressant medication during the 114-day period following the IPSD (inclusive)achieve remission at twelve months as demonstrated by a twelve month (+/-30 days) PHQ-9 score of less than five and at least 180 days (6 months) of continuous treatment with antidepressant medication (Table AMM-D) during the 231-day period following the IPSD (inclusive). Data Source: Electronic Clinical Data, Electronic Health Record, Paper Records Outcome Improvement Target 1 Estimated Incentive Payment: $ 448,387	**Outcome Improvement Target 2** [IT-1.19]: Increase by 5% the percentage of discharges (of 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 who receive at least 84 days (12 weeks) of continuous treatment with antidepressant medication during the 114-day period following the IPSD (inclusive) and at least 180 days (6 months) of continuous treatment with antidepressant medication (Table AMM-D) during the 231-day period following the IPSD (inclusive). Data Source Electronic Clinical Data, Electronic Health Record, Paper Records Outcome Improvement Target 2 Estimated Incentive Payment: $ 1,072,230

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137805107.3.8	*3.IT-1.19*	*Antidepressant Medication Management - NQF 0105 (Standalone measure)*	
Memorial Hermann Hospital			*137805107*
Related Category 1 or 2 Projects:	***137805107.1.5***		
Starting Point/Baseline:	*TBD*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Year 2 Estimated Outcome Amount: $ 241,068	Year 3 Estimated Outcome Amount: $ 279,430	Year 4 Estimated Outcome Amount: $ 448,387	Year 5 Estimated Outcome Amount: $ 1,072,230
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $ 2,041,115			

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Title of Outcome Measure (Improvement Target): IT-9.4: Other Outcome Improvement Target

Unique RHP outcome identification number(s): 137805107.3.9

Outcome Measure Description:
To achieve improvement under this metric, Memorial will engage in project planning during DY2. In DY3, Memorial Hermann will apply the planning developed in DY2 to determine baseline rates for future DYs. In DY4, Memorial Hermann intends to decrease the ED utilization rate described below by at least 5% under the baseline recorded in DY3. In DY5, Memorial Hermann intends to improve the rate by at least 10% under the baseline recorded in DY3.

Memorial will collect ED utilization data for patients enrolled in the patient navigation program which will be established by the Category 2 project associated with this Category 3 outcome. Memorial Hermann will collect this data by comparing the number of Memorial Hermann ER visits in the six months prior to an individual's enrollment in the patient navigation program with the number of Memorial Hermann ER visits in the six months following the same individual's enrollment.

Process Milestones:

- DY2:
  - P-1: Project planning—engage stakeholders, identify current capacity and needed resources, determine timelines, and document implementation plans.
- DY3:
  - P-2: Establish baseline rates.

Outcome Improvement Targets for each year:

- DY4:
  - IT-9.4: Other Outcome Improvement Target—reduce Memorial Hermann ED visits in 6 months after enrollment in patient navigation program by 5% under DY3 baseline.
- DY5:
  - IT-9.4: Other Outcome Improvement Target—reduce Memorial Hermann ED visits in 6 months after enrollment in patient navigation program by 10% under DY3 baseline.

Rationale:
The greater Houston area faces several major healthcare challenges, including a lack of primary care capacity, which can result in negative utilization patterns such as ED overutilization. Memorial Hermann's COPE/ED Navigation project (137805107.2.2) will provide patient navigation and offer alternatives to ED utilization for patients who may not be truly emergent. Memorial Hermann expects to see an improvement in ED utilization as a result of the associated Category 2 project.

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Outcome Measure Valuation:

The valuation of each Memorial Hermann project takes into account the transformational impact of the project, the population served by the project (both number of people and complexity of patient needs), the alignment of the project with community needs, the magnitude of costs avoided or reduced by the project, the degree of collaboration involved in the project, and the sustainability of the project.

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<table>
<tr><td>137805107.3.9</td><td>IT-9.4</td><td colspan="2">Other Outcome Improvement Target</td></tr>
<tr><td colspan="3">Memorial Hermann Hospital</td><td>137805107</td></tr>
<tr><td>Related Category 1 or 2 Projects:</td><td colspan="3">137805107.2.1</td></tr>
<tr><td>Starting Point/Baseline:</td><td colspan="3">TBD</td></tr>
<tr><th>Year 2
(10/1/2012 – 9/30/2013)</th><th>Year 3
(10/1/2013 – 9/30/2014)</th><th>Year 4
(10/1/2014 – 9/30/2015)</th><th>Year 5
(10/1/2015 – 9/30/2016)</th></tr>
<tr><td><u>Process Milestone 1</u> [P-1]: Project planning—engage stakeholders, identify current capacity and needed resources, determine timelines, and document implementation plans.

<u>Data Source</u>: Documentation of project planning.

Process Milestone 1: Estimated Incentive Payment: $404,180</td><td><u>Process Milestone 2</u> [P-2]: Establish baseline rates.

<u>Data Source</u>: EHR; claims.

Process Milestone 3: Estimated Incentive Payment: $468,497</td><td><u>Outcome Improvement Target 1</u> [IT-9.4]: Other outcome improvement target.

Improvement Target: Reduce Memorial Hermann ED visits in 6 months after enrollment by 5% over DY3 baseline.

Numerator: Number of Memorial Hermann visits in 6 months after enrollment in patient navigation program.

<u>Data Source</u>: EHR; claims.

Outcome Improvement Target 1: Estimated Incentive Payment: $751,774</td><td><u>Outcome Improvement Target 2</u> [IT-9.4]: Other outcome improvement target.

Improvement Target: Reduce Memorial Hermann ED visits in 6 months after enrollment by 10% over DY3 baseline.

Numerator: Number of Memorial Hermann visits in 6 months after enrollment in patient navigation program.

<u>Data Source</u>: EHR; claims.

Outcome Improvement Target 2: Estimated Incentive Payment: $1,797,721</td></tr>
<tr><td>Year 2 Estimated Outcome Amount: $434,396</td><td>Year 3 Estimated Outcome Amount: $503,522</td><td>Year 4 Estimated Outcome Amount: $807,976</td><td>Year 5 Estimated Outcome Amount: $1,932,118</td></tr>
<tr><td colspan="4">TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $3,678,012</td></tr>
</table>

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Title of Outcome Measure (Improvement Target): IT-13.3: Proportion with More Than One Emergency Room Visit in the Last Days of Life

Unique RHP outcome identification number(s): 137805107.3.10

Outcome Measure Description:
To achieve improvement under this metric, Memorial Hermann will engage in project planning during DY 2. In DY 3, Memorial Hermann will apply the planning developed in DY 2 in order to determine baseline rates for future DYs. In DY 4, Memorial Hermann intends to improve its proportion of patients who died from cancer with more than one emergency room visit in the last days of life by at least 10% over the baseline recorded in DY 3. In DY 5, Memorial Hermann intends to improve the measure by at least 10% over DY 4.

Process Milestones:
- DY2:
  - P-1: Project planning—engage stakeholders, identify current capacity and needed resources, determine timelines, and document implementation plans
- DY3:
  - P-2: Establish baseline rates

Outcome Improvement Targets for each year:
- DY4:
  - IT-13.3: Proportion with more than one emergency room visit in the last days of life—5% improvement over baseline
- DY5:
  - IT-13.3: Proportion with more than one emergency room visit in the last days of life—10% improvement over baseline

Rationale:
Due to a lack of access to hospice and palliative care, many patients have no choice but to receive end-of-life care which focuses on cure at any cost, rather than on the relief and prevention of suffering. In the last days of life, these patients often receive emergency treatment that is inconsistent with palliative care principles and without proper regard for the patient's quality of life. Memorial Hermann's Palliative Clinical Care Program project (137805107.2.2) will accelerate the growth and increase availability of palliative care in the greater Houston area, providing an alternative to ED utilization for patients in the last days of life. Memorial Hermann therefore expects to see an improvement in this Category 3 outcome as a result of the successful implementation of the associated Category 1 project.

Outcome Measure Valuation:
The valuation of each Memorial Hermann project takes into account the transformational impact of the project, the population served by the project (both number of people and complexity of patient needs), the alignment of the project with community needs, the magnitude of costs avoided or reduced by the project, the degree of collaboration involved in the project, and the sustainability of the project.

137805107.3.10	*IT-13.3*	***Proportion with More Than One Emergency Room Visit in the Last Days of Life***	
Memorial Hermann Hospital			*137805107*
Related Category 1 or 2 Projects:	*137805107.2.2*		
Starting Point/Baseline:	*TBD*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning—engage stakeholders, identify current capacity and needed resources, determine timelines, and document implementation plans. Data Source: Documentation of project planning. Process Milestone 1 Estimated Incentive Payment: $420,075	**Process Milestone 2** [P-2]: Establish baseline rates. Data Source: EHR; claims. Process Milestone 3 Estimated Incentive Payment: $486,972	**Outcome Improvement Target 1** [IT-13.3]: Proportion with more than one emergency room visit in the last days of life (NQF 0211). Improvement Target: 5% improvement over baseline. Data Source: EHR; claims. Outcome Improvement Target 1 Estimated Incentive Payment: $781,340	**Outcome Improvement Target 2** [IT-13.3]: Proportion with more than one emergency room visit in the last days of life (NQF 0211). Improvement Target: 10% improvement over baseline. Data Source: EHR; claims. Outcome Improvement Target 2 Estimated Incentive Payment: $1,868,421
Year 2 Estimated Outcome Amount: $420,075	Year 3 Estimated Outcome Amount: $486,922	Year 4 Estimated Outcome Amount: $781,340	Year 5 Estimated Outcome Amount: $1,868,421
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $3,556,758			

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Memorial Hermann Northwest Hospital

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Title of Outcome Measure (Improvement Target): IT-7.2 Cavities: Percentage of children with untreated dental caries (Healthy People 2020)

Unique RHP outcome identification number(s): 020834001.3.1

Outcome Measure Description:
To achieve improvement under this metric, Memorial Hermann will engage in project planning during DY 2. In DY 3, Memorial Hermann will apply the planning developed in DY 2 in order to determine baseline rates for future DYs. In DY 4, Memorial Hermann intends to improve the untreated dental caries measurement defined below by at least 25% over the baseline recorded in DY 3 for that measurement. In DY 5, Memorial Hermann intends to improve the same measurement by at least 15% over baseline.

Process Milestones:
- DY2:
  - P-1: Project planning—engage stakeholders, identify current capacity and needed resources, determine timelines, and document implementation plans
- DY3:
  - P-2: Establish baseline rates

Outcome Improvement Targets for each year:
- DY4:
  - IT-7.2 Cavities: Percentage of children with untreated dental caries (Healthy People 2020)—25% decrease over DY3 in recall patients
    - Numerator: Number of children with untreated dental caries seen by the mobile dental van program within the measurement period
    - Denominator: Total number of children that have been seen by the mobile dental van program within the measurement period
- DY5:
  - IT-7.2 Cavities: Percentage of children with untreated dental caries (Healthy People 2020—15% decrease over baseline
    - Numerator: Number of children with untreated dental caries seen by the mobile dental van program within the measurement period
    - Denominator: Total number of children that have been seen by the mobile dental van program within the measurement period

Rationale:
The greater Houston area faces several major healthcare challenges, including a lack of primary care capacity, which can result in care completely foregone until medical and dental issues escalate leading to negative utilization patterns such as ED overutilization. Memorial Hermann's School-Based Health project (020834001.1.1) will provide alternatives to improper ED utilization and provide the right care in the right setting through consistent delivery preventive care. Therefore, Memorial Hermann expects to see an improvement in the defined outcome improvement target as a result of the successful implementation of the associated Category 1

project. This specific improvement target has been chosen, in part, because it exemplifies the benefits to be derived from an accessible medical and dental home.

Outcome Measure Valuation:
The valuation of each Memorial Hermann project takes into account the transformational impact of the project, the population served by the project (both number of people and complexity of patient needs), the alignment of the project with community needs, the magnitude of costs avoided or reduced by the project, the degree of collaboration involved in the project, and the sustainability of the project.

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020834001.3.1	*IT-7.2*	*Cavities: Percentage of children with untreated dental caries (Healthy People 2012)*	
Memorial Hermann Hospital System			*020834001*
Related Category 1 or 2 Projects:	*020834001.1.1*		
Starting Point/Baseline:	*TBD in DY3*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1: [P-1]: Project planning—engage stakeholders, identify current capacity and needed resources, determine timelines, and document implementation plans. Data Source: Documentation of project planning. Process Milestone 1 Estimated Incentive Payment: $404,180	**Process Milestone 2:** [P-2]: Establish baseline rates. Data Source: Dental Charts; Excel Report; EHR of initial patients Process Milestone 3 Estimated Incentive Payment: $468,497	**Outcome Improvement Target 1:** [IT-7.2]: Other outcome improvement target. Improvement Target: 25% improvement over baseline. Data Source: Dental Charts; Excel Report; of recall patients Outcome Improvement Target 1 Estimated Incentive Payment: $751,774	**Outcome Improvement Target 2:** [IT-7.2]: Other outcome improvement target. Improvement Target: 15% improvement over baseline. Data Source: Dental Charts; Excel Report; EHR of recall patients Outcome Improvement Target 2 Estimated Incentive Payment: $1,797,721
Year 2 Estimated Outcome Amount: $404,180	Year 3 Estimated Outcome Amount: $468,497	Year 4 Estimated Outcome Amount: $751,774	Year 5 Estimated Outcome Amount: $1,797,721
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $3,422,172			

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Title of Outcome Measure (Improvement Target): IT-9.4: Other Outcome Improvement Target

Unique RHP outcome identification number(s): 020834001.3.2

Outcome Measure Description:
To achieve improvement under this metric, Memorial Hermann will engage in project planning during DY 2. In DY 3, Memorial Hermann will apply the planning developed in DY 2 in order to determine baseline rates for future DYs. In DY 4, Memorial Hermann intends to improve the Right Care, Right Setting measurement defined below by at least 10% over the baseline recorded in DY 3 for that measurement. In DY 5, Memorial Hermann intends to improve the same measurement by at least 15% over baseline.

Process Milestones:

- DY2:
  - P-1: Project planning—engage stakeholders, identify current capacity and needed resources, determine timelines, and document implementation plans
- DY3:
  - P-2: Establish baseline rates

Outcome Improvement Targets for each year:

- DY4:
  - IT-9.4: Other Outcome Improvement Target – 10% improvement over DY3
    - Numerator:
      - Number of Nurse Triage Calls resulting in ED avoidance over a 12 month period
    - Denominator:
      - Number of Nurse Triage Calls received in a 12 month period.
- DY5:
  - IT-9.4: Other Outcome Improvement Target – 15% improvement over DY3
    - Numerator:
      - Number of Nurse Triage Calls resulting in ED avoidance over a 12 month period
    - Denominator:
      - Number of Nurse Triage Calls received in a 12 month period.

Rationale:
The greater Houston area faces several major healthcare challenges, including a lack of primary care capacity, which can result in negative utilization patterns such as ED overutilization. Memorial Hermann's 24-Hour Nurse Triage Line project (020834001.1.2) will provide an alternative to ED utilization for patients who may not be truly emergent; therefore, Memorial Hermann expects to see an improvement in ED utilization as a result of the associated Category 1 project. Percentage improvement is based on volume of calls which are anticipated to increase in the fourth year (from baseline) and the fifth year of the project.

Outcome Measure Valuation:
The valuation of each Memorial Hermann project takes into account the transformational impact of the project, the population served by the project (both number of people and complexity of patient needs), the alignment of the project with community needs, the magnitude of costs avoided or reduced by the project, the degree of collaboration involved in the project, and the sustainability of the project.

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020834001.3.2	*IT-9.4*	*Other Outcome Improvement Target*	
Memorial Hermann Hospital System			*020834001*
Related Category 1 or 2 Projects::	*020834001.1.2*		
Starting Point/Baseline:	*TBD*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning—engage stakeholders, identify current capacity and needed resources, determine timelines, and document implementation plans. Data Source: Documentation of project planning. Process Milestone 1 Estimated Incentive Payment: $408,879	**Process Milestone 2** [P-2]: Establish baseline rates. Data Source: EHR; claims; Triage Line Software. Process Milestone 3 Estimated Incentive Payment: $473,945	**Outcome Improvement Target 1** [IT-9.4]: Other Outcome Improvement Target Improvement Target: ED Avoidance in 10% of Nurse Triage calls over DY3. Data Source: EHR; claims. Outcome Improvement Target 1 Estimated Incentive Payment: $760,516	**Outcome Improvement Target 2** [IT-9.4]: Other Outcome Improvement Target Improvement Target: ED Avoidance in 15% of Nurse Triage calls over baseline. Data Source: EHR; claims. Outcome Improvement Target 2 Estimated Incentive Payment: $1,818,625
Year 2 Estimated Outcome Amount: $408,879	Year 3 Estimated Outcome Amount: $473,945	Year 4 Estimated Outcome Amount: $760,516	Year 5 Estimated Outcome Amount: $1,818,625
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $3,461,965			

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Title of Outcome Measure (Improvement Target): IT-3.8: Behavioral Health/Substance Abuse (BH/SA) 30-day readmission rate

Unique RHP outcome identification number(s): 020834001.3.3

Outcome Measure Description:
To achieve improvement under this metric, Memorial Hermann will engage in project planning during DY 2. In DY 3, Memorial Hermann will apply the planning developed in DY 2 in order to determine baseline rates for future DYs. In DY 4, Memorial Hermann intends to reduce its Behavioral Health/Substance Abuse (BH/SA) 30-day readmission rate by at least 5% over the baseline recorded in DY 3. In DY 5, Memorial Hermann intends to improve its BH/SA 30-day readmission rate by at least 5% over the DY 4 measurement.

Process Milestones:

- DY2:
  - P-1: Project planning—engage stakeholders, identify current capacity and needed resources, determine timelines, and document implementation plans
- DY3:
  - P-2: Establish baseline rates

Outcome Improvement Targets for each year:

- DY4:
  - IT-3.8: Behavioral Health/Substance Abuse (BH/SA) 30-day readmission rate—5% reduction over DY3
- DY5:
  - IT-3.8: Behavioral Health/Substance Abuse (BH/SA) 30-day readmission rate—10% reduction over the baseline measures in DY3

Rationale:
Behavioral health patients in the greater Houston area, particularly uninsured patients, face significant challenges in obtaining the behavioral health care services they need, which can result in negative utilization patterns including unnecessary inpatient admissions. These challenges will be addressed by Memorial Hermann's Psych Response Team—Case Management project (020834001.2.1), which will result in more intensive case management of post-discharge behavioral health patients and more appropriate follow-up and utilization of care by these patients. That care will be provided in a community setting, in part, through Memorial Hermann's efforts to implement a Home Health Psych Services project (020834001.1.3). Therefore, Memorial Hermann expects to see an improvement in the Behavioral Health/Substance Abuse (BH/SA) 30-day readmission rate as a result of the associated Category 1 and 2 projects.

Project Valuation:
The valuation of each Memorial Hermann project takes into account the transformational impact of the project, the population served by the project (both number of people and complexity of patient needs), the alignment of the project with community needs, the magnitude of costs avoided or reduced by the project, the degree of collaboration involved in the project, and the sustainability of the project.

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020834001.3.3	IT-3.8	*Behavioral Health/Substance Abuse (BH/SA) 30-Day Readmission Rate*	
Memorial Hermann Hospital System			*020834001*
Related Category 1 or 2 Projects:	020834001.1.3		
Starting Point/Baseline:	*TBD*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning—engage stakeholders, identify current capacity and needed resources, determine timelines, and document implementation plans. Data Source: Documentation of project planning. Process Milestone 1 Estimated Incentive Payment: $484,076	**Process Milestone 2** [P-2]: Establish baseline rates. Data Source: EHR; claims. Process Milestone 3 Estimated Incentive Payment: $561,107	**Outcome Improvement Target 1** [IT-3.8]: Behavioral Health/Substance Abuse (BH/SA) 30-day readmission rate. Improvement Target: 5% improvement over DY3. Data Source: EHR; claims. Outcome Improvement Target 1 Estimated Incentive Payment: $900,381	**Outcome Improvement Target 2** [IT-3.8]: Behavioral Health/Substance Abuse (BH/SA) 30-day readmission rate. Improvement Target: 10% improvement over baseline Data Source: EHR; claims. Outcome Improvement Target 2 Estimated Incentive Payment: $2,153,084
Year 2 Estimated Outcome Amount: $484,076	Year 3 Estimated Outcome Amount: $561,107	Year 4 Estimated Outcome Amount: $900,381	Year 5 Estimated Outcome Amount: $2,153,084
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $4,098,648			

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Title of Outcome Measure (Improvement Target): IT-6.1: Percent Improvement Over Baseline of Patient Satisfaction Scores

Unique RHP outcome identification number(s): 020834001.3.4

Outcome Measure Description:
To achieve improvement under this metric, Memorial Hermann will engage in project planning during DY 2. In DY 3, Memorial Hermann will apply the planning developed in DY 2 in order to determine baseline rates for future DYs. In DY 4, Memorial Hermann intends to improve its patient satisfaction scores by at least 10% over the baseline recorded in DY 3 for patients' rating of whether patients are getting timely care, appointments, and information. In DY 5, Memorial Hermann intends to improve its patient satisfaction scores by at least 10% over the DY 4 measurement in the same area.

Process Milestones:
- DY2:
  - P-1: Project planning—engage stakeholders, identify current capacity and needed resources, determine timelines, and document implementation plans
- DY3:
  - P-2: Establish baseline rates

Outcome Improvement Targets for each year:
- DY4:
  - IT-6.1: Percent improvement over baseline of patient satisfaction scores—10% improvement over DY3 for patients' rating of whether patients are getting timely care, appointments, and information
- DY5:
  - IT-6.1: Percent improvement over baseline of patient satisfaction scores—15% improvement over baseline for patients' rating of whether patients are getting timely care, appointments, and information

Rationale:
The greater Houston area faces several major healthcare challenges, including a lack of primary care capacity, which can result in negative utilization patterns such as ED overutilization. Improper utilization results in lower levels of patient satisfaction with the care received, since it is not the level of care or type of care most appropriate to the patient's condition. Additionally, patients are often unaware of the utilization options that are available to them, or otherwise not properly equipped to choose the best utilization options. These challenges will be addressed by Memorial Hermann's Convenient Care Centers project (020834001.1.2) and MHMD Care Management project (020834001.2.2), and Memorial Hermann expects to see an improvement in patient satisfaction as a result of the associated Category 1 and 2 projects—specifically, an improvement in patients' rating of whether patients are getting timely care, appointments, and information.

Outcome Measure Valuation:
The valuation of each Memorial Hermann project takes into account the transformational impact of the project, the population served by the project (both number of people and complexity of

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patient needs), the alignment of the project with community needs, the magnitude of costs avoided or reduced by the project, the degree of collaboration involved in the project, and the sustainability of the project.

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020834001.3.4	*IT-6.1*	*Percent Improvement Over Baseline of Patient Satisfaction Scores*	
Memorial Hermann Hospital System			*020834001*
Related Category 1 or 2 Projects::	*020834001.1.4*		
Starting Point/Baseline:	*TBD in DY3*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning—engage stakeholders, identify current capacity and needed resources, determine timelines, and document implementation plans. Data Source: Documentation of project planning. Process Milestone 1 Estimated Incentive Payment: $488,775	**Process Milestone 2** [P-2]: Establish baseline rates. Data Source: Patient survey. Process Milestone 2 Estimated Incentive Payment: $566,554	**Outcome Improvement Target 1** [IT-6.1]: Percent improvement over baseline of patient satisfaction scores. Improvement Target: 10% improvement over DY3. Data Source: Patient survey. Outcome Improvement Target 1 Estimated Incentive Payment: $909,122	**Outcome Improvement Target 2** [IT-6.1]: Percent improvement over baseline of patient satisfaction scores. Improvement Target: 15% improvement over baseline Data Source: Patient survey. Outcome Improvement Target 2 Estimated Incentive Payment: $2,173,988
Year 2 Estimated Outcome Amount: $488,775	Year 3 Estimated Outcome Amount: $566,554	Year 4 Estimated Outcome Amount: $909,122	Year 5 Estimated Outcome Amount: $2,173,988
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $4,138,440			

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Title of Outcome Measure (Improvement Target): OD-1 Primary Care and Chronic Disease Management

Unique RHP outcome identification number(s): 020834001.3.5

Outcome Measure Description:

IT-1.1 Third next available appointment (Non- standalone measure)
Reduce the average length of time in days between the day a patient makes a request for an appointment with a physician and the third available appointment for a new patient physical, routine exam, or return visit exam. The goals will be to decrease number of days to third next available appointment to zero days (same day) for Primary Care.

Process Milestones:

- DY2:
  - P-1: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
- DY3:
  - P-2: Establish baseline rates
  - P-3: Develop and test data systems

Outcome Improvement Targets for each year:

- DY4:
  - IT-1.1:
    Reduce by 1 day the average length of time in days between the day a patient makes a request for an appointment with a physician and the third available appointment for a new patient physical, routine exam, or return visit exam.
- DY5:
  - IT-1.1:
    Reduce the average length of time in days between the day a patient makes a request for an appointment with a physician and the third available appointment for a new patient physical, routine exam, or return visit exam to zero (0) days.

Rationale:

Access to primary care services can have an impact on healthcare outcomes, by providing early screening and treatment and patients are more likely to get these services when they are able to get appointments when first needed that accommodate their schedule. Since the goal of the project is to increase access to care and the third next available appointment is the healthcare industry's standard measure of access to care, we have chosen this outcome measure.

Outcome Measure Valuation:

The valuation of each Memorial project takes into account the transformational impact of the project, the population served by the project (both number of people and complexity of patient needs), the alignment of the project with community needs, the magnitude of costs avoided or reduced by the project, the degree of collaboration involved in the project, and the sustainability of the project.

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020834001.3.5	*3.IT-1.1*	*Third next available appointment (Non- standalone measure)*	
Memorial Hermann Northwest Hospital			*020834001*
Related Category 1 or 2 Projects:	***020834001.1.5***		
Starting Point/Baseline:	*To be determined during DY3.*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Project reports and documents Process Milestone 1 Estimated Incentive Payment: $ 263,403	Process Milestone 2 [P-2]: Establish baseline rates Data Source: Provider reports Process Milestone 2 Estimated Incentive Payment: $ 152,705 Process Milestone 3 [P-3]: Develop and test data systems Data Source: Project reports, EMR, claims Process Milestone 3 Estimated Incentive Payment: $ 152,705	Outcome Improvement Target 1 [IT-1.1]: Reduce by 1 day the average length of time in days between the day a patient makes a request for an appointment with a physician and the third available appointment for a new patient physical, routine exam, or return visit exam. Data Source: Appointment management system Outcome Improvement Target 1 Estimated Incentive Payment: $ 491,474	Outcome Improvement Target 2 [IT-1.1]: Reduce the average length of time in days between the day a patient makes a request for an appointment with a physician and the third available appointment for a new patient physical, routine exam, or return visit exam to zero (0) days. Data Source: Appointment management system Outcome Improvement Target 2 Estimated Incentive Payment: $ 1,187,299
Year 2 Estimated Outcome Amount: $ 263,403	**Year 3 Estimated Outcome Amount: $ 305,410**	**Year 4 Estimated Outcome Amount: $ 491,474**	**Year 2 Estimated Outcome Amount: $ 1,187,299**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $ 2,247,586			

Title of Outcome Measure (Improvement Target): OD-1 Primary Care and Chronic Disease Management

Unique RHP outcome identification number(s): 020834001.3.6

Outcome Measure Description:
IT-1.19 Antidepressant Medication Management - NQF 0105 (Standalone measure)

This measure has two components that assess the management of antidepressant medication in children ages 6 and over: A) the acute phase treatment period consisting at least 84 days (12 weeks) of continuous treatment with antidepressant medication during the 114-day period following the IPSD (inclusive), and B) the continuation phase treatment period consisting of at least 180 days (6 months) of continuous treatment with antidepressant medication (Table AMM-D) during the 231-day period following the IPSD (inclusive). For the acute phase, continuous treatment allows gaps in medication treatment up to a total of 30 days during the 114-day period. Gaps can include either washout period gaps to change medication or treatment gaps to refill the same medication. Regardless of the number of gaps, there may be no more than 30 gap days. Any combination of gaps (e.g., two washout gaps of 15 days each, or two washout gaps of 10 days each and one treatment gap of 10 days) will be counted. For the continuation phase, continuous treatment allows gaps in medication treatment up to a total of 51 days during the 231-day period. Gaps can include either washout period gaps to change medication or treatment gaps to refill the same medication. Regardless of the number of gaps, gap days may total no more than 51. Any combination of gaps (e.g., two washout gaps, each 25 days or two washout gaps of 10 days each and one treatment gap of 10 days) will be counted.

The denominator for this measures is based on discharges (of 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. All discharges for members who have more than one discharge on or between January 1 and December 1 of the measurement year will be included. If the discharge is followed by readmission or direct transfer to an acute facility for a mental health principal diagnosis (within the 30-day follow-up period), only the readmission discharge or the discharge from the facility to which the member was transferred will be counted. Although rehospitalization might not be for a selected mental health disorder, it is probably for a related condition.

Process Milestones:

- DY2:
  - P-1: Project planning—engage stakeholders, identify current capacity and needed resources, determine timelines, and document implementation plans.
- DY3:
  - P-2: Establish baseline rates
  - P-3: Develop and test data systems

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Outcome Improvement Targets for each year:

- DY4:

  IT-1.19 Increase by **3%** the percentage of discharges (of 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 who receive at least 84 days (12 weeks) of continuous treatment with antidepressant medication during the 114-day period following the IPSD (inclusive) and at least 180 days (6 months) of continuous treatment with antidepressant medication (Table AMM-D) during the 231-day period following the IPSD (inclusive).
- DY5:

  IT-1.19 Increase by **5%** the percentage of discharges (of 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 who receive at least 84 days (12 weeks) of continuous treatment with antidepressant medication during the 114-day period following the IPSD (inclusive) and at least 180 days (6 months) of continuous treatment with antidepressant medication (Table AMM-D) during the 231-day period following the IPSD (inclusive).

Rationale:

This outcome measure will be a direct reflection on whether the pediatric population in this service area is receiving appropriate management of anti-depressant medications . Greater access to primary care services can help ensure that pediatric patients receive appropriate medication management, reducing the need for additional acute care services and improving health outcomes.

Outcome Measure Valuation:

The valuation of each Memorial project takes into account the transformational impact of the project, the population served by the project (both number of people and complexity of patient needs), the alignment of the project with community needs, the magnitude of costs avoided or reduced by the project, the degree of collaboration involved in the project, and the sustainability of the project.

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020834001.3.6	*3.IT-1.19*	*Antidepressant Medication Management - NQF 0105 (Standalone measure)*	
Memorial Hermann Northwest Hospital			*020834001*
Related Category 1 or 2 Projects:	***020834001.1.5***		
Starting Point/Baseline:	*TBD*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Project reports and documents Process Milestone 1 Estimated Incentive Payment: $ 263,403	**Process Milestone 2 [P-2]:** Establish baseline rates Data Source: Provider reports Process Milestone 2 Estimated Incentive Payment: $ 152,705 Process Milestone 3 [P-3]: Develop and test data systems Data Source: Project reports, EMR, claims Process Milestone 3 Estimated Incentive Payment: $ 152,705	**Outcome Improvement Target 1** [IT-1.19]: Increase by 35% the percentage of discharges (of 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 children age 18 or younger with a diagnosis of major depression or dysthymia and an initial PHQ-9 score greater than nine who receive at least 84 days (12 weeks) of continuous treatment with antidepressant medication during the 114-day period following the IPSD (inclusive)achieve remission at twelve months as demonstrated by a twelve month (+/-30 days) PHQ-9 score of less than five and at least 180 days (6 months) of continuous treatment with antidepressant medication (Table AMM-D) during the 231-day period following the IPSD (inclusive). <u>Data Source</u>: Electronic Clinical Data, Electronic Health Record, Paper Records Outcome Improvement Target 1 Estimated Incentive Payment: $ 491,474	**Outcome Improvement Target 2** [IT-1.19]: Increase by 5% the percentage of discharges (of 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 who receive at least 84 days (12 weeks) of continuous treatment with antidepressant medication during the 114-day period following the IPSD (inclusive) and at least 180 days (6 months) of continuous treatment with antidepressant medication (Table AMM-D) during the 231-day period following the IPSD (inclusive). <u>Data Source</u> Electronic Clinical Data, Electronic Health Record, Paper Records Outcome Improvement Target 2 Estimated Incentive Payment: $ 1,187,299

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020834001.3.6	*3.IT-1.19*	*Antidepressant Medication Management - NQF 0105 (Standalone measure)*	
Memorial Hermann Northwest Hospital			*020834001*
Related Category 1 or 2 Projects:	***020834001.1.5***		
Starting Point/Baseline:	*TBD*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Year 2 Estimated Outcome Amount: $ 263,403	**Year 3 Estimated Outcome Amount: $ 305,410**	**Year 4 Estimated Outcome Amount: $ 491,474**	**Year 5 Estimated Outcome Amount: $ 1,187,299**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $ 2,247,586			

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Title of Outcome Measure (Improvement Target): IT-3.8: Behavioral Health/Substance Abuse (BH/SA) 30-day readmission rate

Unique RHP outcome identification number(s): 020834001.3.7

Outcome Measure Description:
To achieve improvement under this metric, Memorial Hermann will engage in project planning during DY2. In DY3, Memorial Hermann will apply the planning developed in DY2 in order to determine baseline rates for future DYs. In DY4, Memorial Hermann intends to reduce its Behavioral Health/Substance Abuse (BH/SA) 30-day readmission rate by at least 5% over the baseline recorded in DY3. In DY5, Memorial Hermann intends to improve its BH/SA 30-day readmission rate by at least 5% over the DY4 measurement.

Process Milestones:

- DY2:
  - P-1: Project planning—engage stakeholders, identify current capacity and needed resources, determine timelines, and document implementation plans
- DY3:
  - P-2: Establish baseline rates

Outcome Improvement Targets for each year:

- DY4:
  - IT-3.8: Behavioral Health/Substance Abuse (BH/SA) 30-day readmission rate—5% reduction over DY3
- DY5:
  - IT-3.8: Behavioral Health/Substance Abuse (BH/SA) 30-day readmission rate—10% reduction over baseline

Rationale:
Behavioral health patients in the greater Houston area, particularly uninsured patients, face significant challenges in obtaining the behavioral health care services they need, which can result in negative utilization patterns including unnecessary inpatient admissions. These challenges will be addressed by Memorial Hermann's Psych Response Team—Case Management project (020834001.2.1), which will result in more intensive case management of post-discharge behavioral health patients and more appropriate follow-up and utilization of care by these patients. That care will be provided in a community setting, in part, through Memorial Hermann's efforts to implement a Home Health Psych Services project (020834001.1.1). Therefore, Memorial Hermann expects to see an improvement in the Behavioral Health/Substance Abuse (BH/SA) 30-day readmission rate as a result of the associated Category 1 and 2 projects.

Outcome Measure Valuation:
The valuation of each Memorial Hermann project takes into account the transformational impact, the population served (both number of people and complexity of patient needs), the alignment with community needs, the magnitude of costs avoided or reduced, the degree of collaboration involved, and the sustainability of the project.

020834001.3.7	IT-3.8	***Behavioral Health/Substance Abuse (BH/SA) 30-Day Readmission Rate***	
Memorial Hermann Hospital System			020834001
Related Category 1 or 2 Projects:	020834001.2.1		
Starting Point/Baseline:	*TBD*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning—engage stakeholders, identify current capacity and needed resources, determine timelines, and document implementation plans. Data Source: Documentation of project planning. Process Milestone 1: Estimated Incentive Payment: $465,277	**Process Milestone 2** [P-2]: Establish baseline rates. Data Source: EHR; claims. Process Milestone 3 Estimated Incentive Payment: $539,316	**Outcome Improvement Target 1** [IT-3.8]: Behavioral Health/Substance Abuse (BH/SA) 30-day readmission rate. Improvement Target: 5% improvement over baseline. Data Source: EHR; claims. Outcome Improvement Target 1 Estimated Incentive Payment: $865,414	**Outcome Improvement Target 2** [IT-3.8]: Behavioral Health/Substance Abuse (BH/SA) 30-day readmission rate. Improvement Target: 10% improvement over baseline Data Source: EHR; claims. Outcome Improvement Target 2 Estimated Incentive Payment: $2,069,469
Year 2 Estimated Outcome Amount: $465,277	Year 3 Estimated Outcome Amount: $539,316	Year 4 Estimated Outcome Amount: $865,414	Year 5 Estimated Outcome Amount: $2,069,469
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $3,939,476			

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Title of Outcome Measure (Improvement Target): IT-6.1: Percent Improvement Over Baseline of Patient Satisfaction Scores

Unique RHP outcome identification number(s): 020834001.3.8

Outcome Measure Description:
To achieve improvement under this metric, Memorial Hermann will engage in project planning during DY2. In DY3, Memorial Hermann will apply the planning developed in DY2 to determine baseline rates for future DYs. In DY4, Memorial Hermann intends to improve its patient satisfaction scores over the baseline recorded in DY3 by using patients' rating of whether they are getting timely care, appointments, and information. Targets for patient satisfaction scores will be gauged against emerging best practice standards and industry comparatives.

Process Milestones:

- DY2:
  - P-1: Project planning—engage stakeholders, identify current capacity and needed resources, determine timelines, and document implementation plans.
- DY3:
  - P-2: Establish baseline rates.

Outcome Improvement Targets for each year:

- DY4:
  - IT-6.1: Percent improvement over baseline of patient satisfaction scores—improvement over DY3 for patients' rating of whether patients are getting timely care, appointments, and information.
- DY5:
  - IT-6.1: Percent improvement over baseline of patient satisfaction scores—improvement over baseline for patients' rating of whether patients are getting timely care, appointments, and information.

Rationale:
The greater Houston area faces several major healthcare challenges, including a lack of primary care capacity, which can result in negative utilization patterns such as ED overutilization. Improper utilization results in lower levels of patient satisfaction, since it is not the level or type of care most appropriate to the patient's condition. Additionally, patients are often unaware of the utilization options that are available to them, or are otherwise not properly equipped to choose the best utilization options. These challenges will be addressed by Memorial Hermann's Convenient Care Centers project and MHMD Care Management project, and Memorial Hermann expects to see an improvement in patient satisfaction as a result of the associated Category 1 and 2 projects—specifically, an improvement in patients' rating of whether they are getting timely care, appointments, and information.

Outcome Measure Valuation:
The valuation of each Memorial Hermann project takes into account the transformational impact of the project, the population served by the project (both number of people and complexity of patient needs), the alignment of the project with community needs, the magnitude of costs avoided or reduced by the project, the degree of collaboration involved in the project, and the sustainability of the project.

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020834001.3.8	*IT-6.1*	*Percent Improvement Over Baseline of Patient Satisfaction Scores*	
Memorial Hermann Hospital System			*020834001*
Related Category 1 or 2 Projects:	*020834001.2.2*		
Starting Point/Baseline:	*TBD in DY3*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning—engage stakeholders, identify current capacity and needed resources, determine timelines, and document implementation plans. Data Source: Documentation of project planning. Process Milestone 1 Estimated Incentive Payment: $484,076	**Process Milestone 2** [P-2]: Establish baseline rates. Data Source: Patient survey. Process Milestone 3 Estimated Incentive Payment: $561,107	**Outcome Improvement Target 1** [IT-6.1]: Percent improvement over baseline of patient satisfaction scores. Improvement Target: TBD Data Source: Patient survey. Outcome Improvement Target 1 Estimated Incentive Payment: $900,381	**Outcome Improvement Target 2** [IT-6.1]: Percent improvement over baseline of patient satisfaction scores. Improvement Target - TBD improvement over the baseline established in DY 3. Data Source: Patient survey. Outcome Improvement Target 2 Estimated Incentive Payment: $2,153,084
Year 2 Estimated Outcome Amount: $484,076	Year 3 Estimated Outcome Amount: $561,107	Year 4 Estimated Outcome Amount: $900,381	Year 5 Estimated Outcome Amount: $2,153,084
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $4,098,648			

DRAFT

Memorial Medical Center

Pass 1

DRAFT

Title of Outcome Measure (Improvement Target): IT-6.1 Patient Satisfaction

Unique RHP outcome identification number: 137909111.3.1

Project Description:

To increase the ability of Memorial Medical Center (MMC) to provide the "right care at the right time in the right setting," patient satisfaction with primary and specialty care services through the establishment of a hospital-based clinic shall be essential. This "expanding access to care" initiative will provide critically needed services to a medically underserved area of rural Texas as identified in our Region's community needs assessment. However, ensuring patients have access to services at times that are convenient for them, are able to secure appointments with appropriate providers, (therefore reducing the inappropriate use of the hospital emergency department for non-urgent and primary care service) are critical elements to producing life saving, as well as, cost saving measures.

Outcome Measure Description:

To progressively measure and implement appropriate changes, specific steps and milestones are integrated into Memorial Medical's Center Access to Care four year plan. Following is synopsis of the selected milestones and associated metrics.

During DY2, when the infrastructure for a Hospital Based Clinic is under development, MMC shall assemble a team with Quality Assurance Council to review CG-CAHPS required data on patient experience. After review, the team shall meet with a vendor to develop a customized survey tool to measure and monitor patient outcomes. Open ended questions shall be developed on the survey to all patients to elaborate on their experiences and give insight on how those experiences may be improved. This process milestone is valued at $62,718 for staffing, design development, implementation and monitoring.

For demonstration year 3, we will establish the baseline rates for CG-CAHPS focused areas including timely care, appointments and information. Milestone 2 includes collecting the data from CG-CAHPS surveys and aligning our baseline of achievements or shortcomings to the national average, as well as, personal standards for MMC. We value milestone two at $22,698 for staffing, analysis, and monitoring. Milestone 3 launches a critical step to any successful program, disseminate findings and establish lessons learned and best practices with stakeholders. Utilizing our RHP resources, Quality Assurance Council and other identified stakeholder (i.e. office staff, Physicians, IT, etc.) scores will be aligned with procedures and protocols to develop best practices for positive patient outcomes. Data and feedback are ineffective unless studied, analyzed developed into strategic plans. Because of the importance of this milestone, we value this component at $50,000 for staffing, analysis, oversight and plan development.

In DY4, MMC shall incorporate the milestones in DY3 to produce targeted improvement outcomes in this project year. Target outcome one encompasses a 5% improvement over baseline patient satisfaction scores established in DY3. Focus areas include timely care, appointments and information where goals in patient experiences fell below acceptable standards. Based upon survey results, employee training shall be developed integrating patient experience into the curriculum. Stakeholders and RHP collaborations shall be encouraged to utilize successful models. Further, a case manager/educator shall be placed to assist in information and education for patients. We value this milestone at $116,655 including staffing, analyzing, customized curriculum, supplies, training, and monitoring.

Finally, in DY5, patient experience at the Hospital Based Clinic shall have improved in deficient areas of timely care, appointments and information by 10% by the end of the waiver. Further, 80% of staff in areas identified with deficiencies in patient satisfaction shall be trained using customized models for positive patient outcomes. Patient education and case management shall extend based upon customer needs. We value this DSRIP milestone at $278,957 including staffing, analyzing, customized curriculum, supplies, training, public awareness and monitoring.

Rationale:

We intend to use the CG-CAHPS survey to improve our performance as measured by whether patients are (1) getting timely care, appointments and information. Obtaining patient feedback on our ability to provide the right care at the right time is critical to the success of this project and the internal operations of the clinic. This data will provide us with meaningful and objective information that will be used to determine whether our clinic has met patient expectations related to obtaining timely care and information, and will identify areas where we need to improve. Because the community we serve has an insufficient number of providers and patients are often unable to obtain appointments in a timely manner, the priority goal for this project is ensuring patients receive care when they need it and without significant delays, which will result in improved health outcomes and patient satisfaction. The CG-CAHPS survey is an effective tool for measuring our progress and will provide valuable information and feedback on our performance and areas where improvement is needed.

Because more than 60% of our community out-migrates for healthcare needs, it is important that patient satisfaction and access to care needs are met locally.[299] Measuring that we are meeting the needs of the patients we intend to serve, represents the best outcome for our project. Through survey results and our participation in a collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system.

Outcome Measure Valuation:

When valuing the expansion of access to both primary and specialty care in Calhoun County, we looked at the project three-fold. We found such a project had significant economic, quality of life and cost savings value.

First, we surmised the economic value to the County as a whole, the patient, and industry. Roughly 70% of Calhoun County out-migrates for healthcare needs[12]. With that migration to other communities travels revenue from sales tax for meals, gas, shopping and a half day of work. If 10% of the community (2145 citizens) were to utilize healthcare services locally $100,035 in gas and meals alone would remain in the community. Over 20 years, $2,000,700 would be generated from travel. Further, we calculated the revenue lost by patients leaving their jobs for a half day to travel outside the community for healthcare. If 10,000 workers with the average salary of $40,000 took a half day of personal time for doctors appointments outside the area, their absence would generate a loss to industry in the amount of $76,923 in one year and $1,538,461 over 20 years. Further, the revenue generated by local healthcare services would have a significant economic impact on tax valuation. With positive tax revenue, tax rates could be lowered resulting in incentives for business and industry to develop in the area. Job creation,

[299] BR Healthcare Services, Inc., Memorial Medical Center Market & Service Area Development Report, October, 2010.

housing expansion and development of amenities add to the quality of life for Calhoun County residents.

In July 2012, Formosa Plastics Corporation and Calhoun County agreed to a $2 million tax abatement for future plant expansions. Recognizing the need for access to healthcare, Formosa Plastics designated the funds be used for construction of a Hospital Based Clinic. To industry, the need for access to healthcare locally is valued more than $2 million.

Secondly, we subjectively valued the quality of life associated with the convenience of local healthcare. In determining the value, we took into consideration the value of a coordinated home health model for patient outcomes[300], and the value of support groups to patient recovery. Redford Williams, Director, Behavioral Medicine Research Center at Duke noted, "Back in 1992 we published a paper in JAMA that clearly documented this (importance of support), showing that heart patients with a spouse, a confidant or both had a 5-year mortality rate of only 18 percent, compared to only 50 percent in those with neither spouse nor confidant." Having access to care at home, lends to a "social recovery model" with the convenience of family and friends assisting in the support group towards recovery. We estimate the value of a coordinated care model with the added convenience of a "social recovery model" as $25,000 per person. We attribute the value to wages earned by patient, supporting members and shorter recovery periods. If 100 patients experienced the benefits of quality of life per year, the value would be $2,500,000. Over 20 years, the quality of life would be valued at $50,000,000.

In a recent assessment conducted by iVantage, they concluded that Medicare costs per capita dollar by Physician service type were $531 more expensive in urban areas than rural[301]. In one year, if 2154 (10% of the County) Medicare patients from Calhoun County received their Physician services locally rather than urban areas, Medicare would save $1,139,207. Over the course of twenty years, Medicare would save $22,784,148 in Physician services.

In closing, the access to primary and specialty healthcare through a hospital based clinic is valued at $5,816,165 for year one of the Waiver. For the lifetime of the Waiver 1115, the value of these projects to rural Calhoun County, Texas is valued at $17,264,660.

[300] RHP 3 Working Groups, Stakeholder input, 2012.
[301] iVantage, *Rural Relevance Under Healthcare Reform,* April 2012.

137909111.3.1	*3.IT.6.1*	*Patient Satisfaction*	
Memorial Medical Center			*137909111*
Related Category 1 or 2 Projects:	*137909111.1.1*		
Starting Point/Baseline:	*To be determined*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [*P-1*]: Project Planning Metric: Develop plan for conducting CAHPS survey and contract with vendor for implementation Data Source: Vendor contract and customized CAHPS surveys developed by vendor. Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $ 62,718	**Process Milestone 2 [P-2]**: Establish baseline rates Data Source: CAHPS data from surveys to develop baseline on customer satisfaction with timely care, appointments, and information. Process Milestone 2 Estimated Incentive Payment: $ 22,698 **Process Milestone 3** [P-5]: Disseminate findings, including lessons learned and best practices, to stakeholders Data Source: CAHPS data and vendor reports; Minutes for stakeholder meetings Process Milestone 3 Estimated Incentive Payment: $ 50,000	**Outcome Improvement Target 1** [IT-6.1.1]: Percent improvement over baseline of patient satisfaction sc ores for primary and specialty care. Improvement Target: 5% over baseline (DY3) of patient satisfaction scores for targeted areas of timely care, appointments and information deemed below acceptable standards through staff training. Data Source: CAHPS surveys and reports. Outcome Improvement Target 2 Estimated Incentive Payment*:* $116,655	**Outcome Improvement Target 2** [IT-6.1.1]: Percent improvement over baseline of patient satisfaction scores for primary and specialty care. Improvement Target: 10% over baseline (DY 3) of patient satisfaction scores for targeted areas of timely care, appointments and information deemed below acceptable standards through staff training. Data Source: CAHPS surveys and reports. Outcome Improvement Target 3 Estimated Incentive Payment*:* $278,957
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $ 62,718	Year 3 Estimated Outcome Amount: $ 72,698	Year 4 Estimated Outcome Amount: $ 116,655	Year 5 Estimated Outcome Amount: $ 278,957
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $ 531,027			

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Memorial Medical Center

Pass 2

DRAFT

Title of Outcome Measure (Improvement Target): IT-5.1- Improved cost savings: Demonstrate cost savings in care delivery

Unique RHP outcome identification number: 137909111.3.2

Project Description:
OD-5 Cost of Care – IT-5.1 Improved cost savings: Demonstrate cost savings in care delivery
A Medication Dispensing System will decrease costs through efficiencies gained with automation (labeling, dispensing, tracking, etc.) thus decreasing labor costs. Therefore, we will measure the decreasing average labor cost per prescription as the percentage of total prescriptions processed through automation increases.

a) We will implement cost accounting systems to measure intervention impacts by monitoring average labor cost per prescription.
b) We will establish a method to measure cost containment by using the total salaries and benefits (as the numerator) and total number of automated prescriptions filled (as the denominator) as stated on the monthly operating statements.
c) We will use the current state from the month preceding implementation as our baseline for cost. We currently have no automation.
d) We will measure cost containment by comparing the project's average labor cost per prescription and the percentage of automated prescriptions filled to the baseline at yearly intervals.

This cost savings is based on the current volume of 120,000 prescriptions per year**.**

Outcome Measure Description:
Process Milestones:
DY2: P-2 Establish a baseline rate

Improvement Milestones:
DY3-DY5: IT-5.1 Improved cost savings: Demonstrate cost savings in care delivery (stand-alone)

Outcome Improvement Targets:
DY3: Cost savings: 7% decrease in average labor cost per prescription when processing 20% of the total automated prescription volume by the end of the year.

DY4: Cost savings: 19% decrease in average labor cost per prescription over established baseline by processing 90% of the total automated prescription volume.

DY5: Cost savings: 31% decrease in average labor cost per prescription over established baseline by continuing to process 90% of the total automated prescription volume.

Rationale:
Our process milestone P-2 is to establish a baseline cost based on current state before implementation of automated medication dispensing.

Outcome Improvements will be analyzed by the Cost Benefit Analysis comparing the average labor cost per prescription at the goal percentage rates compared to baseline average labor cost

per prescription. Considering that there is no current automation at Memorial Medical Center's Pharmacy for prescription processing, the baseline rate will be the average labor cost per prescription when 0% of prescriptions are filled with the help of automation. The data source will be the monthly operating statement from the month prior to go-live.

In DY3 cost savings result from a 7% decrease the average labor cost per prescription using the total salaries and benefits/total number of MMC automated prescriptions as found on the monthly operating statement compared to baseline. The cost savings are a result of automation efficiencies.

In DY4, cost savings result from a 19% decrease from baseline in the average labor cost per prescription using the total salaries and benefits/total number of MMC automated prescriptions as found on the monthly operating statement compared to baseline. The cost savings are a result of automation efficiencies.

In DY5, cost savings result from a 31% decrease from baseline in the average labor cost per prescription using the total salaries and benefits/total number of MMC automated prescriptions as found on the monthly operating statement compared to baseline. The cost savings are a result of automation efficiencies.

Outcome Measure Valuation: This project is a supporting pillar for one of the main objectives of the 1115 Waiver; increasing access to primary care for the underserved population in Calhoun County. The value of the project is based on cost avoidance, projecting savings associated with reducing the costs incurred in filling 120,000 current patient prescriptions on an annual basis. Based on the increase in primary care volumes addressed in another Memorial Medical Center Waiver project, further growth in volume is projected. Despite this increase in prescription volume, processing costs are projected to decrease in total with the addition of a medication dispensing system. The prompt availability of needed prescriptions for our underserved patients, particularly those with chronic disease that can be managed effectively with appropriate pharmaceuticals, will result in fewer emergency room visits, and will also help to prevent future downstream inpatient admissions.

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<table>
<tr><td>137909111.3.2</td><td>IT-5.1</td><td colspan="2">Improved cost savings: Demonstrate cost savings in care delivery (stand alone)</td></tr>
<tr><td colspan="3">Memorial Medical Center</td><td>137909111</td></tr>
<tr><td>Related Category 1 or 2 Projects:</td><td colspan="3">137909111.2.1</td></tr>
<tr><td>Starting Point/Baseline:</td><td colspan="3">To be determined</td></tr>
<tr><th>Year 2
(10/1/2012 – 9/30/2013)</th><th>Year 3
(10/1/2013 – 9/30/2014)</th><th>Year 4
(10/1/2014 – 9/30/2015)</th><th>Year 5
(10/1/2015 – 9/30/2016)</th></tr>
<tr><td>Process Milestone 1 [P-2]: Establish a baseline for cost

Metric 1 [P-2.1]: Average labor cost per prescription

Goal: Provide documentation of the updated baseline average cost/Rx

Data Source: Operating statements from the month immediately preceding implementation of automated medication dispensing.

Milestone 1 Estimated Incentive Payment (maximum amount): $9,716</td><td>Outcome Improvement Target 1 [IT-5.1]: Improved cost savings: Demonstrate cost savings in care delivery

Type of analysis: Cost Benefit Analysis using average labor cost per prescription calculated by total salaries and benefits divided by total # of prescriptions distributed through medication dispensing units

Improvement Target: Decrease average labor cost per prescription 7% from established baseline (based on 120,000 annual prescription volume)

Data source: Monthly operating statements – Total Salaries & Benefits and Prescription Statistics

Outcome Improvement Target 1 Estimated Incentive Payment: $11,510</td><td>Outcome Improvement Target 2 [IT-5.1]: Improved cost savings: Demonstrate cost savings in care delivery

Type of analysis: Cost Benefit Analysis using average labor cost per prescription calculated by total salaries and benefits divided by total # of prescriptions distributed through medication dispensing units

Improvement Target: Decrease average labor cost per prescription 19% from baseline (based on 120,000 annual prescription volume)

Data source: Monthly operating statements – Total Salaries & Benefits and Prescription Statistics

Outcome Improvement Target 2 Estimated Incentive Payment: $18,684</td><td>Outcome Improvement Target 3 [IT-5.1]: Improved cost savings: Demonstrate cost savings in care delivery

Type of analysis: Cost Benefit Analysis using average labor cost per prescription calculated by total salaries and benefits divided by total # of prescriptions distributed through medication dispensing units

Improvement Target: Decrease average labor cost per prescription 31% from baseline (based on 120,000 annual prescription volume)

Data source: Monthly operating statements – Total Salaries & Benefits and Prescription Statistics

Outcome Improvement Target 3 Estimated Incentive Payment: $44,520</td></tr>
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137909111.3.2	*IT-5.1*	*Improved cost savings: Demonstrate cost savings in care delivery (stand alone)*	
Memorial Medical Center			*137909111*
Related Category 1 or 2 Projects:	*137909111.2.1*		
Starting Point/Baseline:	*To be determined*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $ 9,716	Year 3 Estimated Outcome Amount: $ 11,510	Year 4 Estimated Outcome Amount: $ 18,684	Year 5 Estimated Outcome Amount: $ 44,520
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:**$ 84,430			

DRAFT

Memorial Medical Center

Pass 3

DRAFT

Title of Outcome Measure (Improvement Target): IT-6.1 Patient Satisfaction
Unique RHP outcome identification number: 137909111.3.3/Pass 3

Outcome Measure Description:
Since this is a new project for Memorial Medical Center, we will use DY 2 & DY 3 to plan the project and establish baseline rates. In DY 4 & DY 5, we will measure IT-6.1 Percent improvement over baseline of patient satisfaction scores specifically related to the measure IT-6.1.1 Patients are getting timely care, appointments, and information. Currently, a structured patient satisfaction survey does not exist to capture this measure at Memorial Medical Center. Therefore, the baseline will be set at 0. However, we expect to improve this measure by 5% by the end of the waiver.

Rationale:
Memorial Medical Center has selected the process milestones and outcome improvement targets because we are certain if the patient receives timely healthcare and education, they are more likely to continue leading healthy lives and obtaining preventive healthcare on a regular basis which ultimately leads to reduced healthcare costs.

Outcome Measure Valuation:
We considered both the costs and benefits to our organization and community in order to value the Outcome Measure – IT-6.1 Percent improvement over baseline of patient satisfaction scores. We believe it will take DY2 and DY3 to effectively develop and plan the Outcome Improvement Targets in DY4 and DY5. We do not currently perform or contract with a company to perform surveys for outpatient services, but we intend to select a vendor in DY 2. We believe with the improvement in patient satisfaction scores specifically the improvement target of patients getting timely care, appointments and information, this will decrease unnecessary Emergency Room visits, hospital stays, etc. because patients will be receiving the care and attention they need on a consistent and dependable basis. This Outcome Measure will serve the total outpatient service population of Memorial Medical Center, and it will ultimately assist Port Lavaca and the surrounding communities to live healthier lives and be healthier communities.

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137909111.3.3	*IT-6.1.1*	*Improving the Patient Experience – The Aidet Project*	
Memorial Medical Center			*137909111*
Related Category 1 or 2 Projects:	*137909111.2.2*		
Starting Point/Baseline:	*To be determined*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project Planning – identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Meeting minutes, agenda and plan Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $15710	**Process Milestone 2** [P-4]: Establish baseline rates Data Source: Meeting minutes, agenda and plan Process Milestone 2 Estimated Incentive Payment: $18825	**Outcome Improvement Target 1** [IT-6.1]: Percent improvement over baseline of patient satisfaction scores – TBD. Improvement Target: Increase patient satisfaction scores for measure 1) Patient is getting timely care, appointments, and information. Data Source: Patient Survey Outcome Improvement Target 1 Estimated Incentive Payment*:* $30858	**Outcome Improvement Target 2** [IT-6.1]: Percent improvement over baseline of patient satisfaction scores – TBD. Improvement Target: Additional increase of patient satisfaction scores for measure 1) Patient is getting timely care, appointments, and information. Data Source: Patient Survey Outcome Improvement Target 2 Estimated Incentive Payment*:* $73458
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $15710	Year 3 Estimated Outcome Amount: $18825	Year 4 Estimated Outcome Amount: $30858	Year 5 Estimated Outcome Amount: $73458
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:**$ 138,851			

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Title of Outcome Measure (Improvement Target): IT-6.1 Patient Satisfaction
Unique RHP outcome identification number: 137909111.3.4/Pass 3

Outcome Measure Description:
Since this is a new project for Memorial Medical Center, we will use DY 2 to plan the project and establish baseline rates. In DY3, DY 4 & DY 5, we will measure IT-6.1 Percent improvement over baseline of patient satisfaction scores specifically related to the measure IT-6.1.1 Patients are getting timely care, appointments, and information. Currently, a structured patient satisfaction survey does not exist to capture this measure at Memorial Medical Center. Therefore, the baseline will be set at 0. However, we expect to improve this measure by 10% by the end of the waiver.

Rationale:
Memorial Medical Center has selected the process milestones and outcome improvement targets because we are certain if the patient receives timely healthcare and education, they are more likely to continue leading healthy lives and obtaining preventive healthcare on a regular basis which ultimately leads to reduced healthcare costs.

Outcome Measure Valuation:
We considered both the costs and benefits to our organization and community in order to value the Outcome Measure – IT-6.1 Percent improvement over baseline of patient satisfaction scores. We believe it will take DY2 and part of DY3 to effectively develop and plan the Outcome Improvement Targets in DY4 and DY5. We do not currently perform or contract with a company to perform surveys for outpatient services, but we intend to select a vendor in DY 2. We believe with the improvement in patient satisfaction scores specifically the improvement target of patients getting timely care, appointments and information, this will decrease unnecessary Emergency Room visits, hospital stays, etc. because patients will be receiving the care and attention they need on a consistent and dependable basis. This Outcome Measure will serve the total outpatient service population of Memorial Medical Center, and it will ultimately assist Port Lavaca and the surrounding communities to live healthier lives and be healthier communities.

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137909111.3.3	*IT-6.1.1*	*Improved cost savings: Demonstrate cost savings in care delivery (stand alone)*	
Memorial Medical Center			*137909111*
Related Category 1 or 2 Projects:	*137909111.2.3*		
Starting Point/Baseline:	*To be determined*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project Planning – identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Meeting minutes, agenda and plan Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $33024	**Process Milestone 2** [P-4]: Establish baseline rates Data Source: Meeting minutes, agenda and plan Process Milestone 2 Estimated Incentive Payment: $39573	**Outcome Improvement Target 1** [IT-6.1]: Percent improvement over baseline of patient satisfaction scores – TBD. Improvement Target: Increase patient satisfaction scores for measure 1) Patient is getting timely care, appointments, and information. Data Source: Patient Survey Outcome Improvement Target 1 Estimated Incentive Payment*:* $64866	**Outcome Improvement Target 2** [IT-6.1]: Percent improvement over baseline of patient satisfaction scores – TBD. Improvement Target: Additional increase of patient satisfaction scores for measure 1) Patient is getting timely care, appointments, and information. Data Source: Patient Survey Outcome Improvement Target 2 Estimated Incentive Payment*:* $154417
Year 2 Estimated Outcome Amount: $33,024	Year 3 Estimated Outcome Amount: $39,573	Year 4 Estimated Outcome Amount: $64,866	Year 5 Estimated Outcome Amount: $154,417
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:**$ 291,880			

Mental Health and Mental Retardation Authority of Harris County

Pass 1

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Title of Outcome Measure (Improvement Target): IT-6.1: Percent improvement over baseline of patient satisfaction scores

Unique RHP outcome identification numbers: 113180703.3.1
Performing Provider/TPI: Mental Health and Mental Retardation Authority of Harris County/ 113180703

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

- Numerator: Percent improvement in targeted patient satisfaction domain
- Denominator: Number of patients who were administered the survey

Process Milestones:

- DY 2:
  - P-1- Project planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2- Establish baseline for patients served
  - P-3: Develop and test data systems
  - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
  - P-5 Disseminate findings, including lessons learned and best practices, to stakeholders
- DY 3:
  - P-1- Project planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2- Establish baseline for numerator and denominator
  - P-3: Develop and test data systems
  - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
  - P-5 Disseminate findings, including lessons learned and best practices, to stakeholders

Outcome Improvement Targets for each year:

- DY 4:
  - IT 6.1: Rate 1: Improve patient satisfaction by 5 % over baseline scores for one domain of patient satisfaction
- DY 5:
  - IT 6.1: Rate 1: Improve patient satisfaction by 10 % over baseline scores for one domain of patient satisfaction

Rationale:

Measurement of patient satisfaction is a key indicator of patient-centered care and has been targeted as a quality indicator by national organizations dedicated to improvement in patient outcomes, e.g. the National Council for Quality Assurance. The Consumer Assessment of Healthcare providers and Systems(CAHPS) Survey, for instance, is one of the few indicators from among the set of 2013 HEDIS measures applicable to mental health treatment programs.

Patient satisfaction measures offer advantages associated with sound psychometrics including reliability as measurement tools, and sensitivity to change. Published scales are

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available in multiple languages (an essential feature in Harris County's multi-cultural environment) and have established validity as reflected in documented relationships between satisfaction scale scores and aspects of both clinical process and outcome measures (e.g. adherence to treatment recommendations, retention in treatment, improvement in symptom and functional status). Finally, external norms and benchmarks are available for comparative purposes, reducing the uncertainty sometimes associated with program evaluations.

The Process milestones were chosen in order to develop a strong collaborative team approach between the clinical staff, administrators, physicians, Quality Improvement Department and the newly formed Outcome Management Department of MHMRA. By working through these process goals in order to develop and test a patient satisfaction measure suited for the particular program population, we will be more accurate in our assessment of the target outcome. As part of DY 2 process goals, the Outcome Management department will complete literature reviews to identify relevant, empirically validated, and empirically based, measures for the identified outcomes and the targeted population (P-2 and P-3). With this information, the team will be able to select a measure to be piloted in DY 3. The procedures for testing data collection will be evaluated using the Plan Do Study Act (PDSA) cycles (P-4). The proposed timeline for the outcome measure of patient satisfaction includes determining a baseline for one or more of the following categories of patient satisfaction by DY 2:

1. Are getting timely care, appointments, and information
2. How well their doctors communicate
3. Patient's rating of doctor access to specialist
4. Patient's involvement in shared decision making
5. Patient's overall health status/functional status

From this baseline, the goals for improvement have been set at 5% and 10% in DY 4 and 5, respectively. After the results of DY 4 have been determined then another cycle of Plan Do Study Act (PDSA) can also be executed to determine the successes and the need for improvements in addressing patient satisfaction. This information can then be provided to clinic staff in order to produce the needed improvements.

Outcome Measure Valuation:

Our local region has identified a general objective and specific community needs that are related to transforming the current health care delivery system. The transformed system is proposed to be a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes. Based on this objective, the proposed program has identified OD-6, Patient Satisfaction, as a targeted outcome for quality improvement goal. It is hypothesized that patients will be better served when they can be offered a full array of services, i.e. when the menu of service options is not sharply curtailed by agency resource limitations. This better fit between patient needs and available services is likely to be reflected in more positive rapport and better perceived communication with treatment providers. Specifically, we believe patient satisfaction that addresses involvement in shared decision making, access to providers, and communication with providers, will reduce chronic over-use of psychiatric emergency services. If patients are dissatisfied with services or the process, they may continue to over-utilize emergency services rather than engaging in preventative care. Since patient satisfaction is proposed as a "stand-alone" measure, it is, by definition, valued at 100% of the Category 3 allocation for this proposed program

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113180703.3.1	IT-6.1	Outcome Measure: Percent improvement over baseline of patient satisfaction scores	
RHP Performing Provider: Mental Health and Mental Retardation Authority of Harris County			TPI: 113180703
Related Category 1 or 2: 1.12.2	113180703.1.1		
Starting Point/Baseline:	TBD YR 3		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1: P-1: Project planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans **Data Source:** Meetings minutes, project flow charts and timelines **Goal:** To gather information that guides project activities toward completion of milestones, while integrating stakeholder input in a meaningful way	**Milestone 6: P-1:** Project planning, engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans **Data Source:** Meetings minutes, project flow charts and timelines **Goal:** To complete project planning process and implement	**Milestone 11:** IT-6.1 Percent improvement over baseline of patient satisfaction scores **Data Source:** Patient survey **Goal:** 5% increase over baseline	**Milestone 12:** IT-6.1 Percent improvement over baseline of patient satisfaction scores **Data Source:** Patient survey **Goal:** 10% increase in baseline
Estimated Incentive Payment: $39,034.88	**Estimated Incentive Payment: $72,962.006**	**Estimated Incentive Payment: $389,838.53**	**Estimated Incentive Payment: $847,475.06**
Milestone 2: P-2: Establish baseline **Data Source:** literature review **Goal:** determine how baseline will be established for patient satisfaction domain	**Milestone 7: P- 2:** Establish baseline **Data Source:** Clinical records; monthly management reports **Goal:** obtain baseline of satisfaction survey from patients receiving service	**N/A**	**N/A**
Estimated Incentive Payment: $39,034.88	**Estimated Incentive Payment: $72,962.006**	**N/A**	**N/A**

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113180703.3.1	IT-6.1	Outcome Measure: Percent improvement over baseline of patient satisfaction scores	
RHP Performing Provider: Mental Health and Mental Retardation Authority of Harris County			TPI: 113180703
Related Category 1 or 2: 1.12.2	113180703.1.1		
Starting Point/Baseline:	TBD YR 3		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Milestone 3 : P-3: Develop and test data systems **Data Source:** Project record—summary of reviews **Goal:** Identify/modify one instrument to test in Yr. 3	**Milestone 8: P-3:** Develop and test data systems **Data Source:** Project record—summary of reviews, completed surveys **Goal:** Test and revise the selected instrument and/or process to enable measure of baseline by end of Yr. 3	**N/A**	**N/A**
Estimated Incentive Payment: $31,438.59	**Estimated Incentive Payment: $72,962.006**	**N/A**	**N/A**
Milestone 4: P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities **Data Source:** Project reports, QI reports **Goal:** To improve processes and outcomes by implementing data-driven course corrections and innovations	**Milestone 9: P-4:** Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities **Data Source:** Project reports, QI reports **Goal:** To identify problems and make improvements in processes and outcomes by implementing data-driven course corrections and innovations	**N/A**	**N/A**
Estimated Incentive Payment: $31,438.59	**Estimated Incentive Payment: $72,962.006**	**N/A**	**N/A**

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113180703.3.1	IT-6.1		Outcome Measure: Percent improvement over baseline of patient satisfaction scores
RHP Performing Provider: Mental Health and Mental Retardation Authority of Harris County			TPI: 113180703
Related Category 1 or 2: 1.12.2	113180703.1.1		
Starting Point/Baseline:	TBD YR 3		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 5: P-5 Disseminate findings, including lessons learned and best practices, to stakeholders **Data Source:** minutes from stakeholder meetings **Goal:** To disseminate information about the project and solicit input from stakeholders representing consumers, families, public agencies and private providers	**Milestone 10: P-5:** Disseminate findings, including lessons learned and best practices, to stakeholders **Data Source:** management team minutes, RHP collaborations **Goal:** To disseminate information about the project and solicit input from stakeholders representing consumers, families, public agencies and private providers	**N/A**	**N/A**
Estimated Incentive Payment: $31,438.59	**Estimated Incentive Payment: $72,962.006**	**N/A**	**N/A**
Year 2 Estimated Outcome Amount: $157,192.95	**Year 3 Estimated Outcome Amount: $364,810.03**	**Year 4 Estimated Outcome Amount: $389,838.53**	**Year 5 Estimated Outcome Amount:$847,475.06**
TOTAL EST. INCENTIVE PAYMENTS FOR 4-DY*:* $1,759,316.57			

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Title of Outcome Measure (Improvement Target): IT-6.1: Percent improvement over baseline of patient satisfaction scores
Unique RHP outcome identification numbers: 113180703.3.2
Performing Provider/TPI: Mental Health and Mental Retardation Authority of Harris County/ 113180703

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

- Numerator: Percent improvement in targeted patient satisfaction domain
- Denominator: Number of patients who were administered the survey

Process Milestones:

- DY 2:
  - P-1- Project planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2- Establish baseline for patients served
  - P-3: Develop and test data systems
  - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
  - P-5 Disseminate findings, including lessons learned and best practices, to stakeholders
- DY 3:
  - P-1- Project planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2- Establish baseline for numerator and denominator
  - P-3: Develop and test data systems
  - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
  - P-5 Disseminate findings, including lessons learned and best practices, to stakeholders

Outcome Improvement Targets for each year:

- DY 4:
  - IT 6.1: Rate 1: Improve patient satisfaction by 5 % over baseline scores for one domain of patient satisfaction
- DY 5:
  - IT 6.1: Rate 1: Improve patient satisfaction by 10 % over baseline scores for one domain of patient satisfaction

Rationale:

Measurement of patient satisfaction is a key indicator of patient-centered care and has been targeted as a quality indicator by national organizations dedicated to improvement in patient outcomes, e.g. the National Council for Quality Assurance. The Consumer Assessment of Healthcare providers and Systems(CAHPS) Survey, for instance, is one of the few indicators from among the set of 2013 HEDIS measures applicable to mental health treatment programs.

Patient satisfaction measures offer advantages associated with sound psychometrics including reliability as measurement tools, and sensitivity to change. Published scales are available in multiple languages (an essential feature in Harris County's multi-cultural

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environment) and have established validity as reflected in documented relationships between satisfaction scale scores and aspects of both clinical process and outcome measures (e.g adherence to treatment recommendations, retention in treatment, improvement in symptom and functional status). Finally, external norms and benchmarks are available for comparative purposes, reducing the uncertainty sometimes associated with program evaluations.

The Process milestones were chosen in order to develop a strong collaborative team approach between the clinical staff, administrators, physicians, Quality Improvement Department and the newly formed Outcome Management Department of MHMRA. By working through these process goals in order to develop and test a patient satisfaction measure suited for the particular program population, we will be more accurate in our assessment of the target outcome. As part of DY 2 process goals, the Outcome Management department will complete literature reviews to identify relevant, empirically validated, and empirically based, measures for the identified outcomes and the targeted population (P-2 and P-3). With this information, the team will be able to select a measure to be piloted in DY 3. The procedures for testing data collection will be evaluated using the Plan Do Study Act (PDSA) cycles (P-4). The proposed timeline for the outcome measure of patient satisfaction includes determining a baseline for one or more of the following categories of patient satisfaction by DY 2:

6. Are getting timely care, appointments, and information
7. How well their doctors communicate
8. Patient's rating of doctor access to specialist
9. Patient's involvement in shared decision making
10. Patient's overall health status/functional status

From this baseline, the goals for improvement have been set at 5% and 10% in DY 4 and 5, respectively. After the results of DY 4 have been determined then another cycle of Plan Do Study Act (PDSA) can also be executed to determine the successes and the need for improvements in addressing patient satisfaction. This information can then be provided to clinic staff in order to produce the needed improvements.

Outcome Measure Valuation:

Our local region has identified a general objective and specific community needs that are related to transforming the current health care delivery system. The transformed system is proposed to be a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes. Based on this objective, the proposed program has identified OD-6, Patient Satisfaction, as a targeted outcome for quality improvement goal. It is hypothesized that patients will be better served when they can be offered a full array of services, i.e. when the menu of service options is not sharply curtailed by agency resource limitations. This better fit between patient needs and available services is likely to be reflected in more positive rapport and better perceived communication with treatment providers. Specifically, we believe patient satisfaction that addresses involvement in shared decision making, access to providers, and communication with providers, will reduce chronic over-use of psychiatric emergency services. If patients are dissatisfied with services or the process, they may continue to over-utilize emergency services rather than engaging in preventative care. Since patient satisfaction is proposed as a "stand-alone" measure, it is, by definition, valued at 100% of the Category 3 allocation for this proposed program.

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113180703.3.2	RHP PP Reference Number: IT-6.1	Outcome Measure: Percent improvement over baseline of patient satisfaction scores	
RHP Performing Provider - MHMRA of Harris County		TPI: 113180703	
Related Category 1 or 2: 2.13	113180703.1.2		
Starting Point/Baseline:	TBD YR 3		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1: P-1: Project planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans **Data Source:** Meetings minutes, project flow charts and timelines **Goal:** To gather information that guides project activities toward completion of milestones, while integrating stakeholder input in a meaningful way	**Process Milestone 6: P-1:** Project planning, engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans **Data Source:** Meetings minutes, project flow charts and timelines **Goal:** To complete project planning process and implement	**Outcome Improvement Target 11:** IT 6.1: Percent improvement over baseline of patient satisfaction scores for one domain of patient satisfaction. **Data Source:** Patient survey **Goal:** 5% increase over baseline	**Outcome Improvement Target 12:** IT 6.1 Percent improvement over baseline of patient satisfaction scores for one domain of patient satisfaction. **Data Source:** Patient survey **Goal:** 10% increase in baseline
Estimated Incentive Payment: $46,486.13	**Estimated Incentive Payment: $107,884.01**	**Estimated Incentive Payment: $576,428.02**	**Estimated Incentive Payment: $1,253,104.39**
Process Milestone 2: P-2: Establish baseline **Data Source:** literature review **Goal:** determine how baseline will be established for patient satisfaction domain	**Process Milestone 7: P- 2:** Establish baseline **Data Source:** Clinical records; monthly management reports **Goal:** obtain baseline of satisfaction survey from patients receiving service	**N/A**	**N/A**
Estimated Incentive Payment: $46,486.13	**Estimated Incentive Payment: $107,884.01**	**N/A**	**N/A**

113180703.3.2	RHP PP Reference Number: IT-6.1	Outcome Measure: Percent improvement over baseline of patient satisfaction scores	
RHP Performing Provider - MHMRA of Harris County		TPI: 113180703	
Related Category 1 or 2: 2.13	113180703.1.2		
Starting Point/Baseline:	TBD YR 3		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 3 : P-3: Develop and test data systems **Data Source:** Project record—summary of reviews **Goal:** Identify/modify one instrument to test in Yr. 3	**Process Milestone 8: P-3:** Develop and test data systems **Data Source:** Project record—summary of reviews, completed surveys **Goal:** Test and revise the selected instrument and/or process to enable measure of baseline by end of Yr. 3	**N/A**	**N/A**
Estimated Incentive Payment: $46,486.13	**Estimated Incentive Payment: $107,884.01**	**N/A**	**N/A**
Process Milestone 4: P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities **Data Source:** Project reports, QI reports **Goal:** To improve processes and outcomes by implementing data-driven course corrections and innovations	**Process Milestone 9: P-4:** Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities **Data Source:** Project reports, QI reports **Goal:** To identify problems and make improvements in processes and outcomes by implementing data-driven course corrections and innovations	**N/A**	**N/A**
Estimated Incentive Payment: $46,486.13	**Estimated Incentive Payment: $107,884.01**	**N/A**	**N/A**

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113180703.3.2	RHP PP Reference Number: IT-6.1	Outcome Measure: Percent improvement over baseline of patient satisfaction scores	
RHP Performing Provider - MHMRA of Harris County		TPI: 113180703	
Related Category 1 or 2: 2.13	113180703.1.2		
Starting Point/Baseline:	TBD YR 3		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 5: P-5 Disseminate findings, including lessons learned and best practices, to stakeholders **Data Source:** management team minutes, RHP collaborations **Goal:** To disseminate information about the project and solicit input from stakeholders representing consumers, families, public agencies and private providers	**Process Milestone 10: P-5:** Disseminate findings, including lessons learned and best practices, to stakeholders **Data Source:** management team minutes, RHP collaborations **Goal:** To disseminate information about the project and solicit input from stakeholders representing consumers, families, public agencies and private providers	**N/A**	**N/A**
Estimated Incentive Payment: $46,486.13	**Estimated Incentive Payment: $107,884.02**	**N/A**	**N/A**
Year 2 Estimated Outcome Amount: $232,430.65	**Year 3 Estimated Outcome Amount: $539,420.06**	**Year 4 Estimated Outcome Amount: $576,428.02**	**Year 5 Estimated Outcome Amount: $1,253,104.39**
TOTAL EST. INCENTIVE PAYMENTS FOR 4-DY*:* $2,601,383.12			

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<u>Title of Outcome Measure (Improvement Target):</u> IT-6.1: Percent improvement over baseline of patient satisfaction scores

<u>Unique RHP outcome identification numbers:</u> 113180703.3.3
<u>Performing Provider/TPI:</u> Mental Health and Mental Retardation Authority of Harris County/ 113180703

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

- Numerator: Percent improvement in targeted patient satisfaction domain
- Denominator: Number of patients who were administered the survey

Process Milestones:

- DY 2:
  - P-1- Project planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2- Establish baseline for numerator and denominator
  - P-3: Develop and test data systems
  - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
  - P-5 Disseminate findings, including lessons learned and best practices, to stakeholders
- DY 3:
  - P-1- Project planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2- Establish baseline for numerator and denominator
  - P-3: Develop and test data systems
  - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
  - P-5 Disseminate findings, including lessons learned and best practices, to stakeholders

Outcome Improvement Targets for each year:

- DY 4:
  - IT 6.1: Rate 1: Improve patient satisfaction by 5 % over baseline scores for one domain of patient satisfaction
- DY 5:
  - IT 6.1: Rate 1: Improve patient satisfaction by 10 % over baseline scores for one domain of patient satisfaction

<u>Rationale</u>:

Measurement of patient satisfaction is a key indicator of patient-centered care and has been targeted as a quality indicator by national organizations dedicated to improvement in patient outcomes, e.g. the National Council for Quality Assurance. The Consumer Assessment of Healthcare providers and Systems(CAHPS) Survey, for instance, is one of the few indicators from among the set of 2013 HEDIS measures applicable to mental health treatment programs.

Patient satisfaction measures offer advantages associated with sound psychometrics including reliability as measurement tools, and sensitivity to change. Published scales are

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available in multiple languages (an essential feature in Harris County's multi-cultural environment) and have established validity as reflected in documented relationships between satisfaction scale scores and aspects of both clinical process and outcome measures (e.g. adherence to treatment recommendations, retention in treatment, improvement in symptom and functional status). Finally, external norms and benchmarks are available for comparative purposes, reducing the uncertainty sometimes associated with program evaluations.

The Process milestones were chosen in order to develop a strong collaborative team approach between the clinical staff, administrators, physicians, Quality Improvement Department and the newly formed Outcome Management Department of MHMRA. By working through these process goals in order to develop and test a patient satisfaction measure suited for the particular program population, we will be more accurate in our assessment of the target outcome. As part of DY 2 process goals, the Outcome Management department will complete literature reviews to identify relevant, empirically validated, and empirically based, measures for the identified outcomes and the targeted population (P-2 and P-3). With this information, the team will be able to select a measure to be piloted in DY 3. The procedures for testing data collection will be evaluated using the Plan Do Study Act (PDSA) cycles (P-4). The proposed timeline for the outcome measure of patient satisfaction includes determining a baseline for one or more of the following categories of patient satisfaction by DY 2:

11. Are getting timely care, appointments, and information
12. How well their doctors communicate
13. Patient's rating of doctor access to specialist
14. Patient's involvement in shared decision making
15. Patient's overall health status/functional status

From this baseline, the goals for improvement have been set at 5% and 10% in DY 4 and 5, respectively. After the results of DY 4 have been determined then another cycle of Plan Do Study Act (PDSA) can also be executed to determine the successes and the need for improvements in addressing patient satisfaction. This information can then be provided to clinic staff in order to produce the needed improvements.

Outcome Measure Valuation:

Our local region has identified a general objective and specific community needs that are related to transforming the current health care delivery system. The transformed system is proposed to be a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes. Based on this objective, the proposed program has identified OD-6, Patient Satisfaction, as a targeted outcome for quality improvement goal. It is hypothesized that patients will be better served when they can be offered a full array of services, i.e. when the menu of service options is not sharply curtailed by agency resource limitations. This better fit between patient needs and available services is likely to be reflected in more positive rapport and better perceived communication with treatment providers. Specifically, we believe patient satisfaction that addresses involvement in shared decision making, access to providers, and communication with providers, will reduce chronic over-use of psychiatric emergency services. If patients are dissatisfied with services or the process, they may continue to over-utilize emergency services rather than engaging in preventative care. Since patient satisfaction is proposed as a "stand-alone" measure, it is, by definition, valued at 100% of the Category 3 allocation for this proposed program.

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113180703.3.3	IT-6.1	Outcome Measure: Percent improvement over baseline of patient satisfaction scores	
RHP Performing Provider - MHMRA of Harris County			TPI: 113180703
Related Category 1 or 2: 1.9	113180703.1.3		
Starting Point/Baseline:	TBD YR 3		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 P-1: Project planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans **Data Source:** Meetings minutes, project flow charts and timelines **Goal:** To integrate stakeholder input in development of program plan	**Milestone 6: P-1:** Project planning, engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans **Data Source:** Meetings minutes, project flow charts and timelines **Goal:** To complete project planning process and implement	**Milestone 11:** IT 6.1 Percent improvement over baseline of patient satisfaction scores for one domain of patient satisfaction. **Data Source**: Patient survey **Goal**: 5% increase over baseline	**Milestone 12: I**T 6.1 Percent improvement over baseline of patient satisfaction scores for one domain of patient satisfaction. **Data Source:** Patient survey **Goal:** 10% increase in baseline
Estimated Incentive Payment: $15,980.98	**Estimated Incentive Payment: $37,288.33**	**Estimated Incentive Payment: $199,164.22**	**Estimated Incentive Payment: $431,791.78**
Milestone 2: P-2: Establish baseline **Data Source:** literature review **Goal:** determine how baseline will be established for patient satisfaction domain	**Milestone 7: P- 2:** Establish baseline **Data Source:** Clinical records; monthly management reports **Goal:** obtain baseline of satisfaction survey from patients receiving service	**N/A**	**N/A**
Estimated Incentive Payment: $15,980.98	**Estimated Incentive Payment: $37,288.33**	**N/A**	**N/A**

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113180703.3.3	IT-6.1	Outcome Measure: Percent improvement over baseline of patient satisfaction scores	
RHP Performing Provider - MHMRA of Harris County			TPI: 113180703
Related Category 1 or 2: 1.9	113180703.1.3		
Starting Point/Baseline:	TBD YR 3		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 3 P-3: Develop and test data systems **Data Source:** Project record—summary of reviews **Goal:** Identify/modify one instrument to test in Yr. 3	**Milestone 8: P-3** Develop and test data systems **Data Source:** Project record—summary of reviews, completed surveys **Goal:** Test and revise the selected instrument and/or process so that satisfaction baseline can be established by end of Yr. 3	**N/A**	**N/A**
Estimated Incentive Payment: $15,980.98	**Estimated Incentive Payment: $37,288.33**	**N/A**	**N/A**
Milestone 4 P-4 Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities **Data Source:** Project reports including examples of how real time data has been used to guide continuous quality improvement **Goal:** To improve processes and outcomes by implementing data-driven course corrections and innovations	**Milestone 9 P-9** Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities **Data Source:** Project reports including examples of how real time data has been used to guide continuous quality improvement **Goal:** To identify problems and make improvements in processes and outcomes by implementing data-driven course corrections and innovations	**N/A**	**N/A**
Estimated Incentive Payment: $15,980.99	**Estimated Incentive Payment: $37,288.32**	**N/A**	**N/A**

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113180703.3.3	IT-6.1	Outcome Measure: Percent improvement over baseline of patient satisfaction scores	
RHP Performing Provider - MHMRA of Harris County			TPI: 113180703
Related Category 1 or 2: 1.9	113180703.1.3		
Starting Point/Baseline:	TBD YR 3		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 5: P-5 Disseminate findings, including lessons learned and best practices, to stakeholders **Metric 5:** Report status, progress and lessons learned to stakeholders **Data Source:** management team minutes, RHP collaborations **Goal:** To disseminate information about the project and solicit input from stakeholders	**Milestone 10: P.10:** Disseminate findings to stakeholders **Metric 10**: Report status, progress and lessons learned to stakeholders **Data Source:** management team minutes, RHP collaborations **Goal:** To disseminate information about the project and solicit input from stakeholders	N/A	**N/A**
Estimated Incentive Payment: $15,980.99	**Estimated Incentive Payment: $37,288.32**	**N/A**	**N/A**
Year 2 Estimated Outcome Amount: $79,904.93	**Year 3 Estimated Outcome Amount: $186,442.63**	**Year 4 Estimated Outcome Amount: $199,164.22**	**Year 5 Estimated Outcome Amount: $431,791.78**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*:* $897,302.56			

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Title of Outcome Measure (Improvement Target): IT-6.1: Percent improvement over baseline of patient satisfaction scores
Unique RHP outcome identification numbers: 113180703.3.4
Performing Provider/TPI: Mental Health and Mental Retardation Authority of Harris County/ 113180703

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

- Numerator: Percent improvement in targeted patient satisfaction domain
- Denominator: Number of patients who were administered the survey

Process Milestones:

- DY 2:
  - P-1- Project planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2- Establish baseline for patients served
  - P-3: Develop and test data systems
  - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
  - P-5 Disseminate findings, including lessons learned and best practices, to stakeholders
- DY 3:
  - P-1- Project planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2- Establish baseline for numerator and denominator
  - P-3: Develop and test data systems
  - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
  - P-5 Disseminate findings, including lessons learned and best practices, to stakeholders

Outcome Improvement Targets for each year:

- DY 4:
  - IT 6.1: Rate 1: Improve patient satisfaction by 5 % over baseline scores for one domain of patient satisfaction
- DY 5:
  - IT 6.1: Rate 1: Improve patient satisfaction by 10 % over baseline scores for one domain of patient satisfaction

Rationale:
Measurement of patient satisfaction is a key indicator of patient-centered care and has been targeted as a quality indicator by national organizations dedicated to improvement in patient outcomes, e.g. the National Council for Quality Assurance. The Consumer Assessment of Healthcare providers and Systems(CAHPS) Survey, for instance, is one of the few indicators from among the set of 2013 HEDIS measures applicable to mental health treatment programs. Patient satisfaction measures offer advantages associated with sound psychometrics including reliability as measurement tools, and sensitivity to change. Published scales are available in multiple languages (an essential feature in Harris County's multi-cultural environment) and have

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established validity as reflected in documented relationships between satisfaction scale scores and aspects of both clinical process and outcome measures (e.g. adherence to treatment recommendations, retention in treatment, improvement in symptom and functional status). Finally, external norms and benchmarks are available for comparative purposes, reducing the uncertainty sometimes associated with program evaluations.

The Process milestones were chosen in order to develop a strong collaborative team approach between the clinical staff, administrators, physicians, Quality Improvement Department and the newly formed Outcome Management Department of MHMRA. By working through these process goals in order to develop and test a patient satisfaction measure suited for the particular program population, we will be more accurate in our assessment of the target outcome. As part of DY 2 process goals, the Outcome Management department will complete literature reviews to identify relevant, empirically validated, and empirically based, measures for the identified outcomes and the targeted population (P-2 and P-3). With this information, the team will be able to select a measure to be piloted in DY 3. The procedures for testing data collection will be evaluated using the Plan Do Study Act (PDSA) cycles (P-4). The proposed timeline for the outcome measure of patient satisfaction includes determining a baseline for one or more of the following categories of patient satisfaction by DY 2:

16. Are getting timely care, appointments, and information
17. How well their doctors communicate
18. Patient's rating of doctor access to specialist
19. Patient's involvement in shared decision making
20. Patient's overall health status/functional status

From this baseline, the goals for improvement have been set at 5% and 10% in DY 4 and 5, respectively. After the results of DY 4 have been determined then another cycle of Plan Do Study Act (PDSA) can also be executed to determine the successes and the need for improvements in addressing patient satisfaction. This information can then be provided to clinic staff in order to produce the needed improvements.

<u>Outcome Measure Valuation</u>:

Our local region has identified a general objective and specific community needs that are related to transforming the current health care delivery system. The transformed system is proposed to be a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes. Based on this objective, the proposed program has identified OD-6, Patient Satisfaction, as a targeted outcome for quality improvement goal. It is hypothesized that patients will be better served when they can be offered a full array of services, i.e. when the menu of service options is not sharply curtailed by agency resource limitations. This better fit between patient needs and available services is likely to be reflected in more positive rapport and better perceived communication with treatment providers. Specifically, we believe patient satisfaction that addresses involvement in shared decision making, access to providers, and communication with providers, will reduce chronic over-use of psychiatric emergency services. If patients are dissatisfied with services or the process, they may continue to over-utilize emergency services rather than engaging in preventative care. Since patient satisfaction is proposed as a "stand-alone" measure, it is, by definition, valued at 100% of the Category 3 allocation for this proposed program.

113180703.3.4	RHP PP Reference Number: IT-6.1	Outcome Measure: Percent improvement over baseline of patient satisfaction scores	
RHP Performing Provider: Mental Health and Mental Retardation Authority of Harris County			TPI: 113180703
Related Category 1 or 2: 1.12.2	113180703.1.4		
Starting Point/Baseline:	TBD YR 3		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1: P-1: Project planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans **Goal:** To gather information that guides project activities toward completion of milestones, while integrating stakeholder input in a meaningful way **Data Source:** Meetings minutes, project flow charts and timelines	**Milestone 6: P-1:** Project planning, engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans **Goal:** To complete project planning process and implement **Data Source:** Meetings minutes, project flow charts and timelines	**Outcome Improvement Target 1** IT 6.1: Percent improvement over baseline of patient satisfaction scores for one domain of patient satisfaction. **Goal:** 5% increase over baseline **Data Source:** Patient survey	**Outcome Improvement Target 2** IT 6.1 Percent improvement over baseline of patient satisfaction scores for one domain of patient satisfaction. **Goal:** 10% increase in baseline **Data Source:** Patient survey
Estimated Incentive Payment: $39,034.88	**Estimated Incentive Payment: $72,962.006**	**Estimated Incentive Payment: $389,838.53**	**Estimated Incentive Payment: $847,475.06**
Milestone 2: P-2: Establish baseline **Data Source:** literature review **Goal:** determine how baseline will be established for patient satisfaction domain	**Milestone 7: P- 2:** Establish baseline **Data Source:** Clinical records; monthly management reports **Goal:** obtain baseline of satisfaction survey from patients receiving service	**N/A**	**N/A**
Estimated Incentive Payment: $39,034.88	**Estimated Incentive Payment: $72,962.006**	**N/A**	**N/A**

113180703.3.4	RHP PP Reference Number: IT-6.1	Outcome Measure: Percent improvement over baseline of patient satisfaction scores
RHP Performing Provider: Mental Health and Mental Retardation Authority of Harris County		TPI: 113180703
Related Category 1 or 2: 1.12.2	113180703.1.4	
Starting Point/Baseline:	TBD YR 3	

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 3 : P-3: Develop and test data systems **Data Source:** Project record—summary of reviews **Goal:** Identify/modify one instrument to test in Yr. 3	**Milestone 8: P-3:** Develop and test data systems **Data Source:** Project record—summary of reviews, completed surveys **Goal:** Test and revise the selected instrument and/or process to enable measure of baseline by end of Yr. 3	**N/A**	**N/A**
Estimated Incentive Payment: $31,438.59	**Estimated Incentive Payment: $72,962.006**	**N/A**	**N/A**
Milestone 4: P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities **Data Source:** Project reports, QI reports **Goal:** To improve processes and outcomes by implementing data-driven course corrections and innovations	**Milestone 9: P-4:** Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities **Data Source:** Project reports, QI reports **Goal:** To identify problems and make improvements in processes and outcomes by implementing data-driven course corrections and innovations	**N/A**	**N/A**
Estimated Incentive Payment: $31,438.59	**Estimated Incentive Payment: $72,962.006**	**N/A**	**N/A**

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113180703.3.4	RHP PP Reference Number: IT-6.1	Outcome Measure: Percent improvement over baseline of patient satisfaction scores	
RHP Performing Provider: Mental Health and Mental Retardation Authority of Harris County			TPI: 113180703
Related Category 1 or 2: 1.12.2	113180703.1.4		
Starting Point/Baseline:	TBD YR 3		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 5: P-5 Disseminate findings, including lessons learned and best practices, to stakeholders **Data Source:** minutes from stakeholder meetings **Goal:** To disseminate information about the project and solicit input from stakeholders representing consumers, families, public agencies and private providers	**Milestone 10: P-5:** Disseminate findings, including lessons learned and best practices, to stakeholders **Data Source:** management team minutes, RHP collaborations **Goal:** To disseminate information about the project and solicit input from stakeholders representing consumers, families, public agencies and private providers	**N/A**	**N/A**
Estimated Incentive Payment: $31,438.59	**Estimated Incentive Payment: $72,962.006**	**N/A**	**N/A**
Year 2 Estimated Outcome Amount: $157,192.95	**Year 3 Estimated Outcome Amount: $364,810.03**	**Year 4 Estimated Outcome Amount: $389,838.53**	**Year 5 Estimated Outcome Amount:$847,475.06**
TOTAL EST. INCENTIVE PAYMENTS FOR 4-DY*(add outcome amounts over DYs 2-5):* $1,759,316.57			

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Title of Outcome Measure (Improvement Target): IT-6.1: Percent improvement over baseline of patient satisfaction scores

Unique RHP outcome identification numbers: 113180703.3.5
Performing Provider/TPI: Mental Health and Mental Retardation Authority of Harris County/ 113180703

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

- Numerator: Percent improvement in targeted patient satisfaction domain
- Denominator: Number of patients who were administered the survey

Process Milestones:

- DY 2:
  - P-1- Project planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2- Establish baseline for patients served
  - P-3: Develop and test data systems
  - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
  - P-5 Disseminate findings, including lessons learned and best practices, to stakeholders
- DY 3:
  - P-1- Project planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2- Establish baseline for numerator and denominator
  - P-3: Develop and test data systems
  - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
  - P-5 Disseminate findings, including lessons learned and best practices, to stakeholders

Outcome Improvement Targets for each year:

- DY 4:
  - IT 6.1: Rate 1: Improve patient satisfaction by 5 % over baseline scores for one domain of patient satisfaction
- DY 5:
  - IT 6.1: Rate 1: Improve patient satisfaction by 10 % over baseline scores for one domain of patient satisfaction

Rationale:

The Process milestones were chosen in order to develop a strong collaborative team approach between the clinical staff, administrators, physicians, Quality Improvement Department and the newly formed Outcome Management Department of MHMRA. By working through these process goals in order to develop and test a patient satisfaction measure suited for the particular program population, we will be more accurate in our assessment of the target outcome. Although MHMRA has attempted to measure patient satisfaction in the past, the instruments may not have been the most valid, empirically supported or may not have had national benchmarks for comparison. As part of DY 2 process goals, the Outcome Management department will complete

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literature reviews to identify relevant, empirically validated, and empirically based, measures for the identified outcomes and the targeted population (P-2 and P-3). With this information, the team will be able to select a measure to be piloted in DY 3. The procedures for testing data collection will be evaluated using the Plan Do Study Act (PDSA) cycles (P-4). The proposed timeline for the outcome measure of patient satisfaction includes determining a baseline for one or more of the following categories of patient satisfaction by DY 2:

1. Are getting timely care, appointments, and information
2. How well their doctors communicate
3. Patient's rating of doctor access to specialist
4. Patient's involvement in shared decision making
5. Patient's overall health status/functional status

From this baseline, the goals for improvement have been set at 5% and 10% in DY 4 and 5, respectively. After the results of DY 4 have been determined then another cycle of Plan Do Study Act (PDSA) can also be executed to determine the successes and the need for improvements in addressing patient satisfaction. This information can then be provided to clinic staff in order to produce the needed improvements.

Outcome Measure Valuation:

Our local region has identified a general objective and specific community needs that are related to transforming the current health care delivery system. The transformed system is proposed to be a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes. Based on this objective, the proposed program has identified OD-6, Patient Satisfaction, as a targeted outcome for quality improvement goal. It is hypothesized that patients will be better served when they can be offered a full array of services, i.e. when the menu of service options is not sharply curtailed by agency resource limitations. This better fit between patient needs and available services is likely to be reflected in more positive rapport and better perceived communication with treatment providers. Specifically, we believe patient satisfaction that addresses involvement in shared decision making, access to providers, and communication with providers, will reduce chronic over-use of psychiatric emergency services. If patients are dissatisfied with services or the process, they may continue to over-utilize emergency services rather than engaging in preventative care.

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Karow, A., Reimer, J., König, H., Heider, D., Bock, T., & Huber, C., Schöttle, D., Meister, K., Rietschel, L., Ohm, G., Schulz, H., Naber, D., Schimmelmann, B. & Lambert, M. (2012). Cost-effectiveness of 12-month therapeutic assertive community treatment as part of integrated care versus standard care in patients with schizophrenia treated with quetiapine immediate release. *The Journal of Clinical Psychiatry, 73*, e402-e408.

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Schoenbaum, M., Unützer, J., Sherbourne, C., Duan, N., Rubenstein, L., Miranda, J. & …Wells, K. (2001). Cost-effectiveness of practice-initiated quality improvement for depression: Results of a randomized controlled trial. *The Journal of the American Medical Association, 286*, 1325-1330.

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113180703.3.5	RHP PP Reference Number: IT-6.1	Outcome Measure: Percent improvement over baseline of patient satisfaction scores	
RHP Performing Provider: Mental Health and Mental Retardation Authority of Harris County			TPI: 113180703
Related Category 1 or 2: 1.12.2	113180703.1.5		
Starting Point/Baseline:	TBD YR 3		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1: P-1: Project planning-engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans **Data Source:** Meetings minutes, project flow charts and timelines **Goal:** To gather information that guides project activities toward completion of milestones, while integrating stakeholder input in a meaningful way	**Milestone 6: P-1** Project planning, engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans **Data Source:** Meetings minutes, project flow charts and timelines **Goal:** To complete project planning process and implement	**Milestone 11: IT 6.1** Percent improvement over baseline of patient satisfaction scores for one domain of patient satisfaction. **Data Source:** Patient survey **Goal:** 5% increase over baseline	**Milestone 12: IT 6.1** Percent improvement over baseline of patient satisfaction scores for one domain of patient satisfaction. **Data Source:** Patient survey **Goal:** 10% increase in baseline
Estimated Incentive Payment: $39,034.88	**Estimated Incentive Payment: $72,962.006**	**Estimated Incentive Payment: $389,838.53**	**Estimated Incentive Payment: $847,475.06**
Milestone 2: P-2 Establish baseline **Data Source:** literature review **Goal:** determine how baseline will be established for patient satisfaction domain	**Milestone 7: P- 2** Establish baseline **Data Source:** Clinical records; monthly management reports **Goal:** obtain baseline of satisfaction survey from patients receiving service	**N/A**	**N/A**
Estimated Incentive Payment: $39,034.88	**Estimated Incentive Payment: $72,962.006**	**N/A**	**N/A**

113180703.3.5	RHP PP Reference Number: IT-6.1		Outcome Measure: Percent improvement over baseline of patient satisfaction scores
RHP Performing Provider: Mental Health and Mental Retardation Authority of Harris County			TPI: 113180703
Related Category 1 or 2: 1.12.2	113180703.1.5		
Starting Point/Baseline:	TBD YR 3		

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 3 : P-3 Develop and test data systems **Data Source:** Project record—summary of reviews **Goal:** Identify/modify one instrument to test in Yr. 3	**Milestone 8: P-3** Develop and test data systems **Data Source:** Project record—summary of reviews, completed surveys **Goal:** Test and revise the selected instrument and/or process to enable measure of baseline by end of Yr. 3	**N/A**	**N/A**
Estimated Incentive Payment: $31,438.59	**Estimated Incentive Payment: $72,962.006**	**N/A**	**N/A**
Milestone 4: P-4 Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities **Data Source:** Project reports, QI reports **Goal:** To improve processes and outcomes by implementing data-driven course corrections and innovations	**Milestone 9: P-4** Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities **Data Source:** Project reports, QI reports **Goal:** To identify problems and make improvements in processes and outcomes by implementing data-driven course corrections and innovations	**N/A**	**N/A**
Estimated Incentive Payment: $31,438.59	**Estimated Incentive Payment: $72,962.006**	**N/A**	**N/A**

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113180703.3.5	RHP PP Reference Number: IT-6.1		Outcome Measure: Percent improvement over baseline of patient satisfaction scores
RHP Performing Provider: Mental Health and Mental Retardation Authority of Harris County			TPI: 113180703
Related Category 1 or 2: 1.12.2	113180703.1.5		
Starting Point/Baseline:	TBD YR 3		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 5: P-5 Disseminate findings, including lessons learned and best practices, to stakeholders **Data Source:** minutes from stakeholder meetings **Goal:** To disseminate information about the project and solicit input from stakeholders representing consumers, families, public agencies and private providers	**Milestone 10: P-5** Disseminate findings, including lessons learned and best practices, to stakeholders **Data Source:** management team minutes, RHP collaborations **Goal:** To disseminate information about the project and solicit input from stakeholders representing consumers, families, public agencies and private providers	**N/A**	**N/A**
Estimated Incentive Payment: $31,438.59	**Estimated Incentive Payment: $72,962.006**		**N/A**
Year 2 Estimated Outcome Amount: $157,192.95	**Year 3 Estimated Outcome Amount: $364,810.03**	**Year 4 Estimated Outcome Amount: $389,838.53**	**Year 5 Estimated Outcome Amount:$847,475.06**
TOTAL EST. INCENTIVE PAYMENTS FOR 4-DY*:* $1,759,316.57			

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Title of Outcome Measure (Improvement Target): IT-6.1: Percent improvement over baseline of patient satisfaction scores

Unique RHP outcome identification numbers: 113180703.3.6
Performing Provider/TPI: Mental Health and Mental Retardation Authority of Harris County/ 113180703

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

- Numerator: Percent improvement in targeted patient satisfaction domain
- Denominator: Number of patients who were administered the survey

Process Milestones:

- DY 2:
  - P-1- Project planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2- Establish baseline for patients served
  - P-3: Develop and test data systems
  - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
  - P-5 Disseminate findings, including lessons learned and best practices, to stakeholders
- DY 3:
  - P-1- Project planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2- Establish baseline for numerator and denominator
  - P-3: Develop and test data systems
  - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
  - P-5 Disseminate findings, including lessons learned and best practices, to stakeholders

Outcome Improvement Targets for each year:

- DY 4:
  - IT 6.1: Rate 1: Improve patient satisfaction by 5 % over baseline scores for one domain of patient satisfaction
- DY 5:
  - IT 6.1: Rate 1: Improve patient satisfaction by 10 % over baseline scores for one domain of patient satisfaction

Rationale:

The Process milestones were chosen in order to develop a strong collaborative team approach between the clinical staff, administrators, physicians, Quality Improvement Department and the newly formed Outcome Management Department of MHMRA. By working through these process goals in order to develop and test a patient satisfaction measure suited for the particular program population, we will be more accurate in our assessment of the target outcome. Although MHMRA has attempted to measure patient satisfaction in the past, the instruments may not have

been the most valid, empirically supported or may not have had national benchmarks for comparison. As part of DY 2 process goals, the Outcome Management department will complete literature reviews to identify relevant, empirically validated, and empirically based, measures for the identified outcomes and the targeted population (P-2 and P-3). With this information, the team will be able to select a measure to be piloted in DY 3. The procedures for testing data collection will be evaluated using the Plan Do Study Act (PDSA) cycles (P-4). The proposed timeline for the outcome measure of patient satisfaction includes determining a baseline for one or more of the following categories of patient satisfaction by DY 2:

6. Are getting timely care, appointments, and information
7. How well their doctors communicate
8. Patient's rating of doctor access to specialist
9. Patient's involvement in shared decision making
10. Patient's overall health status/functional status

From this baseline, the goals for improvement have been set at 5% and 10% in DY 4 and 5, respectively. After the results of DY 4 have been determined then another cycle of Plan Do Study Act (PDSA) can also be executed to determine the successes and the need for improvements in addressing patient satisfaction. This information can then be provided to clinic staff in order to produce the needed improvements.

<u>Outcome Measure Valuation</u>:
Our local region has identified a general objective and specific community needs that are related to transforming the current health care delivery system. The transformed system is proposed to be a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes. Based on this objective, the proposed program has identified OD-6, Patient Satisfaction, as a targeted outcome for quality improvement goal. It is hypothesized that patients will be better served when they can be offered a full array of services, i.e. when the menu of service options is not sharply curtailed by agency resource limitations. This better fit between patient needs and available services is likely to be reflected in more positive rapport and better perceived communication with treatment providers. Specifically, we believe patient satisfaction that addresses involvement in shared decision making, access to providers, and communication with providers, will reduce chronic over-use of psychiatric emergency services. If patients are dissatisfied with services or the process, they may continue to over-utilize emergency services rather than engaging in preventative care.

References:
Barton, G., Hodgekins, J., Mugford, M., Jones, P., Croudace, T. & Fowler, D. (2009). Cognitive behaviour therapy for improving social recovery in psychosis: Cost-effectiveness analysis. *Schizophrenia Research, 112,* 158-163.

Chouinard G. & Albright P. (1997). Economic and health state utility determinations for schizophrenic patients treated with risperidone or haloperidol. *Journal of Clinical Psychopharmacology, 17,* 298-307.

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Hollinghurst, S., Peters, T., Kaur, S., Wiles, N., Lewis, G. & Kessler, D. (2010). Cost-effectiveness of therapist-delivered online cognitive-behavioral therapy for depression: Randomized controlled trial. *British Journal of Psychiatry, 197,* 297-304.

Karow, A., Reimer, J., König, H., Heider, D., Bock, T., & Huber, C., Schöttle, D., Meister, K., Rietschel, L., Ohm, G., Schulz, H., Naber, D., Schimmelmann, B. & Lambert, M. (2012). Cost-effectiveness of 12-month therapeutic assertive community treatment as part of integrated care versus standard care in patients with schizophrenia treated with quetiapine immediate release. *The Journal of Clinical Psychiatry, 73*, e402-e408.

Lehman, A., Dixon, L., Hoch, J., Deforge, B., Kernan, E. & Frank, R. (1999). Cost-effectiveness of assertive community treatment for homeless persons with severe mental illness. *British Journal of Psychiatry, 174*, 346-352.

Mental Health Needs Council, Inc. (2009) Mental Illness in Harris County: Prevalence, Issues of Concern, Recommendations. Houston. Retrieved September 30, 2012, from http://mhnchc.org/mhnc2009report.html.

Pyne, J. M., Rost, K. M., Zhang, M., Williams, D. K., Smith, J. & Fortney, J. (2003). Cost-effectiveness of a primary care depression intervention. Journal of General Internal Medicine 18, 432–441.

Pyne, J., Fortney, J., Tripathi, S., Maciejewski, M., Edlund, M. & Williams, D. (2010). Cost-effectiveness analysis of a rural telemedicine collaborative care intervention for depression. *Archives of General Psychiatry, 67,* 812-821.

Schoenbaum, M., Unützer, J., Sherbourne, C., Duan, N., Rubenstein, L., Miranda, J. & …Wells, K. (2001). Cost-effectiveness of practice-initiated quality improvement for depression: Results of a randomized controlled trial. *The Journal of the American Medical Association, 286*, 1325-1330.

Texas Department of State Health Services (2011). User's manual for the Adult Texas Recommended Assessment Guidelines (Adult-TRAG). Retrieved from http://www.dshs.state.tx.us/mhprograms/RDMTRAG.shtm,September 30, 2012.

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113180703.3.6	RHP PP Reference Number: IT-6.1	Outcome Measure: Percent improvement over baseline of patient satisfaction scores	
RHP Performing Provider: Mental Health and Mental Retardation Authority of Harris County			TPI: 113180703
Related Category 1 or 2: 1.12.2	113180703.1.6		
Starting Point/Baseline:	TBD YR 3		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1: P-1 Project planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans **Data Source:** Meetings minutes, project flow charts and timelines **Goal:** To gather information that guides project activities toward completion of milestones, while integrating stakeholder input in a meaningful way	**Milestone 6: P-1:** Project planning, engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans **Metric 6**: Conduct meetings of stakeholders, project staff, RHP partners and other key parties to gather relevant information **Data Source:** Meetings minutes, project flow charts and timelines **Goal:** To complete project planning process and implement	**Outcome Improvement Target 1** IT 6.1: Percent improvement over baseline of patient satisfaction scores for one domain of patient satisfaction. **Data Source:** Patient survey **Goal:** 5% increase over baseline	**Outcome Improvement Target 2** IT 6.1 Percent improvement over baseline of patient satisfaction scores for one domain of patient satisfaction. **Data Source:** Patient survey **Goal:** 10% increase in baseline
Estimated Incentive Payment: $39,034.88	**Estimated Incentive Payment: $72,962.006**	**Estimated Incentive Payment: $389,838.53**	**Estimated Incentive Payment: $847,475.06**
Milestone 2: P-2 Establish baseline **Data Source:** literature review **Goal:** determine how baseline will be established for patient satisfaction domain	**Milestone 7: P- 2:** Establish baseline **Metric 7**: Select and implement patient satisfaction survey to assess the desired domains of patient satisfaction **Data Source:** Clinical records; monthly management reports **Goal:** obtain baseline of satisfaction survey from patients receiving service	**N/A**	**N/A**
Estimated Incentive Payment: $39,034.88	**Estimated Incentive Payment: $72,962.006**	**N/A**	**N/A**

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113180703.3.6	RHP PP Reference Number: IT-6.1	Outcome Measure: Percent improvement over baseline of patient satisfaction scores	
RHP Performing Provider: Mental Health and Mental Retardation Authority of Harris County			TPI: 113180703
Related Category 1 or 2: 1.12.2	113180703.1.6		
Starting Point/Baseline:	TBD YR 3		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 3 : P-3 Develop and test data systems **Data Source:** Project record—summary of reviews **Goal:** Identify/modify one instrument to test in Yr. 3	**Milestone 8: P-3:** Develop and test data systems **Data Source:** Project record—summary of reviews, completed surveys **Goal:** Test and revise the selected instrument and/or process to enable measure of baseline by end of Yr. 3	**N/A**	**N/A**
Estimated Incentive Payment: $31,438.59	**Estimated Incentive Payment: $72,962.006**	**N/A**	**N/A**
Milestone 4: P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities **Data Source:** Project reports, QI reports **Goal:** To improve processes and outcomes by implementing data-driven course corrections and innovations	**Milestone 9: P-4:** Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities **Data Source:** Project reports, QI reports **Goal:** To identify problems and make improvements in processes and outcomes by implementing data-driven course corrections and innovations	**N/A**	**N/A**
Estimated Incentive Payment: $31,438.59	**Estimated Incentive Payment: $72,962.006**	**N/A**	**N/A**

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113180703.3.6	RHP PP Reference Number: IT-6.1	Outcome Measure: Percent improvement over baseline of patient satisfaction scores	
RHP Performing Provider: Mental Health and Mental Retardation Authority of Harris County			TPI: 113180703
Related Category 1 or 2: 1.12.2	113180703.1.6		
Starting Point/Baseline:	TBD YR 3		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 5: P-5 Disseminate findings, including lessons learned and best practices, to stakeholders **Data Source:** minutes from stakeholder meetings **Goal:** To disseminate information about the project and solicit input from stakeholders representing consumers, families, public agencies and private providers	**Milestone 10: P-5** Disseminate findings, including lessons learned and best practices, to stakeholders **Data Source:** management team minutes, RHP collaborations **Goal:** To disseminate information about the project and solicit input from stakeholders representing consumers, families, public agencies and private providers	**N/A**	**N/A**
Estimated Incentive Payment: $31,438.59	**Estimated Incentive Payment: $72,962.006**		**N/A**
Year 2 Estimated Outcome Amount: $157,192.95	**Year 3 Estimated Outcome Amount: $364,810.03**	**Year 4 Estimated Outcome Amount: $389,838.53**	**Year 5 Estimated Outcome Amount:$847,475.06**
TOTAL EST. INCENTIVE PAYMENTS FOR 4-DY*(add outcome amounts over DYs 2-5)***:**$1,759,316.57			

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Title of Outcome Measure (Improvement Target): IT-6.1: Percent improvement over baseline of patient satisfaction scores
Unique RHP outcome identification numbers: 113180703.3.7
Performing Provider/TPI: Mental Health and Mental Retardation Authority of Harris County/ 113180703

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

- Numerator: Percent improvement in targeted patient satisfaction domain
- Denominator: Number of patients who were administered the survey

Process Milestones:

- DY 2:
  - P-1- Project planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2- Establish baseline for patients served
  - P-3: Develop and test data systems
  - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
  - P-5 Disseminate findings, including lessons learned and best practices, to stakeholders
- DY 3:
  - P-1- Project planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2- Establish baseline for numerator and denominator
  - P-3: Develop and test data systems
  - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
  - P-5 Disseminate findings, including lessons learned and best practices, to stakeholders

Outcome Improvement Targets for each year:

- DY 4:
  - IT 6.1: Rate 1: Improve patient satisfaction by 5 % over baseline scores for one domain of patient satisfaction
- DY 5:
  - IT 6.1: Rate 1: Improve patient satisfaction by 10 % over baseline scores for one domain of patient satisfaction

<u>**Rationale**</u>:

The Process milestones were chosen in order to develop a strong collaborative team approach between the clinical staff, administrators, physicians, Quality Improvement Department and the newly formed Outcome Management Department of MHMRA. By working through these process goals in order to develop and test a patient satisfaction measure suited for the particular program population, we will be more accurate in our assessment of the target outcome. Although MHMRA has attempted to measure patient satisfaction in the past, the instruments may not have been the most valid, empirically supported or may not have had national benchmarks for comparison. As part of DY 2 process goals, the Outcome Management department will complete literature reviews to identify relevant, empirically validated, and empirically based, measures for

the identified outcomes and the targeted population (P-2 and P-3). With this information, the team will be able to select a measure to be piloted in DY 3. The procedures for testing data collection will be evaluated using the Plan Do Study Act (PDSA) cycles (P-4). The proposed timeline for the outcome measure of patient satisfaction includes determining a baseline for one or more of the following categories of patient satisfaction by DY 2:

11. Are getting timely care, appointments, and information
12. How well their doctors communicate
13. Patient's rating of doctor access to specialist
14. Patient's involvement in shared decision making
15. Patient's overall health status/functional status

From this baseline, the goals for improvement have been set at 5% and 10% in DY 4 and 5, respectively. After the results of DY 4 have been determined then another cycle of Plan Do Study Act (PDSA) can also be executed to determine the successes and the need for improvements in addressing patient satisfaction. This information can then be provided to clinic staff in order to produce the needed improvements.

<u>Outcome Measure Valuation</u>:

Our local region has identified a general objective and specific community needs that are related to transforming the current health care delivery system. The transformed system is proposed to be a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes. Based on this objective, the proposed program has identified OD-6, Patient Satisfaction, as a targeted outcome for quality improvement goal. It is hypothesized that patients will be better served when they can be offered a full array of services, i.e. when the menu of service options is not sharply curtailed by agency resource limitations. This better fit between patient needs and available services is likely to be reflected in more positive rapport and better perceived communication with treatment providers. Specifically, we believe patient satisfaction that addresses involvement in shared decision making, access to providers, and communication with providers, will reduce chronic over-use of psychiatric emergency services. If patients are dissatisfied with services or the process, they may continue to over-utilize emergency services rather than engaging in preventative care.

References:

Barton, G., Hodgekins, J., Mugford, M., Jones, P., Croudace, T. & Fowler, D. (2009). Cognitive behaviour therapy for improving social recovery in psychosis: Cost-effectiveness analysis. *Schizophrenia Research, 112,* 158-163.

Chouinard G. & Albright P. (1997). Economic and health state utility determinations for schizophrenic patients treated with risperidone or haloperidol. *Journal of Clinical Psychopharmacology, 17,* 298-307.

Hollinghurst, S., Peters, T., Kaur, S., Wiles, N., Lewis, G. & Kessler, D. (2010). Cost-effectiveness
of therapist-delivered online cognitive-behavioral therapy for depression: Randomized controlled trial. *British Journal of Psychiatry, 197,* 297-304.

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Karow, A., Reimer, J., König, H., Heider, D., Bock, T., & Huber, C., Schöttle, D., Meister, K., Rietschel, L., Ohm, G., Schulz, H., Naber, D., Schimmelmann, B. & Lambert, M. (2012). Cost-effectiveness of 12-month therapeutic assertive community treatment as part of integrated care versus standard care in patients with schizophrenia treated with quetiapine immediate release. *The Journal of Clinical Psychiatry, 73*, e402-e408.

Lehman, A., Dixon, L., Hoch, J., Deforge, B., Kernan, E. & Frank, R. (1999). Cost-effectiveness of
assertive community treatment for homeless persons with severe mental illness. *British Journal of Psychiatry, 174*, 346-352.

Mental Health Needs Council, Inc. (2009) Mental Illness in Harris County: Prevalence, Issues of Concern, Recommendations. Houston. Retrieved September 30, 2012, from http://mhnchc.org/mhnc2009report.html.

Pyne, J. M., Rost, K. M., Zhang, M., Williams, D. K., Smith, J. & Fortney, J. (2003). Cost effectiveness of a primary care depression intervention. Journal of General Internal Medicine 18, 432–441.

Pyne, J., Fortney, J., Tripathi, S., Maciejewski, M., Edlund, M. & Williams, D. (2010). Cost effectiveness analysis of a rural telemedicine collaborative care intervention for depression. *Archives of General Psychiatry, 67*, 812-821.

Schoenbaum, M., Unützer, J., Sherbourne, C., Duan, N., Rubenstein, L., Miranda, J. & …Wells, K.
(2001). Cost-effectiveness of practice-initiated quality improvement for depression: Results of a randomized controlled trial. *The Journal of the American Medical Association, 286*, 1325-1330.

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113180703.3.7	RHP PP Reference Number: IT-6.1	Outcome Measure: Percent improvement over baseline of patient satisfaction scores	
RHP Performing Provider: Mental Health and Mental Retardation Authority of Harris County			TPI: 113180703
Related Category 1 or 2: 1.12.2	Unique Category 1 or 2 project identifiers: 113180703.1.7		
Starting Point/Baseline:	TBD YR 3		

Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Milestone 1: P-1: Project planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans **Data Source:** Meetings minutes, project flow charts and timelines **Goal:** To gather information that guides project activities toward completion of milestones, while integrating stakeholder input in a meaningful way	**Milestone 6: P-1** Project planning, engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans **Data Source:** Meetings minutes, project flow charts and timelines **Goal:** To complete project planning process and implement	**Outcome Improvement Target 1 IT 6.1**: Percent improvement over baseline of patient satisfaction scores for one domain of patient satisfaction. **Data Source:** Patient survey **Goal:** 5% increase over baseline	**Outcome Improvement Target 2 IT 6.1** Percent improvement over baseline of patient satisfaction scores for one domain of patient satisfaction. **Data Source:** Patient survey **Goal:** 10% increase in baseline
Estimated Incentive Payment: $39,034.88	**Estimated Incentive Payment: $72,962.006**	**Estimated Incentive Payment: $389,838.53**	**Estimated Incentive Payment: $847,475.06**
Milestone 2: P-2: Establish baseline **Data Source:** literature review **Goal:** determine how baseline will be established for patient satisfaction domain	**Milestone 7: P- 2:** Establish baseline **Data Source:** Clinical records; monthly management reports **Goal:** obtain baseline of satisfaction survey from patients receiving service	**N/A**	**N/A**
Estimated Incentive Payment: $39,034.88	**Estimated Incentive Payment: $72,962.006**	**N/A**	**N/A**

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113180703.3.7	RHP PP Reference Number: IT-6.1	Outcome Measure: Percent improvement over baseline of patient satisfaction scores	
RHP Performing Provider: Mental Health and Mental Retardation Authority of Harris County			TPI: 113180703
Related Category 1 or 2: 1.12.2	Unique Category 1 or 2 project identifiers: 113180703.1.7		
Starting Point/Baseline:	TBD YR 3		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 3 : P-3: Develop and test data systems **Data Source:** Project record—summary of reviews **Goal:** Identify/modify one instrument to test in Yr. 3	**Milestone 8: P-3:** Develop and test data systems **Data Source:** Project record—summary of reviews, completed surveys **Goal:** Test and revise the selected instrument and/or process to enable measure of baseline by end of Yr. 3	**N/A**	**N/A**
Estimated Incentive Payment: $31,438.59	**Estimated Incentive Payment: $72,962.006**	**N/A**	**N/A**
Milestone 4: P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities **Data Source:** Project reports, QI reports **Goal:** To improve processes and outcomes by implementing data-driven course corrections and innovations	**Milestone 9: P-4:** Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities **Data Source:** Project reports, QI reports **Goal:** To identify problems and make improvements in processes and outcomes by implementing data-driven course corrections and innovations	**N/A**	**N/A**
Estimated Incentive Payment: $31,438.59	**Estimated Incentive Payment: $72,962.006**	**N/A**	**N/A**

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113180703.3.7	RHP PP Reference Number: IT-6.1	Outcome Measure: Percent improvement over baseline of patient satisfaction scores	
RHP Performing Provider: Mental Health and Mental Retardation Authority of Harris County			TPI: 113180703
Related Category 1 or 2: 1.12.2	Unique Category 1 or 2 project identifiers: 113180703.1.7		
Starting Point/Baseline:	TBD YR 3		

Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Milestone 5: P-5 Disseminate findings, including lessons learned and best practices, to stakeholders **Data Source:** minutes from stakeholder meetings **Goal:** To disseminate information about the project and solicit input from stakeholders representing consumers, families, public agencies and private providers	**Milestone 10: P-5** Disseminate findings, including lessons learned and best practices, to stakeholders **Data Source:** management team minutes, RHP collaborations **Goal:** To disseminate information about the project and solicit input from stakeholders representing consumers, families, public agencies and private providers	**N/A**	**N/A**
Estimated Incentive Payment: $31,438.59	**Estimated Incentive Payment: $72,962.006**		**N/A**
Year 2 Estimated Outcome Amount: $157,192.95	**Year 3 Estimated Outcome Amount: $364,810.03**	**Year 4 Estimated Outcome Amount: $389,838.53**	**Year 5 Estimated Outcome Amount:$847,475.06**
TOTAL EST. INCENTIVE PAYMENTS FOR 4-DY: $1,759,316.57			

Title of Outcome Measure (Improvement Target): IT-6.1: Percent improvement over baseline of patient satisfaction scores

Unique RHP outcome identification numbers: 113180703.3.8
Performing Provider/TPI: Mental Health and Mental Retardation Authority of Harris County/ 113180703

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

- Numerator: Percent improvement in targeted patient satisfaction domain
- Denominator: Number of patients who were administered the survey

Process Milestones:

- DY 2:
  - P-1- Project planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2- Establish baseline for patients served
  - P-3: Develop and test data systems
  - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
  - P-5 Disseminate findings, including lessons learned and best practices, to stakeholders
- DY 3:
  - P-1- Project planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2- Establish baseline for numerator and denominator
  - P-3: Develop and test data systems
  - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
  - P-5 Disseminate findings, including lessons learned and best practices, to stakeholders

Outcome Improvement Targets for each year:

- DY 4:
  - IT 6.1: Rate 1: Improve patient satisfaction by 5 % over baseline scores for one domain of patient satisfaction
- DY 5:
  - IT 6.1: Rate 1: Improve patient satisfaction by 10 % over baseline scores for one domain of patient satisfaction

Rationale:

The Process milestones were chosen in order to develop a strong collaborative team approach between the clinical staff, administrators, physicians, Quality Improvement Department and the newly formed Outcome Management Department of MHMRA. By working through these process goals in order to develop and test a patient satisfaction measure suited for the particular program population, we will be more accurate in our assessment of the target outcome. Although MHMRA has attempted to measure patient satisfaction in the past, the instruments may not have been the most valid, empirically supported or may not have had national benchmarks for comparison. As part of DY 2 process goals, the Outcome Management department will complete

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literature reviews to identify relevant, empirically validated, and empirically based, measures for the identified outcomes and the targeted population (P-2 and P-3). With this information, the team will be able to select a measure to be piloted in DY 3. The procedures for testing data collection will be evaluated using the Plan Do Study Act (PDSA) cycles (P-4). The proposed timeline for the outcome measure of patient satisfaction includes determining a baseline for one or more of the following categories of patient satisfaction by DY 2:

16. Are getting timely care, appointments, and information
17. How well their doctors communicate
18. Patient's rating of doctor access to specialist
19. Patient's involvement in shared decision making
20. Patient's overall health status/functional status

From this baseline, the goals for improvement have been set at 5% and 10% in DY 4 and 5, respectively. After the results of DY 4 have been determined then another cycle of Plan Do Study Act (PDSA) can also be executed to determine the successes and the need for improvements in addressing patient satisfaction. This information can then be provided to clinic staff in order to produce the needed improvements.

<u>Outcome Measure Valuation</u>:

Our local region has identified a general objective and specific community needs that are related to transforming the current health care delivery system. The transformed system is proposed to be a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes. Based on this objective, the proposed program has identified OD-6, Patient Satisfaction, as a targeted outcome for quality improvement goal. It is hypothesized that patients will be better served when they can be offered a full array of services, i.e. when the menu of service options is not sharply curtailed by agency resource limitations. This better fit between patient needs and available services is likely to be reflected in more positive rapport and better perceived communication with treatment providers. Specifically, we believe patient satisfaction that addresses involvement in shared decision making, access to providers, and communication with providers, will reduce chronic over-use of psychiatric emergency services. If patients are dissatisfied with services or the process, they may continue to over-utilize emergency services rather than engaging in preventative care.

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<table>
<tr><td>113180703.3.8</td><td>RHP PP Reference Number: IT-6.1</td><td colspan="2">Outcome Measure: Percent improvement over baseline of patient satisfaction scores</td></tr>
<tr><td colspan="3">RHP Performing Provider - MHMRA of Harris County</td><td>TPI: 113180703</td></tr>
<tr><td>Related Category 1 or 2: 2.15</td><td colspan="3">113180703.2.1</td></tr>
<tr><td>Starting Point/Baseline:</td><td colspan="3">TBD YR 3</td></tr>
<tr><th>Year 2
(10/1/2012 – 9/30/2013)</th><th>Year 3
(10/1/2013 – 9/30/2014)</th><th>Year 4
(10/1/2014 – 9/30/2015)</th><th>Year 5
(10/1/2015 – 9/30/2016)</th></tr>
<tr><td>Milestone 1 P-1 Project planning, engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans

Data Source: Meetings minutes, project flow charts and timelines
Goal: To integrate stakeholder input in development of program plan</td><td>Milestone 6: P-1 Project planning, engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans

Data Source: Meetings minutes, project flow charts and timelines
Goal: To complete project planning process and implement</td><td>Outcome Improvement Target 1 IT 6.1 Percent improvement over baseline of patient satisfaction scores for one domain of patient satisfaction.

Data Source: Patient survey
Goal: 5% increase over baseline</td><td>Outcome Improvement Target 2 IT 6.1 Percent improvement over baseline of patient satisfaction scores for one domain of patient satisfaction.

Data Source: Patient survey
Goal: 10% increase in baseline</td></tr>
<tr><td>Estimated Incentive Payment: $45,701.38</td><td>Estimated Incentive Payment: $106,062.78</td><td>Estimated Incentive Payment: $566,697.13</td><td>Estimated Incentive Payment: $1,231,950.27</td></tr>
<tr><td>Milestone 2: P-2 Establish baseline

Data Source: literature review
Goal: determine how baseline will be established for patient satisfaction domain</td><td>Milestone 7: P-2 Establish baseline

Data Source: Clinical records; monthly management reports
Goal: obtain baseline of satisfaction survey from patients receiving service</td><td>N/A</td><td>N/A</td></tr>
<tr><td>Estimated Incentive Payment: $45,701.38</td><td>Estimated Incentive Payment: $106,062.78</td><td>N/A</td><td>N/A</td></tr>
</table>

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113180703.3.8	RHP PP Reference Number: IT-6.1	Outcome Measure: Percent improvement over baseline of patient satisfaction scores	
RHP Performing Provider - MHMRA of Harris County			TPI: 113180703
Related Category 1 or 2: 2.15	113180703.2.1		
Starting Point/Baseline:	TBD YR 3		

Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Milestone 3 : P-3 Develop and test data systems **Data Source:** Project record—summary of reviews **Goal:** Identify/modify one instrument to test in Yr. 3	**Milestone 8:** P-3 Develop and test data systems **Data Source:** Project record—summary of reviews, completed surveys **Goal:** Test and revise the selected process	**N/A**	**N/A**
Estimated Incentive Payment: $45,701.38	**Estimated Incentive Payment: $106,062.78**	**N/A**	**N/A**
Milestone 4: P-4 Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities **Data Source:** Project reports **Goal:** To improve processes and outcomes by implementing data-driven course corrections and innovations	**Milestone 9:** P-4 Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities **Data Source:** Project reports **Goal:** To identify problems and make improvements in processes and outcomes	**N/A**	**N/A**
Estimated Incentive Payment: $45,701.38	**Estimated Incentive Payment: $106,062.78**	**N/A**	**N/A**

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<table>
<tr><td>113180703.3.8</td><td colspan="2">RHP PP Reference Number: IT-6.1</td><td colspan="2">Outcome Measure: Percent improvement over baseline of patient satisfaction scores</td></tr>
<tr><td colspan="4">RHP Performing Provider - MHMRA of Harris County</td><td>TPI: 113180703</td></tr>
<tr><td>Related Category 1 or 2: 2.15</td><td colspan="4">113180703.2.1</td></tr>
<tr><td>Starting Point/Baseline:</td><td colspan="4">TBD YR 3</td></tr>
<tr><td>Year 2
(10/1/2012 – 9/30/2013)</td><td>Year 3
(10/1/2013 – 9/30/2014)</td><td>Year 4
(10/1/2014 – 9/30/2015)</td><td colspan="2">Year 5
(10/1/2015 – 9/30/2016)</td></tr>
<tr><td>Milestone 5: P-5 Disseminate findings, including lessons learned and best practices, to stakeholders

Data Source: management team minutes, RHP collaborations
Goal: To disseminate information about the project and solicit input from stakeholders</td><td>Milestone 10: P-5 Disseminate findings including lessons learned and best practices to stakeholders

Data Source: management team minutes, RHP collaborations
Goal: To disseminate information about the project and solicit input from stakeholders</td><td>N/A</td><td colspan="2">N/A</td></tr>
<tr><td>Estimated Incentive Payment: $45,701.38</td><td>Estimated Incentive Payment: $106,062.78</td><td>N/A</td><td colspan="2">N/A</td></tr>
<tr><td>Year 2 Estimated Outcome Amount: $228,506.90</td><td>Year 3 Estimated Outcome Amount: $530,313.91</td><td>Year 4 Estimated Outcome Amount: $566,697.13</td><td colspan="2">Year 5 Estimated Outcome Amount: $1,231,950.27</td></tr>
<tr><td colspan="5">TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $2,557,468.21</td></tr>
</table>

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Title of Outcome Measure (Improvement Target): IT-6.1: Percent improvement over baseline of patient satisfaction scores
Unique RHP outcome identification numbers: 113180703.3.9
Performing Provider/TPI: Mental Health and Mental Retardation Authority of Harris County/ 113180703

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

- Numerator: Percent improvement in targeted patient satisfaction domain
- Denominator: Number of patients who were administered the survey

Process Milestones:

- DY 2:
  - P-1- Project planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2- Establish baseline for patients served
  - P-3: Develop and test data systems
  - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
  - P-5 Disseminate findings, including lessons learned and best practices, to stakeholders
- DY 3:
  - P-1- Project planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2- Establish baseline for numerator and denominator
  - P-3: Develop and test data systems
  - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
  - P-5 Disseminate findings, including lessons learned and best practices, to stakeholders

Outcome Improvement Targets for each year:

- DY 4:
  - IT 6.1: Rate 1: Improve patient satisfaction by 5 % over baseline scores for one domain of patient satisfaction
- DY 5:
  - IT 6.1: Rate 1: Improve patient satisfaction by 10 % over baseline scores for one domain of patient satisfaction

Rationale:

The Process milestones were chosen in order to develop a strong collaborative team approach between the clinical staff, administrators, physicians, Quality Improvement Department and the newly formed Outcome Management Department of MHMRA. By working through these process goals in order to develop and test a patient satisfaction measure suited for the particular program population, we will be more accurate in our assessment of the target outcome. Although MHMRA has attempted to measure patient satisfaction in the past, the instruments may not have been the most valid, empirically supported or may not have had national benchmarks for comparison. As part of DY 2 process goals, the Outcome Management department will complete literature reviews to identify relevant, empirically validated, and empirically based, measures for

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the identified outcomes and the targeted population (P-2 and P-3). With this information, the team will be able to select a measure to be piloted in DY 3. The procedures for testing data collection will be evaluated using the Plan Do Study Act (PDSA) cycles (P-4). The proposed timeline for the outcome measure of patient satisfaction includes determining a baseline for one or more of the following categories of patient satisfaction by DY 2:

21. Are getting timely care, appointments, and information
22. How well their doctors communicate
23. Patient's rating of doctor access to specialist
24. Patient's involvement in shared decision making
25. Patient's overall health status/functional status

From this baseline, the goals for improvement have been set at 5% and 10% in DY 4 and 5, respectively. After the results of DY 4 have been determined then another cycle of Plan Do Study Act (PDSA) can also be executed to determine the successes and the need for improvements in addressing patient satisfaction. This information can then be provided to clinic staff in order to produce the needed improvements.

Outcome Measure Valuation:

Our local region has identified a general objective and specific community needs that are related to transforming the current health care delivery system. The transformed system is proposed to be a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes. Based on this objective, the proposed program has identified OD-6, Patient Satisfaction, as a targeted outcome for quality improvement goal. It is hypothesized that patients will be better served when they can be offered a full array of services, i.e. when the menu of service options is not sharply curtailed by agency resource limitations. This better fit between patient needs and available services is likely to be reflected in more positive rapport and better perceived communication with treatment providers. Specifically, we believe patient satisfaction that addresses involvement in shared decision making, access to providers, and communication with providers, will reduce chronic over-use of psychiatric emergency services. If patients are dissatisfied with services or the process, they may continue to over-utilize emergency services rather than engaging in preventative care.

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113180703.3.9	RHP PP Reference Number: IT-6.1	Outcome Measure: Percent improvement over baseline of patient satisfaction scores	
RHP Performing Provider - MHMRA of Harris County		TPI: 113180703	
Related Category 1 or 2: 2.13	113180703.2.2		
Starting Point/Baseline:	TBD YR 3		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 P 1: Project planning-engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans **Data Source:** Meetings minutes, project flow charts and timelines **Goal:** To integrate stakeholder input in development of program plan	**Milestone 6: P-1:** Project planning, engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans **Data Source:** Meetings minutes, project flow charts and timelines **Goal:** To complete project planning process and implement	**Outcome Improvement Target1** IT 6.1 Percent improvement over baseline of patient satisfaction scores for one domain of patient satisfaction. **Data Source**: Patient survey **Goal**: 5% increase over baseline	**Outcome Improvement Target 2** IT 6.1 Percent improvement over baseline of patient satisfaction scores for one domain of patient satisfaction. **Data Source:** Patient survey **Goal:** 10% increase in baseline
Estimated Incentive Payment: $43,974.41	**Estimated Incentive Payment: $102,054.88**	**Estimated Incentive Payment: $545,282.77**	**Estimated Incentive Payment: $1,185,397.31**
Milestone 2: P-2: Establish baseline **Data Source:** literature review **Goal:** determine how baseline will be established for patient satisfaction domain	**Milestone 7: P- 2:** Establish baseline **Data Source:** Clinical records; monthly management reports **Goal:** obtain baseline of satisfaction survey from patients receiving service	**N/A**	**N/A**
Estimated Incentive Payment: $43,974.41	**Estimated Incentive Payment: $102,054.88**	**N/A**	**N/A**
Milestone 3 : P-3: Develop and test data systems **Data Source:** Project record—summary of reviews **Goal:** Identify/modify one instrument to test in Yr. 3	**Milestone 8: P-3:** Develop and test data systems **Goal:** Test and revise the selected instrument and/or process so that satisfaction baseline can be established by end of Yr. 3	**N/A**	**N/A**

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113180703.3.9	RHP PP Reference Number: IT-6.1	Outcome Measure: Percent improvement over baseline of patient satisfaction scores	
RHP Performing Provider - MHMRA of Harris County		TPI: 113180703	
Related Category 1 or 2: 2.13	113180703.2.2		
Starting Point/Baseline:	TBD YR 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)**
Estimated Incentive Payment: $43,974.42	**Estimated Incentive Payment: $102,054.88**	**N/A**	**N/A**
Milestone 4: P.4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities **Data Source:** Project reports including examples of how real time data has been used to guide continuous quality improvement **Goal:** To improve processes and outcomes by implementing data-driven course corrections and innovations	**Milestone 9: P-4** Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities **Data Source:** Project reports including examples of how real time data has been used to guide continuous quality improvement **Goal:** To identify problems and make improvements in processes and outcomes by implementing data-driven course corrections and innovations	**N/A**	**N/A**
Estimated Incentive Payment: $43,974.42	**Estimated Incentive Payment: $102,054.88**	**N/A**	**N/A**
Milestone 5: P-5 Disseminate findings, including lessons learned and best practices, to stakeholders **Data Source:** management team minutes, RHP collaborations **Goal:** To disseminate information about the project and solicit input from stakeholders	**Milestone 10: P-5** Disseminate findings to stakeholders **Data Source:** management team minutes, RHP collaborations **Goal:** To disseminate information about the project and solicit input from stakeholders	**N/A**	**N/A**

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<table>
<tr><td>113180703.3.9</td><td colspan="2">RHP PP Reference Number: IT-6.1</td><td colspan="2">Outcome Measure: Percent improvement over baseline of patient satisfaction scores</td></tr>
<tr><td colspan="3">RHP Performing Provider - MHMRA of Harris County</td><td colspan="2">TPI: 113180703</td></tr>
<tr><td>Related Category 1 or 2: 2.13</td><td colspan="4">113180703.2.2</td></tr>
<tr><td>Starting Point/Baseline:</td><td colspan="3">TBD YR 3</td><td></td></tr>
<tr><td>Year 2
(10/1/2012 – 9/30/2013)</td><td>Year 3
(10/1/2013 – 9/30/2014)</td><td colspan="2">Year 4
(10/1/2014 – 9/30/2015)</td><td>Year 5
(10/1/2015 – 9/30/2016)</td></tr>
<tr><td>Estimated Incentive Payment: $43,974.42</td><td>Estimated Incentive Payment: $102,054.88</td><td colspan="2">N/A</td><td>N/A</td></tr>
<tr><td>Year 2 Estimated Outcome Amount: $219,872.08</td><td>Year 3 Estimated Outcome Amount: $510,274.40</td><td colspan="2">Year 4 Estimated Outcome Amount: $545,282.77</td><td>Year 5 Estimated Outcome Amount: $1,185,397.31</td></tr>
<tr><td colspan="5">TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $2,460,826.56</td></tr>
</table>

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Title of Outcome Measure (Improvement Target): IT-6.1: Percent improvement over baseline of patient satisfaction scores

Unique RHP outcome identification numbers: 113180703.3.10

Outcome Measure Description:

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

- Numerator: Percent improvement in targeted patient satisfaction domain
- Denominator: Number of patients who were administered the survey

Process Milestones:

- DY 2:
  - P-1- Project planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2- Establish baseline for patients served
  - P-3: Develop and test data systems
  - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
  - P-5 Disseminate findings, including lessons learned and best practices, to stakeholders
- DY 3:
  - P-1- Project planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2- Establish baseline for numerator and denominator
  - P-3: Develop and test data systems
  - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
  - P-5 Disseminate findings, including lessons learned and best practices, to stakeholders

Outcome Improvement Targets for each year:

- DY 4:
  - IT 6.1: Rate 1: Improve patient satisfaction by 5 % over baseline scores for one domain of patient satisfaction
- DY 5:
  - IT 6.1: Rate 1: Improve patient satisfaction by 10 % over baseline scores for one domain of patient satisfaction

Rationale:

The Process milestones were chosen in order to develop a strong collaborative team approach between the clinical staff, administrators, physicians, Quality Improvement Department

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and the newly formed Outcome Management Department of MHMRA. By working through these process goals in order to develop and test a patient satisfaction measure suited for the particular program population, we will be more accurate in our assessment of the target outcome. Although MHMRA has attempted to measure patient satisfaction in the past, the instruments may not have been the most valid, empirically supported or may not have had national benchmarks for comparison. As part of DY 2 process goals, the Outcome Management department will complete literature reviews to identify relevant, empirically validated, and empirically based, measures for the identified outcomes and the targeted population (P-2 and P-3). With this information, the team will be able to select a measure to be piloted in DY 3. The procedures for testing data collection will be evaluated using the Plan Do Study Act (PDSA) cycles (P-4). The proposed timeline for the outcome measure of patient satisfaction includes determining a baseline for one or more of the following categories of patient satisfaction by DY 2:

26. Are getting timely care, appointments, and information
27. How well their doctors communicate
28. Patient's rating of doctor access to specialist
29. Patient's involvement in shared decision making
30. Patient's overall health status/functional status

From this baseline, the goals for improvement have been set at 5% and 10% in DY 4 and 5, respectively. After the results of DY 4 have been determined then another cycle of Plan Do Study Act (PDSA) can also be executed to determine the successes and the need for improvements in addressing patient satisfaction. This information can then be provided to clinic staff in order to produce the needed improvements.

Outcome Measure Valuation:

Our local region has identified a general objective and specific community needs that are related to transforming the current health care delivery system. The transformed system is proposed to be a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes. Based on this objective, the proposed program has identified OD-6, Patient Satisfaction, as a targeted outcome for quality improvement goal. It is hypothesized that patients will be better served when they can be offered a full array of services, i.e. when the menu of service options is not sharply curtailed by agency resource limitations. This better fit between patient needs and available services is likely to be reflected in more positive rapport and better perceived communication with treatment providers. Specifically, we believe patient satisfaction that addresses involvement in shared decision making, access to providers, and communication with providers, will reduce chronic over-use of psychiatric emergency services. If patients are dissatisfied with services or the process, they may continue to over-utilize emergency services rather than engaging in preventative care.

<table>
<tr><td>113180703.3.10</td><td colspan="2">IT-6.1</td><td>Percent improvement over baseline of patient satisfaction scores</td></tr>
<tr><td colspan="2">MHMRA of Harris County</td><td colspan="2">113180703</td></tr>
<tr><td colspan="2">Related Category 1 or 2:</td><td colspan="2">113180703.2.3</td></tr>
<tr><td colspan="2">Starting Point/Baseline:</td><td colspan="2">TBD YR 3</td></tr>
<tr><th>Year 2

(10/1/2012 – 9/30/2013)</th><th>Year 3

(10/1/2013 – 9/30/2014)</th><th>Year 4

(10/1/2014 – 9/30/2015)</th><th>Year 5

(10/1/2015 – 9/30/2016)</th></tr>
<tr><td>Milestone 1: P -1: Project planning-engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
Metric 1: Conduct meetings of stakeholders, project staff, RHP partners and other key parties to gather relevant information
Data Source: Meetings minutes, project flow charts and timelines
Goal: To integrate stakeholder input in development of program plan</td><td>Milestone 6: P-1: Project planning, engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
Metric 6: Conduct meetings of stakeholders, project staff, RHP partners and other key parties to gather relevant information
Data Source: Meetings minutes, project flow charts and timelines
Goal: To complete project planning process and implement</td><td>Milestone 11: OD-6: Patient Satisfaction
Metric 11: IT 6-1 Percent improvement over baseline of patient satisfaction scores
a. Numerator: Percent improvement in targeted patient satisfaction domain
b. Denominator: Number of patients who were administered the survey
Data Source: Patient survey
Goal: 5% increase over baseline</td><td>Milestone 12: OD-6: Patient Satisfaction
Metric 12: IT 6-1 Percent improvement over baseline of patient satisfaction scores
a Numerator: Percent improvement in targeted patient satisfaction domain
b. Denominator: Number of patients who were administered the survey
Data Source: Patient survey
Goal: 10% increase over baseline</td></tr>
<tr><td>Estimated Incentive Payment: $5,281.98</td><td>Estimated Incentive Payment: $12,258.32</td><td>Estimated Incentive Payment: $65,496.61</td><td>Estimated Incentive Payment: $ $142,383.93</td></tr>
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113180703.3.10	IT-6.1	Percent improvement over baseline of patient satisfaction scores	
MHMRA of Harris County		113180703	
Related Category 1 or 2:		113180703.2.3	
Starting Point/Baseline:		TBD YR 3	

Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Milestone 2: P-2: Establish baseline **Metric 2**: Identify domains of patient satisfaction to be measured **Data Source:** literature review **Goal:** determine how baseline will be established for patient satisfaction domain	**Milestone 7: P- 2:** Establish baseline **Metric 7**: Select and implement patient satisfaction survey to assess the desired domains of patient satisfaction **Data Source:** Clinical records; monthly management reports **Goal:** obtain baseline of satisfaction survey from patients receiving service	**N/A**	**N/A**
Estimated Incentive Payment: $5,281.98	**Estimated Incentive Payment: $12,258.32**	**N/A**	**N/A**

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113180703.3.10	IT-6.1	Percent improvement over baseline of patient satisfaction scores	
MHMRA of Harris County		113180703	
Related Category 1 or 2:		113180703.2.3	
Starting Point/Baseline:		TBD YR 3	
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Milestone 3: P-3: Develop and test data systems **Metric 3**: Review satisfaction measures for use with the target population and their clinical teams **Data Source:** Project record—summary of reviews **Goal:** Identify/modify one instrument to test in Yr. 3	**Milestone 8: P-3:** Develop and test data systems **Metric 8**: Review satisfaction measures for use with the target population **Data Source:** Project record—summary of reviews, completed surveys **Goal:** Test and revise the selected instrument and/or process so that satisfaction baseline can be established by end of Yr. 3	**N/A**	**N/A**
Estimated Incentive Payment: $5,281.98	**Estimated Incentive Payment: $12,258.32**	**N/A**	**N/A**

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113180703.3.10	IT-6.1	Percent improvement over baseline of patient satisfaction scores	
MHMRA of Harris County	113180703		
Related Category 1 or 2:	113180703.2.3		
Starting Point/Baseline:	TBD YR 3		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Milestone 4: P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities **Metric 4:** Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles **Data Source:** Project reports including examples of how real time data has been used to guide continuous quality improvement **Goal:** To improve processes and outcomes by implementing data-driven course corrections and innovations	**Milestone 9: P-9:** Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities **Metric 9:** Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles **Data Source:** Project reports including examples of how real time data has been used to guide continuous quality improvement **Goal:** To identify problems and make improvements in processes and outcomes by implementing data-driven course corrections and innovations	**N/A**	**N/A**
Estimated Incentive Payment: $5,281.98	**Estimated Incentive Payment: $12,258.32**	**N/A**	**N/A**

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113180703.3.10	IT-6.1	Percent improvement over baseline of patient satisfaction scores	
MHMRA of Harris County		113180703	
Related Category 1 or 2:		113180703.2.3	
Starting Point/Baseline:		TBD YR 3	
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Milestone 5: P-5 Disseminate findings, including lessons learned and best practices, to stakeholders **Metric 5:** Report status, progress and lessons learned to stakeholders **Data Source:** management team minutes, RHP collaborations **Goal:** To disseminate information about the project and solicit input from stakeholders	**Milestone 10: P-5:** Disseminate findings to stakeholders **Metric 10**: Report status, progress and lessons learned to stakeholders **Data Source:** management team minutes, RHP collaborations **Goal:** To disseminate information about the project and solicit input from stakeholders	**N/A**	**N/A**
Estimated Incentive Payment: $5,281.98	**Estimated Incentive Payment: $12,258.32**	**N/A**	**N/A**
Year 2 Estimated Outcome Amount:$26,409.92	**Year 3 Estimated Outcome Amount: $61,291.58**	**Year 4 Estimated Outcome Amount: $65,496.61**	**Year 5 Estimated Outcome: Amount: $142,383.93**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: **$295,582.04**			

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Boyer, C., McAlpine, D., Pottick, K., & Olfson, M. (2000). Identifying risk factors and key strategies in linkage to outpatient psychiatric care. *The American Journal of Psychiatry*, *157,* 1592-1598.

Chouinard, G. & Albright, P. (1997). Economic and health state utility determinations for schizophrenic patients treated with risperidone or haloperidol. *Journal of Clinical Psychopharmacology, 17,* 298-307.

Dixon, L., Goldberg, R., Lannone, V., Lucksted, A., Brown, C., Kreyenbuhl, J., & ... Potts, W. (2009). Use of a critical time intervention to promote continuity of care after psychiatric inpatient hospitalization. *Psychiatric Services*, *60,* 451-458.

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Title of Outcome Measure (Improvement Target): IT-6.1: Percent improvement over baseline of patient satisfaction scores

Unique RHP outcome identification numbers: 113180703.3.11

Outcome Measure Description:

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

- Numerator: Percent improvement in targeted patient satisfaction domain
- Denominator: Number of patients who were administered the survey

Process Milestones:

- DY 2:
  - P-1- Project planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2- Establish baseline for patients served
  - P-3: Develop and test data systems
  - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
  - P-5 Disseminate findings, including lessons learned and best practices, to stakeholders
- DY 3:
  - P-1- Project planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2- Establish baseline for numerator and denominator
  - P-3: Develop and test data systems
  - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
  - P-5 Disseminate findings, including lessons learned and best practices, to stakeholders

Outcome Improvement Targets for each year:

- DY 4:
  - IT 6.1: Rate 1: Improve patient satisfaction by 5 % over baseline scores for one domain of patient satisfaction
- DY 5:
  - IT 6.1: Rate 1: Improve patient satisfaction by 10 % over baseline scores for one domain of patient satisfaction

Rationale:

The Process milestones were chosen in order to develop a strong collaborative team approach between the clinical staff, administrators, physicians, Quality Improvement Department

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and the newly formed Outcome Management Department of MHMRA. By working through these process goals in order to develop and test a patient satisfaction measure suited for the particular program population, we will be more accurate in our assessment of the target outcome. Although MHMRA has attempted to measure patient satisfaction in the past, the instruments may not have been the most valid, empirically supported or may not have had national benchmarks for comparison. As part of DY 2 process goals, the Outcome Management department will complete literature reviews to identify relevant, empirically validated, and empirically based, measures for the identified outcomes and the targeted population (P-2 and P-3). With this information, the team will be able to select a measure to be piloted in DY 3. The procedures for testing data collection will be evaluated using the Plan Do Study Act (PDSA) cycles (P-4). The proposed timeline for the outcome measure of patient satisfaction includes determining a baseline for one or more of the following categories of patient satisfaction by DY 2:

31. Are getting timely care, appointments, and information
32. How well their doctors communicate
33. Patient's rating of doctor access to specialist
34. Patient's involvement in shared decision making
35. Patient's overall health status/functional status

From this baseline, the goals for improvement have been set at 5% and 10% in DY 4 and 5, respectively. After the results of DY 4 have been determined then another cycle of Plan Do Study Act (PDSA) can also be executed to determine the successes and the need for improvements in addressing patient satisfaction. This information can then be provided to clinic staff in order to produce the needed improvements.

Outcome Measure Valuation:

Our local region has identified a general objective and specific community needs that are related to transforming the current health care delivery system. The transformed system is proposed to be a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes. Based on this objective, the proposed program has identified OD-6, Patient Satisfaction, as a targeted outcome for quality improvement goal. It is hypothesized that patients will be better served when they can be offered a full array of services, i.e. when the menu of service options is not sharply curtailed by agency resource limitations. This better fit between patient needs and available services is likely to be reflected in more positive rapport and better perceived communication with treatment providers. Specifically, we believe patient satisfaction that addresses involvement in shared decision making, access to providers, and communication with providers, will reduce chronic over-use of psychiatric emergency services. If patients are dissatisfied with services or the process, they may continue to over-utilize emergency services rather than engaging in preventative care.

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113180703.3.11	IT-6.1	Percent improvement over baseline of patient satisfaction scores	
MHMRA of Harris County			113180703
Related Category 1 or 2:	113180703.2.4		
Starting Point/Baseline:	TBD YR 3		

Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Milestone 1: P 1: Project planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans **Metric 1**: Conduct meetings of stakeholders, project staff, RHP partners and other key parties to gather relevant information **Data Source:** Meetings minutes, project flow charts and timelines **Goal:** To integrate stakeholder input in development of program plan	**Milestone 6: P-1:** Project planning, engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans **Metric 6**: Conduct meetings of stakeholders, project staff, RHP partners and other key parties to gather relevant information **Data Source:** Meetings minutes, project flow charts and timelines **Goal:** To complete project planning process and implement	**Milestone 11: OD-6:** Patient Satisfaction **Metric 11**: **IT 6.1** Percent improvement over baseline of patient satisfaction scores a. Numerator: Percent improvement in targeted patient satisfaction domain b. Denominator: Number of patients who were administered the survey **Data Source**: Patient survey **Goal**: 5% increase over baseline	**Milestone 12: OD-6:** Patient Satisfaction **Metric 12: IT 6.1** Percent improvement over baseline of patient satisfaction scores a Numerator: Percent improvement in targeted patient satisfaction domain b Denominator: Number of patients who were administered the survey **Data Source:** Patient survey **Goal:** 10% increase in baseline
Estimated Incentive Payment: $2,817.04	**Estimated Incentive Payment: $6,537.73**	**Estimated Incentive Payment:$34,931.32**	**Estimated Incentive Payment: $75,937.64**

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113180703.3.11	IT-6.1	Percent improvement over baseline of patient satisfaction scores	
MHMRA of Harris County			113180703
Related Category 1 or 2:	113180703.2.4		
Starting Point/Baseline:	TBD YR 3		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Milestone 2: P-2: Establish baseline **Metric 2**: Identify domains of patient satisfaction to be measured **Data Source:** literature review **Goal:** determine how baseline will be established for patient satisfaction domain	**Milestone 7: P- 2:** Establish baseline **Metric 7**: Select and implement patient satisfaction survey to assess the desired domains of patient satisfaction **Data Source:** Clinical records; monthly management reports **Goal:** obtain baseline of satisfaction survey from patients receiving service	**N/A**	**N/A**
Estimated Incentive Payment: $2,817.04	**Estimated Incentive Payment: $6,537.73**	**N/A**	**N/A**

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113180703.3.11	IT-6.1	Percent improvement over baseline of patient satisfaction scores	
MHMRA of Harris County			113180703
Related Category 1 or 2:	113180703.2.4		
Starting Point/Baseline:	TBD YR 3		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Milestone 3 : P-3: Develop and test data systems **Metric 3**: Review satisfaction measures for use with the target population and their clinical teams **Data Source:** Project record—summary of reviews **Goal:** Identify/modify one instrument to test in Yr. 3	**Milestone 8: P-3:** Develop and test data systems **Metric 8**: Review satisfaction measures for use with the target population **Data Source:** Project record—summary of reviews, completed surveys **Goal:** Test and revise the selected instrument and/or process so that satisfaction baseline can be established by end of Yr. 3	**N/A**	**N/A**
Estimated Incentive Payment: $2,817.04	**Estimated Incentive Payment: $6,537.73**	**N/A**	**N/A**

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113180703.3.11	IT-6.1	Percent improvement over baseline of patient satisfaction scores	
MHMRA of Harris County			113180703
Related Category 1 or 2:	113180703.2.4		
Starting Point/Baseline:	TBD YR 3		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Milestone 4: P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities **Metric 4:** Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles **Data Source:** Project reports including examples of how real time data has been used to guide continuous quality improvement **Goal:** To improve processes and outcomes by implementing data-driven course corrections and innovations	**Milestone 9: P-4:** Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities **Metric 9:** Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles **Data Source:** Project reports including examples of how real time data has been used to guide continuous quality improvement **Goal:** To identify problems and make improvements in processes and outcomes by implementing data-driven course corrections and innovations	**N/A**	**N/A**
Estimated Incentive Payment: $2,817.04	**Estimated Incentive Payment: $6,537.73**	**N/A**	**N/A**

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<table>
<tr><td>113180703.3.11</td><td>IT-6.1</td><td colspan="2">Percent improvement over baseline of patient satisfaction scores</td></tr>
<tr><td colspan="3">MHMRA of Harris County</td><td>113180703</td></tr>
<tr><td>Related Category 1 or 2:</td><td colspan="3">113180703.2.4</td></tr>
<tr><td>Starting Point/Baseline:</td><td colspan="3">TBD YR 3</td></tr>
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(10/1/2012 – 9/30/2013)</td><td>Year 3

(10/1/2013 – 9/30/2014)</td><td>Year 4

(10/1/2014 – 9/30/2015)</td><td>Year 5

(10/1/2015 – 9/30/2016)</td></tr>
<tr><td>Milestone 5: P-5 Disseminate findings, including lessons learned and best practices, to stakeholders

Metric 5: Report status, progress and lessons learned to stakeholders

Data Source: management team minutes, RHP collaborations

Goal: To disseminate information about the project and solicit input from stakeholders</td><td>Milestone 10: P-5: Disseminate findings to stakeholders

Metric 10: Report status, progress and lessons learned to stakeholders

Data Source: management team minutes, RHP collaborations

Goal: To disseminate information about the project and solicit input from stakeholders</td><td>N/A</td><td>N/A</td></tr>
<tr><td>Estimated Incentive Payment: $2,817.05</td><td>Estimated Incentive Payment: $6,537.73</td><td>N/A</td><td>N/A</td></tr>
<tr><td>Year 2 Estimated Outcome Amount: $14,085.21</td><td>Year 3 Estimated Outcome Amount: $32,688.65</td><td>Year 4 Estimated Outcome Amount: $34,931.32</td><td>Year 5 Estimated Outcome Amount: $75,937.64</td></tr>
<tr><td colspan="4">TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $157,642.82</td></tr>
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References

Karow, A., Reimer, J., König, H., Heider, D., Bock, T., & Huber, C., Schöttle, D., Meister, K., Rietschel, L., Ohm, G., Schulz, H., Naber, D., Schimmelmann, B., & Lambert, M. (2012). Cost-effectiveness of 12-month therapeutic assertive community treatment as part of integrated care versus standard care in patients with schizophrenia treated with quetiapine immediate release. *The Journal of Clinical Psychiatry, 73,* e402-e408.

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Title of Outcome Measure (Improvement Target): IT-6.1: Percent improvement over baseline of patient satisfaction scores

Unique RHP outcome identification numbers: 113180703.3.12

Outcome Measure Description:

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

- Numerator: Percent improvement in targeted patient satisfaction domain
- Denominator: Number of patients who were administered the survey

Process Milestones:

- DY 2:
  - P-1- Project planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2- Establish baseline for patients served
  - P-3: Develop and test data systems
  - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
  - P-5 Disseminate findings, including lessons learned and best practices, to stakeholders
- DY 3:
  - P-1- Project planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2- Establish baseline for numerator and denominator
  - P-3: Develop and test data systems
  - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
  - P-5 Disseminate findings, including lessons learned and best practices, to stakeholders

Outcome Improvement Targets for each year:

- DY 4:
  - IT 6.1: Rate 1: Improve patient satisfaction by 5 % over baseline scores for one domain of patient satisfaction
- DY 5:
  - IT 6.1: Rate 1: Improve patient satisfaction by 10 % over baseline scores for one domain of patient satisfaction

Rationale:

The Process milestones were chosen in order to develop a strong collaborative team approach between the clinical staff, administrators, physicians, Quality Improvement Department

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and the newly formed Outcome Management Department of MHMRA. By working through these process goals in order to develop and test a patient satisfaction measure suited for the particular program population, we will be more accurate in our assessment of the target outcome. Although MHMRA has attempted to measure patient satisfaction in the past, the instruments may not have been the most valid, empirically supported or may not have had national benchmarks for comparison. As part of DY 2 process goals, the Outcome Management department will complete literature reviews to identify relevant, empirically validated, and empirically based, measures for the identified outcomes and the targeted population (P-2 and P-3). With this information, the team will be able to select a measure to be piloted in DY 3. The procedures for testing data collection will be evaluated using the Plan Do Study Act (PDSA) cycles (P-4). The proposed timeline for the outcome measure of patient satisfaction includes determining a baseline for one or more of the following categories of patient satisfaction by DY 2:

36. Are getting timely care, appointments, and information
37. How well their doctors communicate
38. Patient's rating of doctor access to specialist
39. Patient's involvement in shared decision making
40. Patient's overall health status/functional status

From this baseline, the goals for improvement have been set at 5% and 10% in DY 4 and 5, respectively. After the results of DY 4 have been determined then another cycle of Plan Do Study Act (PDSA) can also be executed to determine the successes and the need for improvements in addressing patient satisfaction. This information can then be provided to clinic staff in order to produce the needed improvements.

Outcome Measure Valuation:

Our local region has identified a general objective and specific community needs that are related to transforming the current health care delivery system. The transformed system is proposed to be a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes. Based on this objective, the proposed program has identified OD-6, Patient Satisfaction, as a targeted outcome for quality improvement goal. It is hypothesized that patients will be better served when they can be offered a full array of services, i.e. when the menu of service options is not sharply curtailed by agency resource limitations. This better fit between patient needs and available services is likely to be reflected in more positive rapport and better perceived communication with treatment providers. Specifically, we believe patient satisfaction that addresses involvement in shared decision making, access to providers, and communication with providers, will reduce chronic over-use of psychiatric emergency services. If patients are dissatisfied with services or the process, they may continue to over-utilize emergency services rather than engaging in preventative care.

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113180703.3.12	IT-6.1	Percent improvement over baseline of patient satisfaction scores	
MHMRA of Harris County			113180703
Related Category 1 or 2:	113180703.2.5		
Starting Point/Baseline:	TBD YR 3		

Year 2 (10/1/2012 – 9/30/2013)	**Year 3** (10/1/2013 – 9/30/2014)	**Year 4** (10/1/2014 – 9/30/2015)	**Year 5** (10/1/2015 – 9/30/2016)
Milestone 1–P 1: Project planning-engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans **Metric 1**: Conduct meetings of stakeholders, project staff, RHP partners and other key parties to gather relevant information **Data Source:** Meetings minutes, project flow charts and timelines **Goal:** To integrate stakeholder input in development of program plan	**Milestone 6: P-1:** Project planning, engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans **Metric 6**: Conduct meetings of stakeholders, project staff, RHP partners and other key parties to gather relevant information **Data Source:** Meetings minutes, project flow charts and timelines **Goal:** To complete project planning process and implement	**Milestone 11: OD-6:** Patient Satisfaction **Metric 11: IT 6.1:** Percent improvement over baseline of patient satisfaction scores for one domain of patient satisfaction. a. Numerator: Percent improvement in targeted patient satisfaction domain b. Denominator: Number of patients who were administered the survey **Data Source**: Patient survey **Goal**: 5% increase over baseline	**Milestone 12: OD-6:** Patient Satisfaction **Metric 12: IT 6.1** Percent improvement over baseline of patient satisfaction scores for one domain of patient satisfaction. a Numerator: Percent improvement in targeted patient satisfaction domain b Denominator: Number of patients who were administered the survey **Data Source:** Patient survey **Goal:** 10% increase in baseline
Estimated Incentive Payment: $28,504.45	**Estimated Incentive Payment: $66,152.53**	**Estimated Incentive Payment: $353,455.30**	**Estimated Incentive Payment: $768,381.08**

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113180703.3.12	IT-6.1	Percent improvement over baseline of patient satisfaction scores	
MHMRA of Harris County			113180703
Related Category 1 or 2:	113180703.2.5		
Starting Point/Baseline:	TBD YR 3		

Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Milestone 2: P-2: Establish baseline **Metric 2**: Identify domains of patient satisfaction to be measured **Data Source:** literature review **Goal:** determine how baseline will be established for patient satisfaction domain	**Milestone 7: P- 2:** Establish baseline **Metric 7**: Select and implement patient satisfaction survey to assess the desired domains of patient satisfaction **Data Source:** Clinical records; monthly management reports **Goal:** obtain baseline of satisfaction survey from patients receiving service	N/A	N/A
Estimated Incentive Payment: $28,504.46	**Estimated Incentive Payment: $66,152.53**	**N/A**	**N/A**

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113180703.3.12	IT-6.1	Percent improvement over baseline of patient satisfaction scores	
MHMRA of Harris County			113180703
Related Category 1 or 2:	113180703.2.5		
Starting Point/Baseline:	TBD YR 3		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Milestone 3 : P-3: Develop and test data systems **Metric 3**: Review satisfaction measures for use with the target population and their clinical teams **Data Source:** Project record—summary of reviews **Goal:** Identify/modify one instrument to test in Yr. 3	**Milestone 8: P-3:** Develop and test data systems **Metric 8**: Review satisfaction measures for use with the target population **Data Source:** Project record—summary of reviews, completed surveys **Goal:** Test and revise the selected instrument and/or process so that satisfaction baseline can be established by end of Yr. 3	N/A	N/A
Estimated Incentive Payment: $28,504.46	**Estimated Incentive Payment: $66,152.54**	**N/A**	**N/A**

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113180703.3.12	IT-6.1	Percent improvement over baseline of patient satisfaction scores	
MHMRA of Harris County			113180703
Related Category 1 or 2:	113180703.2.5		
Starting Point/Baseline:	TBD YR 3		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3** (10/1/2013 – 9/30/2014)	**Year 4** (10/1/2014 – 9/30/2015)	**Year 5** (10/1/2015 – 9/30/2016)
Milestone 4: P.4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities **Metric 4:** Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles **Data Source:** Project reports including examples of how real time data has been used to guide continuous quality improvement **Goal:** To improve processes and outcomes by implementing data-driven course corrections and innovations	**Milestone 9: P-4:** Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities **Metric 9:** Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles **Data Source:** Project reports **Goal:** To identify problems and make improvements in processes and outcomes by implementing data-driven course corrections and innovations	N/A	N/A
Estimated Incentive Payment: $28,504.46	**Estimated Incentive Payment: $66,152.54**	**N/A**	**N/A**

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113180703.3.12	IT-6.1	Percent improvement over baseline of patient satisfaction scores	
MHMRA of Harris County			113180703
Related Category 1 or 2:	113180703.2.5		
Starting Point/Baseline:	TBD YR 3		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Milestone 5: P-5: Disseminate findings, including lessons learned and best practices, to stakeholders **Metric 5:** Report status, progress and lessons learned to stakeholders **Data Source:** management team minutes, RHP collaborations **Goal:** To disseminate information about the project and solicit input from stakeholders	**Milestone 10: P-5:** Disseminate findings to stakeholders **Metric 10**: Report status, progress and lessons learned to stakeholders **Data Source:** management team minutes, RHP collaborations **Goal:** To disseminate information about the project and solicit input from stakeholders	N/A	N/A
Estimated Incentive Payment: $28,504.46	**Estimated Incentive Payment: $66,152.54**	**N/A**	**N/A**
Year 2 Estimated Outcome Amount: $142,522.29	**Year 3 Estimated Outcome Amount: $330,762.68**	**Year 4 Estimated Outcome Amount:$353,455.30**	**Year 5 Estimated Outcome Amount: $768,381.08**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*:* $1,595,121.35			

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Scott, R. (2000). Evaluation of a mobile crisis program: Effectiveness, efficiency, and consumer satisfaction. *Psychiatric Services, 51*, 1153-1156.

Hugo, M., Smout, M. & Bannister, J. (2002). A comparison in hospitalization rates between a community-based mobile emergency service and a hospital-based emergency service. *Australian & New Zealand Journal of Psychiatry, 36*, 504-508.

Hickey, S., Strang, S., & Cantu, A. (2012). *Psychiatric emergency service use among MHMRA of Harris County consumers.* Presentation to the Board of Directors at MHMRA, Houston, Texas.

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Title of Outcome Measure (Improvement Target): IT-6.1: Percent improvement over baseline of patient satisfaction scores

Unique RHP outcome identification numbers: 113180703.3.13

Outcome Measure Description:

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

- Numerator: Percent improvement in targeted patient satisfaction domain
- Denominator: Number of patients who were administered the survey

Process Milestones:

- DY 2:
  - P-1- Project planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2- Establish baseline for patients served
  - P-3: Develop and test data systems
  - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
  - P-5 Disseminate findings, including lessons learned and best practices, to stakeholders
- DY 3:
  - P-1- Project planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2- Establish baseline for numerator and denominator
  - P-3: Develop and test data systems
  - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
  - P-5 Disseminate findings, including lessons learned and best practices, to stakeholders

Outcome Improvement Targets for each year:

- DY 4:
  - IT 6.1: Rate 1: Improve patient satisfaction by 5 % over baseline scores for one domain of patient satisfaction
- DY 5:
  - IT 6.1: Rate 1: Improve patient satisfaction by 10 % over baseline scores for one domain of patient satisfaction

Rationale:

The Process milestones were chosen in order to develop a strong collaborative team approach between the clinical staff, administrators, physicians, Quality Improvement Department and the newly formed Outcome Management Department of MHMRA. By working through these process goals in order to develop and test a patient satisfaction measure suited for the particular program population, we will be more accurate in our assessment of the target outcome. Although MHMRA has attempted to measure patient satisfaction in the past, the instruments may not have been the most valid, empirically supported or may not have had national benchmarks for comparison. As part of DY 2 process goals, the Outcome Management department will complete literature reviews to identify relevant, empirically validated, and

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empirically based, measures for the identified outcomes and the targeted population (P-2 and P-3). With this information, the team will be able to select a measure to be piloted in DY 3. The procedures for testing data collection will be evaluated using the Plan Do Study Act (PDSA) cycles (P-4). The proposed timeline for the outcome measure of patient satisfaction includes determining a baseline for one or more of the following categories of patient satisfaction by DY 2:

41. Are getting timely care, appointments, and information
42. How well their doctors communicate
43. Patient's rating of doctor access to specialist
44. Patient's involvement in shared decision making
45. Patient's overall health status/functional status

From this baseline, the goals for improvement have been set at 5% and 10% in DY 4 and 5, respectively. After the results of DY 4 have been determined then another cycle of Plan Do Study Act (PDSA) can also be executed to determine the successes and the need for improvements in addressing patient satisfaction. This information can then be provided to clinic staff in order to produce the needed improvements.

Outcome Measure Valuation:

Our local region has identified a general objective and specific community needs that are related to transforming the current health care delivery system. The transformed system is proposed to be a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes. Based on this objective, the proposed program has identified OD-6, Patient Satisfaction, as a targeted outcome for quality improvement goal. It is hypothesized that patients will be better served when they can be offered a full array of services, i.e. when the menu of service options is not sharply curtailed by agency resource limitations. This better fit between patient needs and available services is likely to be reflected in more positive rapport and better perceived communication with treatment providers. Specifically, we believe patient satisfaction that addresses involvement in shared decision making, access to providers, and communication with providers, will reduce chronic over-use of psychiatric emergency services. If patients are dissatisfied with services or the process, they may continue to over-utilize emergency services rather than engaging in preventative care.

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113180703.3.13	IT-6.1	Percent improvement over baseline of patient satisfaction scores	
MHMRA of Harris County			113180703
Related Category 1 or 2:	113180703.2.6		
Starting Point/Baseline:	TBD YR 3		
Year 2	**Year 3**	**Year 4**	**Year 5**
(10/1/2012 – 9/30/2013)	**(10/1/2013 – 9/30/2014)**	**(10/1/2014 – 9/30/2015)**	**(10/1/2015 – 9/30/2016)**
Milestone 1: P-1: Project planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans **Metric 1**: Conduct meetings of stakeholders, project staff, RHP partners and other key parties to gather relevant information **Data Source:** Meetings minutes, project flow charts and timelines **Goal:** To gather information that guides project activities toward completion of milestones, while integrating stakeholder input in a meaningful way	**Milestone 6: P-1:** Project planning, engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans **Metric 6**: Conduct meetings of stakeholders, project staff, RHP partners and other key parties to gather relevant information **Data Source:** Meetings minutes, project flow charts and timelines **Goal:** To complete project planning process and implement plans	**Milestone 11: OD-6:** Patient Satisfaction **Metric 11: IT 6.1** Percent improvement over baseline of patient satisfaction scores a. Numerator: Percent improvement in targeted patient satisfaction domain b. Denominator: Number of patients who were administered the survey **Data Source:** Patient survey **Goal:** 5% increase over baseline	**Milestone 12: OD-6:** Patient Satisfaction **Metric 12: IT 6.1** Percent improvement over baseline of patient satisfaction scores a Numerator: Percent improvement in targeted patient satisfaction domain b Denominator: Number of patients who were administered the survey **Data Source:** Patient survey **Goal:** 10% increase in baseline
Estimated Incentive Payment: $33,956.32	**Estimated Incentive Payment: $78,805.12**	**Estimated Incentive Payment: $421,058.58**	**Estimated Incentive Payment: $915,344.73**
Milestone 2: P-2: Establish baseline **Metric 2**: Identify domains of patient satisfaction to be measured **Data Source:** literature review **Goal:** determine how baseline will be established for patient satisfaction domain	**Milestone 7: P- 2:** Establish baseline **Metric 7**: Select and implement patient satisfaction survey to assess the desired domains of patient satisfaction **Data Source:** Clinical records; monthly management reports **Goal:** obtain baseline of satisfaction survey from patients receiving service	**N/A**	**N/A**

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113180703.3.13	IT-6.1	Percent improvement over baseline of patient satisfaction scores	
MHMRA of Harris County			113180703
Related Category 1 or 2:	113180703.2.6		
Starting Point/Baseline:	TBD YR 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)**
Estimated Incentive Payment: $33,956.34	**Estimated Incentive Payment: $78,805.14**	**N/A**	**N/A**
Milestone 3 : P-3: Develop and test data systems **Metric 3**: Review satisfaction measures for use with the target population and their clinical teams**Data Source:** Project record—summary of reviews **Goal:** Identify/modify one instrument to test in Yr. 3	**Milestone 8: P-3:** Develop and test data systems **Metric 8**: Review satisfaction measures for use with the target population**Data Source:** Project record—summary of reviews, completed surveys **Goal:** Test and revise the selected instrument and/or process so that satisfaction baseline can be established by end of Yr. 3	**N/A**	**N/A**
Estimated Incentive Payment: $33,956.34	**Estimated Incentive Payment: $78,805.14**	**N/A**	**N/A**

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113180703.3.13	IT-6.1	Percent improvement over baseline of patient satisfaction scores	
MHMRA of Harris County			113180703
Related Category 1 or 2:	113180703.2.6		
Starting Point/Baseline:	TBD YR 3		

Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Milestone 4: P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities **Metric 4:** Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles **Data Source:** Project reports including examples of how real time data has been used to guide continuous quality improvement **Goal:** To improve processes and outcomes by implementing data-driven course corrections and innovations	**Milestone 9: P-9:** Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities **Metric 9:** Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles **Data Source:** Project reports including examples of how real time data has been used to guide continuous quality improvement **Goal:** To identify problems and make improvements in processes and outcomes by implementing data-driven course corrections and innovations	**N/A**	**N/A**
Estimated Incentive Payment: $33,956.34	**Estimated Incentive Payment: $78,805.14**	**N/A**	**N/A**

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113180703.3.13	IT-6.1	Percent improvement over baseline of patient satisfaction scores	
MHMRA of Harris County			113180703
Related Category 1 or 2:	113180703.2.6		
Starting Point/Baseline:	TBD YR 3		

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 5: P-5 Disseminate findings, including lessons learned and best practices, to stakeholders **Metric 5:** Report status, progress and lessons learned to stakeholders **Data Source:** management team minutes, RHP collaborations **Goal:** To disseminate information about the project and solicit input from stakeholders representing consumers, families, public agencies and private providers	**Milestone 10: P-5:** Disseminate findings, including lessons learned and best practices, to stakeholders **Metric 10**: Report status, progress and lessons learned to stakeholders **Data Source:** management team minutes, RHP collaborations **Goal:** To disseminate information about the project and solicit input from stakeholders representing consumers, families, public agencies and private providers	N/A	N/A
Estimated Incentive Payment: $33,956.34	**Estimated Incentive Payment: $78,805.14**	**N/A**	**N/A**
Year 2 Estimated Outcome Amount: $169,781.68	**Year 3 Estimated Outcome Amount: $394,025.68**	**Year 4 Estimated Outcome Amount: $421,058.58**	**Year 5 Estimated Outcome Amount: $915,344.73**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $1,900,210.67			

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Travis, J., Solomon, A. & Waul, M. (2001) From prison to home: The dimensions and consequences of prisoner reentry. *The Urban Institute, 1-64.*

Title of Outcome Measure (Improvement Target): IT-9.1 Decrease in mental health admissions and readmissions to criminal justice settings

Unique RHP outcome identification numbers: 113180703.3.14

Outcome Measure Description:

IT-9.1 Decrease in mental health admissions and readmissions to criminal justice settings

- The number of individuals receiving CIRT intervention who had a potentially preventable admission/readmission to a criminal justice setting during the demonstration years

Process Milestones:

- DY 2:
  - P-1- Project planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2- Establish baselines for patients served
  - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
  - P-5 Disseminate findings, including lessons learned and best practices, to stakeholders
- DY 3:
  - P-2- Establish baseline for numerator and denominator
  - P-3: Develop and test data systems
  - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
  - P-5 Disseminate findings, including lessons learned and best practices, to stakeholders

Outcome Improvement Targets for each year:

- DY 4:
  - IT-9.1: Decrease in the number of individuals receiving CIRT intervention who had a potentially preventable admission/readmission to a criminal justice setting during the demonstration years by 5% from baseline
- DY 5:
  - IT-9.1: Decrease in the number of individuals receiving CIRT intervention who had a potentially preventable admission/readmission to a criminal justice setting during the demonstration years by 10% from baseline

Rationale:

The Process milestones were chosen as stated above in order to develop a strong collaborative team approach between the clinical staff, administrators, stake-holders, law-enforcement officers, Quality Improvement Department and the newly formed Outcome

Management Department of MHMRA. The first steps in DY 2 will be project planning (P-1) then establishment of baselines (P-2) for the number of CIRT interventions and the number of arrests. The procedures for testing data collection will be evaluated using the Plan Do Study Act (PDSA) cycles (P-4). In DY 3 a similar process will provide for accurate measurement of baselines from which to measure the success of the CIRT intervention. In particular, we chose to add Process milestone P-3 Develop and test data systems in order to determine any new systemic changes in data collection that the collaborations may have allowed for that may not have been available in DY2.

We hope that the ratio of arrests to intervention will decrease as CIRT teams and officers have more experience working collaboratively. At this time, we are not selecting a specific metric or percent of expected change. The rationale for determining this rate at a later time is that the base rate of arrests is expected to be low and the percent of change will need to appropriately reflect meaningful changes in arrests. CIRT administrators and stakeholders will work in conjunction with the MHMRA Outcomes Department and the MHMRA Quality Improvement Department to determine an appropriate rate of change.

Once initial rates of change in DY 4 have been determined another cycle of Plan Do Study Act (PDSA) can also be executed to determine the successes and the need for improvements in reducing preventable mental health admissions and readmissions to criminal justice settings. This information can then be provided to clinic staff in order to produce the needed improvements.

Outcome Measure Valuation:

We have selected preventable mental health admissions/readmissions to criminal justice setting as a measure because many of the recipients of CIRT have a history of arrests and emergency calls to law enforcement. Without CIRT, these calls would traditionally result in the dispatch of a law enforcement officer with limited mental health training/experience. Research has indicated non-trained officers may be more likely to arrest mentally ill patients, or interpret their behaviors as threatening, compared to trained officers. Therefore, we believe that the CIRT expansion will result in better assessment and management of these individuals, which would result in fewer and more appropriate arrests. In recent surveys it has been noted that 25% of the inmates in Harris County Jail are receiving psychotropic medications. Further, more than 16% have histories of treatment within the public mental health system. In many instances, it appear likely that individuals with mental disorders are arrested and jailed at significant public expense when appropriate crisis-oriented mental health care could potentially avert criminalization of episodes of untreated mental disorder. It is also important to note that all patients have a right to be treated in the least-restrictive environment possible; ending interventions without detention ensure patients' rights are respected and community treatment is more likely.

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113180703.3.14	IT-9.1	Decrease in mental health admissions and readmissions to criminal justice settings	
MHMRA of Harris County			113180703
Related Category 1 or 2:	113180703.2.7		
Starting Point/Baseline:	TBD YR 3		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Milestone 1: P-1: Project planning engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans **Metric 1: P-1**: Conduct meetings of stakeholders, project staff, RHP partners and other key parties to gather relevant information **Data Source:** Meetings minutes and timelines **Goal**: To gather information that guides project activities toward completion of milestones, while integrating stakeholder input in a meaningful way	**Milestone 5**: P-2: Establish Baselines **Metric 5: P-2**: Percent of arrests per consumer pre/post CIRT intervention a. Numerator: The number of arrests per year per consumer after receiving CIRT intervention. b Denominator: The number of arrests per year per consumer before receiving CIRT intervention Data Sources: MHMRA and police records **Goal:** Establish baseline	**Milestone 9: OD-9:** Right Care, Right Setting **Metric 9: IT-9.1:** Decrease in criminal justice arrests a. Numerator: The number of arrests per year per consumer after receiving CIRT intervention. b Denominator: The number of arrests per year per consumer before receiving CIRT intervention **Data Sources:** MHMRA and police records **Goal:** 5% reduction in arrests from baseline	**Milestone 10: OD-9:** Right Care, Right Setting **Metric 10: IT-9.1:** Decrease in criminal justice arrests a. Numerator: The number of arrests per year per consumer after receiving CIRT intervention. b Denominator: The number of arrests per year per consumer before receiving CIRT intervention **Data Sources:** MHMRA and police records **Goal:** 10% reduction in arrests from baseline
Estimated Incentive Payment: $21,525.67	**Estimated Incentive Payment: $49,956.30**	**Estimated Incentive Payment: $213,534.61**	**Estimated Incentive Payment: $464,205.68**

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113180703.3.14	IT-9.1	Decrease in mental health admissions and readmissions to criminal justice settings	
MHMRA of Harris County			113180703
Related Category 1 or 2:	113180703.2.7		
Starting Point/Baseline:	TBD YR 3		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Milestone 2: P-3: Develop and test data systems **Metric 2: P-3**: Develop and test systems to track baseline data for CIRT **Data Source:** Meeting minutes **Goal:** Establish method to track CIRT data across multiple organizations (e.g., MHMRA and police departments)	**Milestone 6:** P-3 Develop and test data systems **Metric 6:** establish and test data collection protocol incorporating available law enforcement data **Data Source:** Law enforcement partners, project records **Goal:** Test and revise data collection system in order to measure of baseline by end of Yr. 3	**N/A**	**N/A**
Estimated Incentive Payment: $21,525.67	**Estimated Incentive Payment: $49,956.30**	**N/A**	**N/A**

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<table>
<tr><td>113180703.3.14</td><td>IT-9.1</td><td colspan="2">Decrease in mental health admissions and readmissions to criminal justice settings</td></tr>
<tr><td colspan="3">MHMRA of Harris County</td><td>113180703</td></tr>
<tr><td>Related Category 1 or 2:</td><td colspan="3">113180703.2.7</td></tr>
<tr><td>Starting Point/Baseline:</td><td colspan="3">TBD YR 3</td></tr>
<tr><th>Year 2

(10/1/2012 – 9/30/2013)</th><th>Year 3

(10/1/2013 – 9/30/2014)</th><th>Year 4

(10/1/2014 – 9/30/2015)</th><th>Year 5

(10/1/2015 – 9/30/2016)</th></tr>
<tr><td>Milestone 3: P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities

Metric 3: P-4: Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles

Data Source: Project reports and Meeting minutes

Goal: To improve processes and outcomes by implementing data-driven course corrections and innovations</td><td>Milestone 7: P.4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities

Metric 7: P-4: Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles

Data Source: Project reports and meeting minutes

Goal: To improve processes and outcomes by implementing data-driven course corrections and innovations</td><td>N/A</td><td>N/A</td></tr>
<tr><td>Estimated Incentive Payment: $21,525.66</td><td>Estimated Incentive Payment: $49,956.30</td><td>N/A</td><td>N/A</td></tr>
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113180703.3.14	IT-9.1	Decrease in mental health admissions and readmissions to criminal justice settings	
MHMRA of Harris County		113180703	
Related Category 1 or 2:	113180703.2.7		
Starting Point/Baseline:	TBD YR 3		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Milestone 4: P-5: Disseminate findings, lessons learned, and best practices, to stakeholders **Metric 4: P-5**: Report status, progress and lessons learned to stakeholders **Data Source:** Meeting minutes **Goal:** To disseminate information about the project and solicit input from stakeholders representing consumers, families, public agencies and private providers	**Milestone 8: P-5:** Disseminate findings, lessons learned and best practices to stakeholders **Metric 8: P-5:** Report status, progress and lessons learned to stakeholders **Data Source:** Meeting minutes **Goal:** To disseminate information about the project and solicit input from stakeholders representing consumers, families, public agencies and private providers	**N/A**	**N/A**
Estimated Incentive Payment: $21,525.66	**Estimated Incentive Payment: $49,956.31**	**N/A**	**N/A**
Year 2 Estimated Outcome Amount: $86,102.66	**Year 3 Estimated Outcome Amount: $199,825.21**	**Year 4 Estimated Outcome Amount: $213,534.61**	**Year 5 Estimated Outcome Amount: $464,205.68**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5): $963,668.17			

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Mental Health and Mental Retardation Authority of Harris County

Pass 2

DRAFT

Title of Outcome Measure (Improvement Target): IT-6.1: Percent improvement over baseline of patient satisfaction scores

Unique RHP outcome identification number: 113180703.3.15 / Pass 2

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

- Numerator: Percent improvement in targeted patient satisfaction domain
- Denominator: Number of patients who were administered the survey

Process Milestones:

- DY 2:
  - P-1- Project planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2- Establish baseline for patients served
  - P-3: Develop and test data systems
  - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
  - P-5 Disseminate findings, including lessons learned and best practices, to stakeholders
- DY 3:
  - P-1- Project planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2- Establish baseline for numerator and denominator
  - P-3: Develop and test data systems
  - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
  - P-5 Disseminate findings, including lessons learned and best practices, to stakeholders

Outcome Improvement Targets for each year:

- DY 4:
  - IT 6.1: Rate 1: Improve patient satisfaction by 5 % over baseline scores for one domain of patient satisfaction
- DY 5:
  - IT 6.1: Rate 1: Improve patient satisfaction by 10 % over baseline scores for one domain of patient satisfaction

Rationale: Measurement of patient satisfaction is a key indicator of patient-centered care and has been targeted as a quality indicator by national organizations dedicated to improvement in patient outcomes, e.g. the National Council for Quality Assurance. The Consumer Assessment

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of Healthcare providers and Systems(CAHPS) Survey, for instance, is one of the few indicators from among the set of 2013 HEDIS measures applicable to mental health treatment programs.

Patient satisfaction measures offer advantages associated with sound psychometrics including reliability as measurement tools, and sensitivity to change. Published scales are available in multiple languages (an essential feature in Harris County's multi-cultural environment) and have established validity as reflected in documented relationships between satisfaction scale scores and aspects of both clinical process and outcome measures (e.g adherence to treatment recommendations, retention in treatment, improvement in symptom and functional status). Finally, external norms and benchmarks are available for comparative purposes, reducing the uncertainty sometimes associated with program evaluations.

The process milestones were chosen in order to develop a strong collaborative team approach between the clinical staff, administrators, physicians, Quality Improvement Department and the newly formed Outcome Management Department of MHMRA. By working through these process goals in order to develop and test a patient satisfaction measure suited for the particular program population, we will be more accurate in our assessment of the target outcome. As part of DY 2 process goals, the Outcome Management department will complete literature reviews to identify relevant, empirically validated, and empirically based, measures for the identified outcomes and the targeted population (P-2 and P-3). With this information, the team will be able to select a measure to be piloted in DY 3. The procedures for testing data collection will be evaluated using the Plan Do Study Act (PDSA) cycles (P-4). The proposed timeline for the outcome measure of patient satisfaction includes determining a baseline for one or more of the following categories of patient satisfaction by DY 2:

46. Are getting timely care, appointments, and information
47. How well their doctors communicate
48. Patient's rating of doctor access to specialist
49. Patient's involvement in shared decision making
50. Patient's overall health status/functional status

From this baseline, the goals for improvement have been set at 5% and 10% in DY 4 and 5, respectively. After the results of DY 4 have been determined then another cycle of Plan Do Study Act (PDSA) can also be executed to determine the successes and the need for improvements in addressing patient satisfaction. This information can then be provided to clinic staff in order to produce the needed improvements.

Outcome Measure Valuation: Our local region has identified a general objective and specific community needs that are related to transforming the current health care delivery system. The transformed system is proposed to be a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes. Based on this objective, the proposed program has identified OD-6, Patient Satisfaction, as a targeted outcome for quality

improvement goal. It is hypothesized that patients will be better served when they can be offered a full array of services, i.e. when the menu of service options is not sharply curtailed by agency resource limitations. This better fit between patient needs and available services is likely to be reflected in more positive rapport and better perceived communication with treatment providers. Specifically, we believe patient satisfaction that addresses involvement in shared decision making, access to providers, and communication with providers, will reduce chronic over-use of psychiatric emergency services. If patients are dissatisfied with services or the process, they may continue to over-utilize emergency services rather than engaging in preventative care. Since patient satisfaction is proposed as a "stand-alone" measure, it is, by definition, valued at 100% of the Category 3 allocation for this proposed program.

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113180703.3.15	RHP PP Reference Number: IT-6.1	Outcome Measure: Percent improvement over baseline of patient satisfaction scores	
RHP Performing Provider - MHMRA of Harris County		**TPI: 113180703**	
Related Category 1 or 2: 2.13	**Unique Category 1 or 2 project identifiers: 113180703.1.8**		
Starting Point/Baseline: TBD YR 3			
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1: P-1: Project planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans **Metric 1**: Conduct meetings of stakeholders, project staff, RHP partners and other key parties to gather relevant information **Data Source:** Meetings minutes, project flow charts and timelines **Goal:** To gather information that guides project activities toward completion of milestones, while integrating stakeholder input in a meaningful way	**Milestone 6: P-1:** Project planning, engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans **Metric 6**: Conduct meetings of stakeholders, project staff, RHP partners and other key parties to gather relevant information **Data Source:** Meetings minutes, project flow charts and timelines **Goal:** To complete project planning process and implement	**Milestone 11:** OD-6: Patient Satisfaction **Metric 11:** IT 6.1: Percent improvement over baseline of patient satisfaction scores for one domain of patient satisfaction. a. Numerator: Average current score minus average baseline score. b. Denominator: Average baseline score **Data Source:** Patient survey **Goal:** 5% increase over baseline	**Milestone 12: OD-6:** Patient Satisfaction **Metric 12: IT 6.1** Percent improvement over baseline of patient satisfaction scores for one domain of patient satisfaction. a. Numerator: Average current score minus average baseline score. b. Denominator: Average baseline score **Data Source:** Patient survey **Goal:** 10% increase in baseline
Estimated Incentive Payment:	**Estimated Incentive Payment:**	**Estimated Incentive Payment:**	**Estimated Incentive Payment:**
$29,343.00	**$69,523.06**	**$376,168.51**	**$814,862.73**
Milestone 2: P-2: Establish baseline **Metric 2**: Identify domains of patient satisfaction to be measured **Data Source:** literature review **Goal:** determine how baseline will be established for patient satisfaction domain	**Milestone 7: P- 2:** Establish baseline**Metric 7**: Select and implement patient satisfaction survey to assess the desired domains of patient satisfaction **Data Source:** Clinical records; monthly management reports **Goal:** obtain baseline of satisfaction survey from patients receiving service	**N/A**	**N/A**

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113180703.3.15	RHP PP Reference Number: IT-6.1	Outcome Measure: Percent improvement over baseline of patient satisfaction scores	
RHP Performing Provider - MHMRA of Harris County			TPI: 113180703
Related Category 1 or 2: 2.13	Unique Category 1 or 2 project identifiers: 113180703.1.8		
Starting Point/Baseline: TBD YR 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)**
Estimated Incentive Payment:	**Estimated Incentive Payment:**	**N/A**	**N/A**
$29,343.00	**$69,523.06**	**N/A**	**N/A**
Milestone 3 : P-3: Develop and test data systems **Metric 3**: Review satisfaction measures for use with the target population and their clinical teams **Data Source:** Project record—summary of reviews**Goal:** Identify/modify one instrument to test in Yr. 3	**Milestone 8: P-3:** Develop and test data systems **Metric 8**: Review satisfaction measures for use with the target population **Data Source:** Project record—summary of reviews, completed surveys **Goal:** Test and revise the selected instrument and/or process to enable measure of baseline by end of Yr. 3	**N/A**	**N/A**
Estimated Incentive Payment:	**Estimated Incentive Payment:**	**N/A**	**N/A**
$29,343.00	**$69,523.06**	**N/A**	**N/A**

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113180703.3.15	RHP PP Reference Number: IT-6.1	Outcome Measure: Percent improvement over baseline of patient satisfaction scores	
RHP Performing Provider - MHMRA of Harris County		**TPI: 113180703**	
Related Category 1 or 2: 2.13	**Unique Category 1 or 2 project identifiers: 113180703.1.8**		
Starting Point/Baseline: TBD YR 3			
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 4: P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities **Metric 4:** Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles **Data Source:** Project reports, QI reports **Goal:** To improve processes and outcomes by implementing data-driven course corrections and innovations	**Milestone 9: P-4:** Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities **Metric 9:** Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles **Data Source:** Project reports, QI reports **Goal:** To identify problems and make improvements in processes and outcomes by implementing data-driven course corrections and innovations	**N/A**	**N/A**
Estimated Incentive Payment:	**Estimated Incentive Payment:**	**N/A**	**N/A**
$29,343.01	**$69,523.05**	**N/A**	**N/A**

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113180703.3.15	RHP PP Reference Number: IT-6.1	Outcome Measure: Percent improvement over baseline of patient satisfaction scores	
RHP Performing Provider - MHMRA of Harris County			**TPI: 113180703**
Related Category 1 or 2: 2.13	**Unique Category 1 or 2 project identifiers: 113180703.1.8**		
Starting Point/Baseline: TBD YR 3			
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 5: P-5 Disseminate findings, including lessons learned and best practices, to stakeholders **Metric 5:** Report status, progress and lessons learned to stakeholders **Data Source:** management team minutes, RHP collaborations **Goal:** To disseminate information about the project and solicit input from stakeholders representing consumers, families, public agencies and private providers	**Milestone 10: P-5:** Disseminate findings, including lessons learned and best practices, to stakeholders **Metric 10**: Report status, progress and lessons learned to stakeholders **Data Source:** management team minutes, RHP collaborations **Goal:** To disseminate information about the project and solicit input from stakeholders representing consumers, families, public agencies and private providers	**N/A**	**N/A**
Estimated Incentive Payment:	**Estimated Incentive Payment:**	**N/A**	**N/A**
$29,343.01	**$69,523.05**	**N/A**	**N/A**
Year 2 Estimated Outcome Amount:	**Year 3 Estimated Outcome Amount:**	**Year 4 Estimated Outcome Amount:**	**Year 5 Estimated Outcome Amount:**
$146,715.02	**$347,615.28**	**$376,168.51**	**$814,862.73**
TOTAL EST. INCENTIVE PAYMENTS FOR 4-DY*:* $1,685,361.54			

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Title of Outcome Measure (Improvement Target): IT-6.1: Percent improvement over baseline of patient satisfaction scores
Unique RHP outcome identification numbers: 113180703.16 / Pass 2
Outcome Measure Description:

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

- Numerator: Percent improvement in targeted patient satisfaction domain
- Denominator: Number of patients who were administered the survey

Process Milestones:

- DY 2:
  - P-1- Project planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2- Establish baseline for patients served
  - P-3: Develop and test data systems
  - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
  - P-5 Disseminate findings, including lessons learned and best practices, to stakeholders
- DY 3:
  - P-1- Project planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2- Establish baseline for numerator and denominator
  - P-3: Develop and test data systems
  - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
  - P-5 Disseminate findings, including lessons learned and best practices, to stakeholders

Outcome Improvement Targets for each year:

- DY 4:
  - IT 6.1: Rate 1: Improve patient satisfaction by 5 % over baseline scores for one domain of patient satisfaction
- DY 5:
  - IT 6.1: Rate 1: Improve patient satisfaction by 10 % over baseline scores for one domain of patient satisfaction

Rationale:

Measurement of patient satisfaction is a key indicator of patient-centered care and has been targeted as a quality indicator by national organizations dedicated to improvement in patient outcomes, e.g. the National Council for Quality Assurance. The Consumer Assessment of Healthcare providers and Systems(CAHPS) Survey, for instance, is one of the few indicators from among the set of 2013 HEDIS measures applicable to mental health treatment programs.

Patient satisfaction measures offer advantages associated with sound psychometrics including reliability as measurement tools, and sensitivity to change. Published scales are available in multiple languages (an essential feature in Harris County's multi-cultural environment) and have

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established validity as reflected in documented relationships between satisfaction scale scores and aspects of both clinical process and outcome measures (e.g adherence to treatment recommendations, retention in treatment, improvement in symptom and functional status). Finally, external norms and benchmarks are available for comparative purposes, reducing the uncertainty sometimes associated with program evaluations.

The Process milestones were chosen in order to develop a strong collaborative team approach between the clinical staff, administrators, physicians, Quality Improvement Department and the newly formed Outcome Management Department of MHMRA. By working through these process goals in order to develop and test a patient satisfaction measure suited for the particular program population, we will be more accurate in our assessment of the target outcome. As part of DY 2 process goals, the Outcome Management department will complete literature reviews to identify relevant, empirically validated, and empirically based, measures for the identified outcomes and the targeted population (P-2 and P-3). With this information, the team will be able to select a measure to be piloted in DY 3. The procedures for testing data collection will be evaluated using the Plan Do Study Act (PDSA) cycles (P-4). The proposed timeline for the outcome measure of patient satisfaction includes determining a baseline for one or more of the following categories of patient satisfaction by DY 2:

51. Are getting timely care, appointments, and information
52. How well their doctors communicate
53. Patient’s rating of doctor access to specialist
54. Patient’s involvement in shared decision making
55. Patient’s overall health status/functional status

From this baseline, the goals for improvement have been set at 5% and 10% in DY 4 and 5, respectively. After the results of DY 4 have been determined then another cycle of Plan Do Study Act (PDSA) can also be executed to determine the successes and the need for improvements in addressing patient satisfaction. This information can then be provided to clinic staff in order to produce the needed improvements.

Outcome Measure Valuation: Our local region has identified a general objective and specific community needs that are related to transforming the current health care delivery system. The transformed system is proposed to be a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes. Based on this objective, the proposed program has identified OD-6, Patient Satisfaction, as a targeted outcome for quality improvement goal. It is hypothesized that patients will be better served when they can be offered a full array of services, i.e. when the menu of service options is not sharply curtailed by agency resource limitations. This better fit between patient needs and available services is likely to be reflected in more positive rapport and better perceived communication with treatment providers. Specifically, we believe patient satisfaction that addresses involvement in shared decision making, access to providers, and communication with providers, will reduce chronic over-use of psychiatric emergency services. If patients are dissatisfied with services or the process, they may continue to over-utilize emergency services rather than engaging in preventative care. Since patient satisfaction is proposed as a “stand-alone” measure, it is, by definition, valued at 100% of the Category 3 allocation for this proposed program.

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113180703.3.16	IT-6.1	Percent improvement over baseline of patient satisfaction scores	
MHMRA of Harris County			113180703
Related Category 1 or 2 Projects:	113180703.2.8		
Starting Point/Baseline:	TBD YR3		
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Process Milestone 1 [P-1]: Project planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Metric 1: Conduct meetings of stakeholders, project staff, RHP partners and other key parties to gather relevant information Goal: To gather information that guides project activities toward completion of milestones, while integrating stakeholder input in a meaningful way Data Source: Meetings minutes, project flow charts and timelines Process Milestone 1Estimated Incentive Payment: $15,602.51 **Process Milestone 2** P-2: Establish baseline Metric 1: Identify domains of patient satisfaction to be measured Goal: determine how baseline will be established for patient satisfaction domain	**Process Milestone 6** [P-1]: Project planning, engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Metric 1: Conduct meetings of stakeholders, project staff, RHP partners and other key parties to gather relevant information Goal: To complete project planning process and implement Data Source: Meetings minutes, project flow charts and timelines Process Milestone 6 Estimated Incentive Payment: $36,967.37 **Process Milestone 7** [P- 2]: Establish baseline Metric 1: Select and implement patient satisfaction survey to assess the desired domains of patient satisfaction Goal: obtain baseline of satisfaction survey from patients receiving service Data Source:	**Outcome Improvement Target 1** [IT 6.1]: Percent improvement over baseline of patient satisfaction scores for one domain of patient satisfaction. Improvement Target: 5% increase over baseline Data Source: Patient survey Numerator: Average current score minus average baseline score. Denominator: Average baseline score Outcome Improvement Target Estimated Incentive Payment: $200,0019.42	**Outcome Improvement Target 2** [IT 6.1]: Percent improvement over baseline of patient satisfaction scores for one domain of patient satisfaction. Improvement Target: 10% increase in baseline Data Source: Patient survey Numerator: Average current score minus average baseline score. Denominator: Average baseline score Outcome Improvement Target Estimated Incentive Payment: $433,285.54

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113180703.3.16	IT-6.1	Percent improvement over baseline of patient satisfaction scores	
MHMRA of Harris County			113180703
Related Category 1 or 2 Projects:	113180703.2.8		
Starting Point/Baseline:	TBD YR3		
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Data Source: literature review Process Milestone 2 Estimated Incentive Payment: $15,602.51 **Process Milestone 3** [P-3]: Develop and test data systems <u>Metric 1:</u> Review satisfaction measures for use with the target population and their clinical teams Goal: Identify/modify one instrument to test in Yr. 3Data Source: Project record—summary of reviews Process Milestone 3 Estimated Incentive Payment: $15,602.50 **Process Milestone 4** [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities <u>Metric 1:</u> Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles	Clinical records; monthly management reports Process Milestone 7 Estimated Incentive Payment: $36,967.37 **Process Milestone 8** [P-3]: Develop and test data systems <u>Metric 1:</u> Review satisfaction measures for use with the target population Goal: Test and revise the selected instrument and/or process to enable measure of baseline by end of Yr. 3 Data Source: Project record—summary of reviews, completed surveys Process Milestone 8 Estimated Incentive Payment: $36,967.37 **Process Milestone 9** [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities <u>Metric 1:</u> Project planning and		

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113180703.3.16	IT-6.1	Percent improvement over baseline of patient satisfaction scores	
MHMRA of Harris County			113180703
Related Category 1 or 2 Projects:	113180703.2.8		
Starting Point/Baseline:	TBD YR3		
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Goal: To improve processes and outcomes by implementing data-driven course corrections and innovations Data Source: Project reports, QI reports Process Milestone 4 Estimated Incentive Payment: $15,602.51 **Process Milestone 5** [P-5]: Disseminate findings, including lessons learned and best practices, to stakeholders Metric 1: Report status, progress and lessons learned to stakeholders Goal: To disseminate information about the project and solicit input from stakeholders representing consumers, families, public agencies and private providers Data Source: management team minutes, RHP collaborations Process Milestone 5 Estimated Incentive Payment: $15,602.51	implementation documentation demonstrates plan, do, study act quality improvement cycles Goal: To identify problems and make improvements in processes and outcomes by implementing data-driven course corrections and innovations Data Source: Project reports, QI reports Process Milestone 9 Estimated Incentive Payment: $36,967.37 **Process Milestone 10** [P-5]: Disseminate findings, including lessons learned and best practices, to stakeholders Metric 1: Report status, progress and lessons learned to stakeholders Goal: To disseminate information about the project and solicit input from stakeholders representing consumers, families, public agencies and private providers Data Source: management team minutes, RHP collaborations		

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113180703.3.16	IT-6.1	Percent improvement over baseline of patient satisfaction scores	
MHMRA of Harris County			113180703
Related Category 1 or 2 Projects:	113180703.2.8		
Starting Point/Baseline:	TBD YR3		
Year 2 (10/1/2012 – 9/30/2013)	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 10 Estimated Incentive Payment: $36,967.37		
Year 2 Estimated Outcome Amount: $78,012.52	Year 3 Estimated Outcome Amount: $184,836.86	Year 4 Estimated Outcome Amount: $200,019.42	Year 5 Estimated Outcome Amount: $$433,285.54
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $896,154.34			

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Title of Outcome Measure (Improvement Target): IT-6.1: Percent improvement over baseline of patient satisfaction scores
Unique RHP outcome identification number: 113180703.3.17 / Pass 2
Outcome Measure Description:
IT-6.1: Percent improvement over baseline of patient satisfaction scores

- Numerator: Percent improvement in targeted patient satisfaction domain
- Denominator: Number of patients who were administered the survey

Process Milestones:

- DY 2:
  - P-1- Project planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2- Establish baseline for patients served
  - P-3: Develop and test data systems
  - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
  - P-5 Disseminate findings, including lessons learned and best practices, to stakeholders
- DY 3:
  - P-1- Project planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2- Establish baseline for numerator and denominator
  - P-3: Develop and test data systems
  - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
  - P-5 Disseminate findings, including lessons learned and best practices, to stakeholders

Outcome Improvement Targets for each year:

- DY 4:
  - IT 6.1: Rate 1: Improve patient satisfaction by 5 % over baseline scores for one domain of patient satisfaction
- DY 5:
  - IT 6.1: Rate 1: Improve patient satisfaction by 10 % over baseline scores for one domain of patient satisfaction

Rationale: Measurement of patient satisfaction is a key indicator of patient-centered care and has been targeted as a quality indicator by national organizations dedicated to improvement in patient outcomes, e.g. the National Council for Quality Assurance. The Consumer Assessment of Healthcare providers and Systems(CAHPS) Survey, for instance, is one of the few indicators from among the set of 2013 HEDIS measures applicable to mental health treatment programs.

Patient satisfaction measures offer advantages associated with sound psychometrics including reliability as measurement tools, and sensitivity to change. Published scales are available in multiple languages (an essential feature in Harris County's multi-cultural environment) and have established validity as reflected in documented relationships between satisfaction scale scores

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and aspects of both clinical process and outcome measures (e.g adherence to treatment recommendations, retention in treatment, improvement in symptom and functional status). Finally, external norms and benchmarks are available for comparative purposes, reducing the uncertainty sometimes associated with program evaluations.

The Process milestones were chosen in order to develop a strong collaborative team approach between the clinical staff, administrators, physicians, Quality Improvement Department and the newly formed Outcome Management Department of MHMRA. By working through these process goals in order to develop and test a patient satisfaction measure suited for the particular program population, we will be more accurate in our assessment of the target outcome. As part of DY 2 process goals, the Outcome Management department will complete literature reviews to identify relevant, empirically validated, and empirically based, measures for the identified outcomes and the targeted population (P-2 and P-3). With this information, the team will be able to select a measure to be piloted in DY 3. The procedures for testing data collection will be evaluated using the Plan Do Study Act (PDSA) cycles (P-4). The proposed timeline for the outcome measure of patient satisfaction includes determining a baseline for one or more of the following categories of patient satisfaction by DY 2:

56. Getting timely care, appointments, and information
57. How well their doctors communicate
58. Patient's rating of doctor access to specialist
59. Patient's involvement in shared decision making
60. Patient's overall health status/functional status

From this baseline, the goals for improvement have been set at 5% and 10% in DY 4 and 5, respectively. After the results of DY 4 have been determined then another cycle of Plan Do Study Act (PDSA) can also be executed to determine the successes and the need for improvements in addressing patient satisfaction. This information can then be provided to clinic staff in order to produce the needed improvements.

Outcome Measure Valuation: Our local region has identified general objective and specific community needs that are related to transforming the current health care delivery system. The transformed system is proposed to be a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes. Based on this objective, the proposed program has identified OD-6, Patient Satisfaction, as a targeted outcome for quality improvement goal. It is hypothesized that patients will be better served when they can be offered a full array of services, i.e. when the menu of service options is not sharply curtailed by agency resource limitations. This better fit between patient needs and available services is likely to be reflected in more positive rapport and better perceived communication with treatment providers. Specifically, we believe patient satisfaction that addresses involvement in shared decision making, access to providers, and communication with providers, will reduce chronic over-use of psychiatric emergency services. If patients are dissatisfied with services or the process, they may continue to over-utilize emergency services rather than engaging in preventative care. Since patient satisfaction is proposed as a "stand-alone" measure, it is, by definition, valued at 100% of the Category 3 allocation for this proposed program.

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113180703.3.17	IT-6.1	Percent improvement over baseline of patient satisfaction scores	
MHMRA of Harris County			113180703
Related Category 1 or 2 Projects:	113180703.2.9		
Starting Point/Baseline:	TBD YR3		
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Process Milestone 1 [P-1]: Project planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Metric 1: Conduct meetings of stakeholders, project staff, RHP partners and other key parties to gather relevant information Goal: To gather information that guides project activities toward completion of milestones, while integrating stakeholder input in a meaningful way Data Source: Meetings minutes, project flow charts and timelines Process Milestone 1 Estimated Incentive Payment: $16,570.72 **Process Milestone 2** [P-2]: Establish baseline Metric 1: Identify domains of patient satisfaction to be measured Goal: determine how baseline will be established for patient satisfaction domain	**Process Milestone 6** [P-1]: Project planning, engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Metric 1: Conduct meetings of stakeholders, project staff, RHP partners and other key parties to gather relevant information Goal: To complete project planning process and implement Data Source: Meetings minutes, project flow charts and timelines Process Milestone 6 Estimated Incentive Payment: $39,261.39 **Process Milestone 7** [P- 2]: Establish baseline Metric 1: Select and implement patient satisfaction survey Goal: obtain baseline of satisfaction survey from patients receiving service Data Source: Clinical records; monthly management reports	**Outcome Improvement Target 1** [IT 6.1]: Percent improvement over baseline of patient satisfaction scores for one domain of patient satisfaction. Goal: 5% increase over baseline Numerator: Average current score minus average baseline score. Denominator: Average baseline score Data Source: Patient survey Outcome Improvement Target 1 Estimated Incentive Payment: $212,431.69	**Outcome Improvement Target 2** [IT 6.1]: Percent improvement over baseline of patient satisfaction scores for one domain of patient satisfaction. Goal: 10% increase over baseline Numerator: Average current score minus average baseline score. Denominator: Average baseline score Data Source: Patient survey Outcome Improvement Target 2 Estimated Incentive Payment: $ $460,173.21

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113180703.3.17	IT-6.1	Percent improvement over baseline of patient satisfaction scores	
MHMRA of Harris County			113180703
Related Category 1 or 2 Projects:	113180703.2.9		
Starting Point/Baseline:	TBD YR3		
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Data Source: literature review Process Milestone 2 Estimated Incentive Payment: $16,570.72 **Process Milestone 3** [P-3]: Develop and test data systems Metric 1: Review satisfaction measures for use with the target population and their clinical teams Goal: Identify/modify one instrument to test in Yr. 3 Data Source: Project record—summary of reviews Process Milestone 3 Estimated Incentive Payment: $16,570.72 **Process Milestone 4** [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Metric 1: Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles Goal: To improve processes and outcomes by implementing data-driven course corrections and	Process Milestone 7 Estimated Incentive Payment: $39,261.39 **Process Milestone 8** [P-3]: Develop and test data systems Metric 1: Review satisfaction measures for use with the target population Goal: Test and revise the selected instrument and/or process to enable measurement of baseline by end of Yr. 3 Data Source: Project record—summary of reviews, completed surveys Process Milestone 8 Estimated Incentive Payment: $39,261.39 **Process Milestone 9** [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Metric 1: Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles		

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113180703.3.17	IT-6.1	Percent improvement over baseline of patient satisfaction scores	
MHMRA of Harris County			113180703
Related Category 1 or 2 Projects:	113180703.2.9		
Starting Point/Baseline:	TBD YR3		
Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
innovations Data Source: Project reports, QI reports Process Milestone 4 Estimated Incentive Payment: $16,570.72 **Process Milestone 5** [P-5]: Disseminate findings, including lessons learned and best practices, to stakeholders Metric 1: Report status, progress and lessons learned to stakeholders Goal: To disseminate information about the project and solicit input from stakeholders representing consumers, families, public agencies and private providers Data Source: management team minutes, RHP collaborations Process Milestone 5 Estimated Incentive Payment: $16,570.72	Goal: To identify problems and make improvements in processes and outcomes by implementing data-driven course corrections and innovations Data Source: Project reports, QI reports Process Milestone 9 Estimated Incentive Payment: $39,261.39 **Process Milestone 10** [P-5]: Disseminate findings, including lessons learned and best practices, to stakeholders Metric 1: Report status, progress and lessons learned to stakeholders Goal: To updated and disseminate current information about the project and solicit input from stakeholders representing consumers, families, public agencies and private providers Data Source: management team minutes, RHP collaborations Process Milestone 10 Estimated Incentive Payment: $39,261.39		

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113180703.3.17	IT-6.1	Percent improvement over baseline of patient satisfaction scores	
MHMRA of Harris County			113180703
Related Category 1 or 2 Projects:	113180703.2.9		
Starting Point/Baseline:	TBD YR3		
Year 2 (10/1/2012 – 9/30/2013)	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: $82,853.61	Year 3 Estimated Outcome Amount: $196,306.97	Year 4 Estimated Outcome Amount: $212,431.69	Year 5 Estimated Outcome Amount: $460,173.21
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:** *$951,765.48*			

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Mental Health and Mental Retardation Authority of Harris County

Pass 3

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Title of Outcome Measure (Improvement Target): IT-9.1 Decrease in mental health admissions and readmissions to criminal justice settings

Unique RHP outcome identification numbers: 113180703.3.18

Outcome Measure Description:

IT-9.1 Decrease in mental health admissions and readmissions to criminal justice settings

- The number of permanent members who had a potentially preventable admission/readmission to a criminal justice setting during the demonstration years

Process Milestones:

- DY 2:
  - P-1- Project planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2- Establish baselines for patients served
  - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
  - P-5 Disseminate findings, including lessons learned and best practices, to stakeholders
- DY 3:
  - P-2- Establish baseline for numerator and denominator
  - P-3: Develop and test data systems
  - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
  - P-5 Disseminate findings, including lessons learned and best practices, to stakeholders

Outcome Improvement Targets for each year:

- DY 4:
  - IT-9.1: Decrease in the number of permanent members who had a potentially preventable admission/readmission to a criminal justice setting during the demonstration year by 5% from baseline
- DY 5:
  - IT-9.1: Decrease in the number permanent members who had a potentially preventable admission/readmission to a criminal justice setting during the demonstration years by 10% from baseline

Rationale:

The Process milestones were chosen as stated above in order to develop a strong collaborative team approach between the clinical staff, administrators, stake-holders, law-

enforcement officers, Quality Improvement Department and the newly formed Outcome Management Department of MHMRA. The first steps in DY 2 will be project planning (P-1) then establishment of baselines (P-2) for the number of permanent members and the number of arrests. The procedures for testing data collection will be evaluated using the Plan Do Study Act (PDSA) cycles (P-4). In DY 3 a similar process will provide for accurate measurement of baselines from which to measure the success of the psychosocial rehab intervention. In particular, we chose to add Process milestone P-3 Develop and test data systems in order to determine any new systemic changes in data collection that the collaborations may have allowed for that may not have been available in DY2.

We hope that the ratio of arrests to intervention will decrease as the enhancement and development of the St. Joseph House take place. At this time, we are not selecting a specific metric or percent of expected change. The rationale for determining this rate at a later time is that the base rate of arrests is expected to be low and the percent of change will need to appropriately reflect meaningful changes in arrests. St. Joseph House administrators and stakeholders will work in conjunction with the MHMRA Outcomes Department and the MHMRA Quality Improvement Department to determine an appropriate rate of change.

Once initial rates of change in DY 4 have been determined another cycle of Plan Do Study Act (PDSA) can also be executed to determine the successes and the need for improvements in reducing preventable mental health admissions and readmissions to criminal justice settings. This information can then be provided to clinic staff in order to produce the needed improvements.

Outcome Measure Valuation:

We have selected preventable mental health admissions/readmissions to criminal justice setting as a measure because many of the individuals in the St. Joseph's House have a history of arrests. In recent surveys it has been noted that 25% of the inmates in Harris County Jail are receiving psychotropic medications. Further, more than 16% have histories of treatment within the public mental health system. In many instances, it appear likely that individuals with mental disorders are arrested and jailed at significant public expense when appropriate mental health care could potentially avert criminalization of episodes of untreated mental disorder. It is also important to note that all patients have a right to be treated in the least-restrictive environment possible; therefore, St. Joseph's House is an intervention that would ensure patients' rights are respected and community treatment is more likely.

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113180703.3.18	IT-9.1	Decrease in mental health admissions and readmissions to criminal justice settings	
MHMRA of Harris County			113180703
Related Category 1 or 2:	113180703.1.9		
Starting Point/Baseline:	TBD DY3		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Meetings minutes and timelines Estimated Incentive Payment: $18,968.48 **Process Milestone 2**: [P-3] Develop and test data systems Data Source: Meeting minutes Estimated Incentive Payment: $ $18,968.48 **Process Milestone 3** [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Data Source: Project reports and Meeting minutes Estimated Incentive Payment: $18,968.48	**Milestone 5**: P-2: Establish Baselines Data Sources: MHMRA, St. Joseph House Estimated Incentive Payment: $45,460.28 **Milestone 6**: [P-3] Develop and test data systems Data Source: Law enforcement partners, project records Estimated Incentive Payment: $45,460.28 **Milestone 7** [P-4]: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Data Source: Project reports and meeting minutes Estimated Incentive Payment: $45,460.28 **Milestone 8** [P-5]: Disseminate findings, lessons learned and best	**Outcome Improvement Target 1 [IT-9.1]:** Decrease in criminal justice arrests Improvement Target: 5% reduction in arrests from baseline Data Sources**:** MHMRA, St. Joseph House Estimated Incentive Payment: $198,711.91	**Outcome Improvement Target 2 [IT-9.1]:** Decrease in criminal justice arrests Improvement Target: 10% reduction in arrests from baseline Data Sources**:** MHMRA, St. Joseph House Estimated Incentive Payment: $430,040.92

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113180703.3.18	IT-9.1	Decrease in mental health admissions and readmissions to criminal justice settings	
MHMRA of Harris County			113180703
Related Category 1 or 2:	113180703.1.9		
Starting Point/Baseline:	TBD DY3		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 4 [P-5]: Disseminate findings, lessons learned, and best practices, to stakeholders Data Source: Meeting minutes Estimated Incentive Payment: $18,968.47	practices to stakeholders Data Source: Meeting minutes Estimated Incentive Payment: $45,460.28		
Year 2 Estimated Outcome Amount: $75,874	Year 3 Estimated Outcome Amount: $181,841	Year 4 Estimated Outcome Amount: $198,712	Year 5 Estimated Outcome Amount: $430,041
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5): $886,468			

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Title of Outcome Measure (Improvement Target): IT-6.1: Percent improvement over baseline of patient satisfaction scores

Unique RHP outcome identification numbers: 113180703.3.19

Performing Provider/TPI: Mental Health and Mental Retardation Authority of Harris County/ 113180703

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

- Numerator: Percent improvement in targeted patient satisfaction domain
- Denominator: Number of patients who were administered the survey

Process Milestones:

- DY 2:
  - P-1- Project planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2- Establish baseline for numerator and denominator
  - P-3: Develop and test data systems
  - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
  - P-5 Disseminate findings, including lessons learned and best practices, to stakeholders
- DY 3:
  - P-1- Project planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-2- Establish baseline for numerator and denominator
  - P-3: Develop and test data systems
  - P-4: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities
  - P-5 Disseminate findings, including lessons learned and best practices, to stakeholders
  -

Outcome Improvement Targets for each year:

- DY 4:
  - IT 6.1: Rate 1: Improve patient satisfaction by 5 % over baseline scores for one domain of patient satisfaction
- DY 5:
  - IT 6.1: Rate 1: Improve patient satisfaction by 10 % over baseline scores for one domain of patient satisfaction

Rationale: Measurement of patient satisfaction is a key indicator of patient-centered care and has been targeted as a quality indicator by national organizations dedicated to improvement in patient outcomes, e.g. the National Council for Quality Assurance. The Consumer Assessment of Healthcare providers and Systems(CAHPS) Survey, for instance, is one of the few indicators from among the set of 2013 HEDIS measures applicable to mental health treatment programs.

Patient satisfaction measures offer advantages associated with sound psychometrics including reliability as measurement tools, and sensitivity to change. Published scales are available in multiple languages (an essential feature in Harris County's multi-cultural environment) and have established validity as reflected in documented relationships between satisfaction scale scores and aspects of both clinical process and outcome measures (e.g. adherence to treatment recommendations, retention in treatment, improvement in symptom and functional status). Finally, external norms and benchmarks are available for comparative purposes, reducing the uncertainty sometimes associated with program evaluations.

The process milestones were chosen in order to develop a strong collaborative team approach between the clinical staff, administrators, physicians, Quality Improvement Department and the newly formed Outcome Management Department of MHMRA. By working through these process goals in order to develop and test a patient satisfaction measure suited for the particular program population, we will be more accurate in our assessment of the target outcome. As part of DY 2 process goals, the Outcome Management department will complete literature reviews to identify relevant, empirically validated, and empirically based, measures for the identified outcomes and the targeted population (P-2 and P-3). With this information, the team will be able to select a measure to be piloted in DY 3. The procedures for testing data collection will be evaluated using the Plan Do Study Act (PDSA) cycles (P-4). The proposed timeline for the outcome measure of patient satisfaction includes determining a baseline for one or more of the following categories of patient satisfaction by DY 2:

61. Are getting timely care, appointments, and information
62. How well their provider communicates
63. Patient's rating of doctor access to specialist
64. Patient's involvement in shared decision making
65. Patient's overall health status/functional status

From this baseline, the goals for improvement have been set at 5% and 10% in DY 4 and 5, respectively. After the results of DY 4 have been determined then another cycle of Plan Do Study Act (PDSA) can also be executed to determine the successes and the need for improvements in addressing patient satisfaction. This information can then be provided to clinic staff in order to produce the needed improvements.

Outcome Measure Valuation: Our local region has identified a general objective and specific community needs that are related to transforming the current health care delivery system. The transformed system is proposed to be a patient-centered, coordinated delivery model that improves patient satisfaction and health outcomes. Based on this objective, the proposed program has identified OD-6, Patient Satisfaction, as a targeted outcome for quality improvement goal. It is hypothesized that patients will be better served when they can be offered a full array of services, i.e. when the menu of service options is not sharply curtailed by agency resource limitations. This better fit between patient needs and available services is likely to be reflected in more positive rapport and better perceived communication with treatment providers. Specifically, we believe patient satisfaction that addresses involvement in shared decision making, access to providers, and communication with providers, will reduce chronic over-use of

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psychiatric emergency services. If patients are dissatisfied with services or the process, they may continue to over-utilize emergency services rather than engaging in preventative care. Since patient satisfaction is proposed as a "stand-alone" measure, it is, by definition, valued at 100% of the Category 3 allocation for this proposed program.

References

Dewa, C., Hoch, J., 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. *Canadian Journal of Psychiatry, 54,* 379-388.

Katon, W., Russo, J., Lin, E., Schmittdiel, J., Ciechanowski, P., Ludman, E. & Von Korff, M. (2012).Cost-effectiveness of a multi-condition collaborative care intervention: A randomized controlled trial. *Archives of General Psychiatry, 69,* 506-514.

Liu, C., Hedrick, S., Chaney, E., Heagerty, P., Felker, B., Hasenberg, N. & Katon, W. (2003). Costeffectiveness of collaborative care for depression in a primary care veteran population. *Psychiatric Services, 54,* 698-704.

Pyne, J., Rost, K., Zhang, M., Williams, D., Smith, J. & Fortney, J. (2003). Cost-effectiveness of a primary care depression intervention. *Journal of General Internal Medicine, 18*, 432-441.

Rost, K., Pyne, J., Dickinson, L., & LoSasso, A. (2005). Cost-effectiveness of enhancing primary care depression management on an ongoing basis. *Annals of Family Medicine, 3,* 7-14.

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

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113180703.3.19	RHP PP Reference Number: IT-6.1	Outcome Measure: Percent improvement over baseline of patient satisfaction scores	
RHP Performing Provider - MHMRA of Harris County		**TPI: 113180703**	
Related Category 1 or 2: 1.9		**Category 1 or 2 project identifiers:113180703.1.10**	
Starting Point/Baseline: TBD YR 3			
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 P-1: Project planning- engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans **Data Source:** Meetings minutes, project flow charts and timelines	**Process Milestone 6: P-1:** Project planning, engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans **Data Source:** Meetings minutes, project flow charts and timelines	**Improvement Outcome Measure1:** [IT 6.1] Percent improvement over baseline of patient satisfaction scores for one domain of patient satisfaction. **Data Source**: Patient survey **Improvement Target**: 5% increase over baseline	**Improvement Outcome Measure 2** [**I**T 6.1] Percent improvement over baseline of patient satisfaction scores for one domain of patient satisfaction. **Data Source:** Patient survey **Improvement Target:** 10% increase in baseline
Estimated Incentive Payment:	**Estimated Incentive Payment:**	**Estimated Incentive Payment:**	**Estimated Incentive Payment:**
$6,028.25	**$14,447.44**	**$78,939.21**	**$170,835.72**
Process Milestone 2: P-2: Establish baseline **Data Source:** literature review	**Process Milestone 7: P- 2:** Establish baseline **Data Source:** Clinical records; monthly management reports		
Estimated Incentive Payment:	**Estimated Incentive Payment: $**		
$6,028.25	**$14,447.44**		
Process Milestone 3 P-3: Develop and test data systems **Data Source:** Project record—summary of reviews	**Process Milestone 8: P-3** Develop and test data systems **Data Source:** Project record—summary of reviews, completed surveys		
Estimated Incentive Payment:	**Estimated Incentive Payment:**		
$6,028.25	**$14,447.44**		

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113180703.3.19	RHP PP Reference Number: IT-6.1	Outcome Measure: Percent improvement over baseline of patient satisfaction scores	
RHP Performing Provider - MHMRA of Harris County			**TPI: 113180703**
Related Category 1 or 2: 1.9		**Category 1 or 2 project identifiers:113180703.1.10**	
Starting Point/Baseline: TBD YR 3			
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 4 P-4 Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities **Data Source:** Project reports including examples of how real time data has been used to guide continuous quality improvement	**Process Milestone 9 P-9** Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities **Data Source:** Project reports including examples of how real time data has been used to guide continuous quality improvement		
Estimated Incentive Payment:	**Estimated Incentive Payment:**		
$6,028.25	**$14,447.45**		
Process Milestone 5: P-5 Disseminate findings, including lessons learned and best practices, to stakeholders **Data Source:** management team minutes, RHP collaborations	**Process Milestone 10: P.10:** Disseminate findings to stakeholders **Data Source:** management team minutes, RHP collaborations		
Estimated Incentive Payment:	**Estimated Incentive Payment:**		
$6,028.25	**$14,447.45**		
Year 2 Estimated Outcome Amount:	**Year 3 Estimated Outcome Amount:**	**Year 4 Estimated Outcome Amount:**	**Year 5 Estimated Outcome Amount:**
$30,141	**$72,237**	**$78,939**	**$170,836**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: **$352,153**			

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Methodist Willowbrook Hospital

Pass 1

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Title of Outcome Measure (Improvement Target): IT 1.18 - *Follow up after Hospitalization for Mental Illness*

Unique RHP outcome identification number(s): 140713201.3.1

Outcome Measure Description:

IT-1.18 Follow-Up After Hospitalization for Mental Illness- NQF 0576236 (Standalone measure)

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.

Our goal is that by year four we will have 60% with follow up within 30 days, and by year 5 we will have 80%.

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.

As it is difficult to arrange appointments so close to discharge because of patient and physician factors, our goal is that by the fourth year we will have 40% follow up within seven days and by the fifth year, 50%.

Process Milestones:

- DY2:
  - P-1: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
- DY3:
  - P-2: Establish baseline rates

Outcome Improvement Targets for each year:

- DY4: IT-1.18 Follow-Up After Hospitalization for Mental Illness- NQF 0576236 (Standalone measure)
  - Improvement Target: 60% above baseline
- DY5: IT 1.18 Follow-Up After Hospitalization for Mental Illness- NQF 0576236 (Standalone measure)
  - Improvement Target: 80% above baseline

Rationale:

Process milestones in DY 2 are focused on training, education and partnership development. These efforts are largely external efforts focused on our medical staff, collaborating healthcare providers and community partners.

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Process milestones in DY 3 are focused on establishing our baseline, factors that are driving utilization and establishing a process to follow up with patients post-discharge. These are largely internal efforts with our hospital based work teams.

Outcome Measure Valuation:

We have selected IT 1.18 as our quality outcome metric as we feel this is most important quality outcome to determine the success or impact of our project. Through a focused effort to follow up and coordinate the post discharge care needs of our targeted population we will demonstrate true value to the community. Meaning, our targeted population will receive higher quality care in the correct care setting, all at a lower cost.

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<table>
<tr><td>140713201.3.1</td><td>IT-1.18</td><td colspan="2">Follow up after hospitalization for mental illness</td></tr>
<tr><td colspan="3">Methodist Willowbrook</td><td>140713201</td></tr>
<tr><td>Related Category 1 or 2 Projects:</td><td colspan="3">140713201.2.1</td></tr>
<tr><td>Starting Point/Baseline:</td><td colspan="3">To be established in DY3</td></tr>
<tr><th>Year 2

(10/1/2012 – 9/30/2013)</th><th>Year 3

(10/1/2013 – 9/30/2014)</th><th>Year 4

(10/1/2014 – 9/30/2015)</th><th>Year 5

(10/1/2015 – 9/30/2016)</th></tr>
<tr><td>Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans

Data Source: EHR; Business Intelligence

Process Milestone 1 Estimated Incentive Payment (maximum amount): $ 119,846</td><td>Process Milestone 2 [P-2]: Establish baseline

Data Source: EMR

Process Milestone 2 Estimated Incentive Payment: $119,846</td><td>Outcome Improvement Target 1 [IT-1.18]: Follow-Up After Hospitalization for Mental Illness-NQF 0576236

Improvement Target: 60% above baseline

Data Source: EHR, Claims

Outcome Improvement Target 1 Estimated Incentive Payment: $179,769</td><td>Outcome Improvement Target 2 [IT-1.18]: Follow-Up After Hospitalization for Mental Illness-NQF 0576236

Improvement Target: 80% above baseline

Data Source: EHR, Claims

Outcome Improvement Target 2 Estimated Incentive Payment: $395,491</td></tr>
<tr><td>Year 2 Estimated Outcome Amount: $ 119,846</td><td>Year 3 Estimated Outcome Amount: $119,846</td><td>Year 4 Estimated Outcome Amount: $179,769</td><td>Year 5 Estimated Outcome Amount: $395,491</td></tr>
<tr><td colspan="4">TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5): $ 814,952</td></tr>
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OakBend Medical Center

Pass 1

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Title of Outcome Measure (Improvement Target): IT-3.2 Congestive Heart Failure 30-Day Readmission Rate

Unique RHP Outcome Identification Number(s): 127303903.3.1

Performing Provider Name/TPI: OakBend Medical Center (OBMC) / 127303903

Outcome Measure Description:

This outcome will measure the number of readmissions (for patients 18 years and older), for any cause, within 30 days of discharge from the index HF admission. Given data limitations, only readmissions to the same facility will be included as part of each hospital's rates.

Rationale:

The relationship between hospital readmission rates and quality of care is well-documented, and is driven by a general consensus that readmissions may result from circumstances surrounding the initial hospital stay. If the project is successful, then it will result in more effective management of chronic conditions, which in turn will result in the reduction of unnecessary readmissions. Congestive heart failure is an exemplar diagnosis for which effective disease management has been shown to reduce unnecessary hospital admissions. Therefore, the reduction in CHF admissions will be a reasonable metric by which to judge the effectiveness of this project.

Outcome Measure Valuation:

OBMC values each Category 3 outcome measure based on the specific needs of the community, the projected impact on the health outcomes of the community, the level of advancement to the healthcare delivery system, and the time, effort, and clinical resources necessary to affect each outcome.

In valuing this outcome measure, OBMC took into account the extent to which the reduction of potentially preventable CHF readmissions would potentially meet the goals of the Waiver (support the development of a coordinated care delivery system, improve outcomes while containing costs, improve the healthcare infrastructure), the extent to which it will address the community needs, the population served, and the resources and cost necessary to achieve a reduction in CHF readmission rates.

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127303903.3.1	***3.IT-3.2***	*Congestive Heart Failure 30-Day Readmission Rate*	
OakBend Medical Center			*127303903*
Related Category 1 or 2 Projects:	***127303903.1.1***		
Starting Point/Baseline	July 2012		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. Process Milestone 1 Estimated Incentive Payment*:* $66,062	**Process Milestone 2** [P-2]: Establish baseline rates. Process Milestone 2 Estimate Incentive Payment: $38,287 **Outcome Improvement Target 1** [IT-3.2]: Potentially Preventable Readmissions: Congestive Heart Failure 30 Day Readmission Rate (Standalone Measure) Improvement Target: 2% improvement over baseline. Data Source: EHR and/or claims (OakBend data only). Outcome Improvement Target 1 Estimated Incentive Payment*:* $38,287	**Outcome Improvement Target 2** [IT-3.2]: Potentially Preventable Readmissions: Congestive Heart Failure 30 Day Readmission Rate (Standalone Measure) Improvement Target: 5% improvement over baseline. Data Source: EHR and/or claims (OakBend data only). Outcome Improvement Target 2 Estimated Incentive Payment*:* $122,875	**Outcome Improvement Target 3** [IT-3.2]: Potentially Preventable Readmissions: Congestive Heart Failure 30 Day Readmission Rate (Standalone Measure) Improvement Target: 8% improvement over baseline. Data Source: EHR and/or claims (OakBend data only). Outcome Improvement Target 3 Estimated Incentive Payment*:* $293,831
Year 2 Estimated Outcome Amount *(add incentive payments amounts from each milestone/outcome improvement target)*: **$66,062**	Year 3 Estimated Outcome Amount: **$76,574**	Year 4 Estimated Outcome Amount: **$122,875**	Year 5 Estimated Outcome Amount: **$293,831**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)*: **$559,342**			

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Title of Outcome Measure (Improvement Target): IT-2.1 Congestive Heart Failure Admission Rate (CHF)

Unique RHP Outcome Identification Number(s): *127303903.3.2*
Performing Provider Name/TPI: OakBend Medical Center (OBMC) / 127303903

Outcome Measure Description:

The outcome for this measure is the reduction of preventable readmissions for all non-maternal discharges of age 18 years and older with a principal diagnosis code for congestive heart failure. All readmissions are counted as outcomes except those that are considered planned.

Rationale:

The increase in access to primary care physician services will decrease the number of admissions for diseases that can be adequately managed like CHF.

Outcome Measure Valuation:

OBMC values each Category 3 outcome measure based on the specific needs of the community, the projected impact on the health outcomes of the community, the level of advancement to the healthcare delivery system, and the time, effort, and clinical resources necessary to affect each outcome.

In valuing this outcome measure, OBMC took into account the extent to which the reduction in readmissions for CHF would potentially meet the goals of the Waiver (support the development of a coordinated care delivery system, improve outcomes while containing costs, improve the healthcare infrastructure), the extent to which it will address the community needs, the population served, and the resources and cost necessary to achieve this outcome.

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127303903.3.2	*3.IT-2.1*	*Congestive Heart Failure Admission Rate (CHF)*	
OAKBEND MEDICAL CENTER			*127303903*
Related Category 1 or 2 Projects:	*127303903.1.2*		
Starting Point/Baseline	July 2012		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Planning documentation. Process 1 Estimated Incentive Payment*:* $42,940 **Process Milestone 2** [P-2]: Establish baseline rates Data Source: EHR; Claims. Process 2 Estimated Incentive Payment*:* $42,940	**Outcome Improvement Target 1** [IT-2.1]: Potentially Preventable Admissions: Congestive Heart Failure Admission Rate (CHF) Improvement Target: 2% improvement over DY2 baseline. Data Source: EHR, Claims. Outcome Improvement Target 1 Estimated Incentive Payment*:* $99,546	**Outcome Improvement Target 2** [IT-2.1]: Potentially Preventable Admissions: Congestive Heart Failure Admission Rate (CHF) Improvement Target: 4% improvement over DY2 baseline. Data Source: EHR, Claims. Outcome Improvement Target 2 Estimated Incentive Payment*:* $159,737	**Outcome Improvement Target 3** [IT-2.1]:Potentially Preventable Admissions: Congestive Heart Failure Admission Rate (CHF) Improvement Target: 6% improvement over DY2 baseline. Data Source: EHR, Claims. Outcome Improvement Target 3 Estimated Incentive Payment*:* $381,980
Year 2 Estimated Outcome Amount *(add incentive payments amounts from each milestone/outcome improvement target)*: **$85,880**	Year 3 Estimated Outcome Amount: **$99,546**	Year 4 Estimated Outcome Amount: **$159,737**	Year 5 Estimated Outcome Amount: **$381,980**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)*: **$727,143**			

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Title of Outcome Measure (Improvement Target: IT-3.1 All Cause 30-Day Readmission Rate

Unique RHP Outcome Identification Number(s): 127303903.3.3
Performing Provider/TPI: OakBend Medical Center (OBMC) / 127303903

Outcome Measure Description:

The outcome for this measure is unplanned all cause 30-day readmission, IT-3.1. Readmission is defined as an inpatient admission to any acute care facility which occurs within 30 days of the discharge date of an eligible index admission. All readmissions are counted as outcomes except those that are considered planned.

Process Milestones:

- DY2: P-1; P-2
- DY3: IT-3.1

Outcome Improvement Target(s) for each year:

- DY4: IT-3.1
- DY5: IT-3.1

Rationale:

The expansion of specialty care capacity will promote and encourage patients to access care which will lead to better clinical outcomes for the community. OBMC took these potential effects into account when considering the appropriate incentive payment value for this project.

Outcome Measure Valuation:

OBMC values each Category 3 outcome measure based on the specific needs of the community, the projected impact on the health outcomes of the community, the level of advancement to the healthcare delivery system, and the time, effort, and clinical resources necessary to effect each outcome.

In valuing this outcome measure, OBMC took into account the extent to which the reduction in all cause readmissions would potentially meet the goals of the Waiver (support the development of a coordinated care delivery system, improve outcomes while containing costs, improve the healthcare infrastructure), the extent to which it will address the community needs, the population served, and the resources and cost necessary to achieve decrease in all cause readmissions.

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127303903.3.3	*IT-3.1*	*All Cause 30-Day Readmission Rate*	
OakBend Medical Center			*127303903*
Related Category 1 or 2 Projects:	***127303903.1.3***		
Starting Point/Baseline	July 2012		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. **Data Source:** Planning documentation. Process 2 Estimated Incentive Payment*:* **$46,243** **Process Milestone 2** [P-2]: Establish baseline rates. **Data Source: EHR; Claims.** Process 2 Estimated Incentive Payment*:* **$46,243**	**Outcome Improvement Target 1** [IT-3.1]: Potentially Preventable Readmissions: All Cause 30-Day Readmission Rate **Baseline/Goal:** 1% improvement over DY2 baseline. **Data Source:** EHR, Claims. Outcome Improvement Target 1 Estimated Incentive Payment*:* **$107,204**	**Outcome Improvement Target 2** [IT-3.1]: Potentially Preventable Readmissions: All Cause 30-Day Readmission Rate **Baseline/Goal:** 2% improvement over DY2 baseline. **Data Source:** EHR, Claims. Outcome Improvement Target 2 Estimated Incentive Payment*:* **$172,025**	**Outcome Improvement Target 3** [IT-3.1]: Potentially Preventable Readmissions: All Cause 30-Day Readmission Rate **Baseline/Goal:** 3% improvement over DY2 baseline. **Data Source:** EHR, Claims. Outcome Improvement Target 3 Estimated Incentive Payment*:* **$411,363**
Year 2 Estimated Outcome Amount: **$92,486**	Year 3 Estimated Outcome Amount: **$107,204**	Year 4 Estimated Outcome Amount: **$172,025**	Year 5 Estimated Outcome Amount: **$411,363**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)*: **$783,078**			

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<u>Title of Outcome Measure (Improvement Target)</u>: IT-6.1 Percent Improvement Over Baseline of Patient Satisfaction Scores

<u>Unique RHP Outcome Identification Number</u>(s):127303903.3.4

<u>Outcome Measure Description</u>:

OD-6 Percent improvement over baseline of patient satisfaction scores for one or more of the patient satisfaction domains that the provider targets for improvement in a specific tool. Certain supplemental modules for the adult CG-CAHPS survey may be used to establish: (1) if patients are getting timely care, appointments, and information; (2) how well their doctors communicate; (3) patient rating of doctor access to specialist; (4) patient involvement in shared decision-making, and (5) patient overall health status/functional status.

Process Milestones:

- DY2: P-2
- DY3: IT-6.1

Outcome Improvement Target(s) for each year:

- DY4: IT-6.1
- DY5: IT-6.1

<u>Rationale:</u>

This outcome measure is explicitly related to the improvement of patient satisfaction, which is also the express purpose of this project.

<u>Outcome Measure Valuation</u>:

OBMC values each Category 3 outcome measure based on the specific needs of the community, the projected impact on the health outcomes of the community, the level of advancement to the healthcare delivery system, and the time, effort, and clinical resources necessary to effect each outcome.

In valuing this outcome measure, OBMC took into account the extent to which the improvement of patient satisfaction would potentially meet the goals of the Waiver (support the development of a coordinated care delivery system, improve outcomes while containing costs, improve the healthcare infrastructure), the extent to which it will address the community needs, the population served, and the resources and cost necessary to achieve an increase in patient satisfaction.

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127303903.3.4	*3.IT-6.1*	*Percent Improvement Over Baseline of Patient Satisfaction Scores*	
OakBend Medical Center			*127303903*
Related Category 1 or 2 Projects:	***127303903.2.1***		
Starting Point/Baseline	July 2012		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-2]: Establish baseline rates. **Data Source:** Raw patient satisfaction scores provided by Jackson Group (third-party vendor). Process 1 Estimated Incentive Payment*:* **$52,849**	**Outcome Improvement Target 1** [IT-6.1]: Patient Satisfaction: Percent Improvement Over Baseline of Patient Satisfaction Scores (all questions within a survey need to be answered to be a standalone measure). **Goal:** 1 Percent improvement over DY2 baseline of patient satisfaction scores for one or more of the patient satisfaction domains targeted for improvement in a specific tool. Certain supplemental modules for the adult CG-CAHPS survey may be used to establish: (1) if patients are getting timely care, appointments, and information (standalone measure). (2) how well their doctors communicate (standalone measure). (3) patient's rating of doctor access to specialist (standalone measure). (4) patient's involvement in shared decision-making (standalone measure). **Data Source:** Patient survey. Raw patient satisfaction scores	**Outcome Improvement Target 2** [IT-6.1]: Patient Satisfaction: Percent Improvement Over Baseline of Patient Satisfaction Scores (all questions within a survey need to be answered to be a standalone measure). **Goal:** 2 Percent improvement over DY2 baseline of patient satisfaction scores for one or more of the patient satisfaction domains targeted for improvement in a specific tool. Certain supplemental modules for the adult CG-CAHPS survey may be used to establish: (1) if patients are getting timely care, appointments, and information (standalone measure). (2) how well their doctors communicate (standalone measure). (3) patient's rating of doctor access to specialist (standalone measure). (4) patient's involvement in shared decision-making (standalone measure). **Data Source:** Patient survey. Raw patient satisfaction scores provided by Jackson Group (third-party vendor). Outcome Improvement Target 2 Estimated Incentive Payment*:* **$98,300**	**Outcome Improvement Target 3** [IT-6.1]: Patient Satisfaction: Percent Improvement Over Baseline of Patient Satisfaction Scores (all questions within a survey need to be answered to be a standalone measure). **Goal:** 3 Percent improvement over DY2 baseline of patient satisfaction scores for one or more of the patient satisfaction domains targeted for improvement in a specific tool. Certain supplemental modules for the adult CG-CAHPS survey may be used to establish: (1) if patients are getting timely care, appointments, and information (standalone measure). (2) how well their doctors communicate (standalone measure). (3) patient's rating of doctor access to specialist (standalone measure). (4) patient's involvement in shared decision-making (standalone measure). . **Data Source:** Patient survey. Raw

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	provided by Jackson Group (third-party vendor). Outcome Improvement Target 1 Estimated Incentive Payment*:* **$61,259**		patient satisfaction scores provided by Jackson Group (third-party vendor). Outcome Improvement Target 3 Estimated Incentive Payment*:* **$235,065**
Year 2 Estimated Outcome Amount *(add incentive payments amounts from each milestone/outcome improvement target)*: **$52,849**	Year 3 Estimated Outcome Amount: **$61,259**	Year 4 Estimated Outcome Amount: **$98,300**	Year 5 Estimated Outcome Amount: **$235,065**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)*: **$447,473**			

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Title of Outcome Measure (Improvement Target): IT-9.2 ED Appropriate Utilization (Standalone Measure)

Unique RHP Outcome Identification Number(s): 127303903.3.5
Performing Provider Name/TPI: OakBend Medical Center (OBMC) / 127303903

Outcome Measure Description:

This outcome will focus on reducing ED admissions for patients with targeted conditions.

Process Milestones:

- DY 2: P-1;P-2
- DY3: P-2

Outcome Improvement Targets for each year:

- DY-4: IT-9.2 ED appropriate utilization
- DY-5: IT-9.2 ED appropriate utilization

Rationale:

If the project is successful, then it will result in improved access to care for patients with targeted conditions. By improving access to care and ensuring that patients receive the right care in the right setting, this project will reduce the inappropriate use of the Emergency Department to deliver the same care.

Outcome Measure Valuation:

OBMC values each Category 3 outcome measure based on the specific needs of the community, the projected impact on the health outcomes of the community, the level of advancement to the healthcare delivery system, and the time, effort, and clinical resources necessary to effect each outcome.

In valuing this outcome measure, OBMC took into account the extent to which the reduction of ED utilization would potentially meet the goals of the Waiver (support the development of a coordinated care delivery system, improve outcomes while containing costs, improve the healthcare infrastructure), the extent to which it will address the community needs, the population served, and the resources and cost necessary to achieve a reduction in ED utilization.

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127303903.3.5	3.IT-9.2	ED Appropriate Utilization (Standalone Measure)	
OAKBEND MEDICAL CENTER			127303903
Related Category 1 or 2 Projects:	127303903.2.2		
Starting Point/Baseline	July 2012		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1[P-1] Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. Data Source: Process Milestone 1 Estimated Incentive Payment*:* **$99,092**	**Process Milestone 2** [P-2] Establish baseline rates. Data Source: Codes for specific diagnoses from EMR. Process Milestone 2 Estimate Incentive Payment: **$114,861**	**Outcome Improvement Target 1** [IT-9.2] ED Appropriate Utilization (Standalone Measure) Improvement Target: Reduce Emergency Department visits for target conditions o Congestive Heart Failure o Diabetes o End Stage Renal Disease o Chronic Obstructive Pulmonary Disease Baseline/Goal: 2 percent improvement over baseline Data Source: Codes for specific diagnoses from EMR Outcome Improvement Target 1 Estimated Incentive Payment*:* **$184,312**	**Outcome Improvement Target 2** [IT-9.2] ED Appropriate Utilization (Standalone Measure) Improvement Target: Reduce Emergency Department visits for target conditions o Congestive Heart Failure o Diabetes o End Stage Renal Disease o Chronic Obstructive Pulmonary Disease Baseline/Goal: 5 percent improvement over baseline Data Source: Codes for specific diagnoses from EMR. Outcome Improvement Target 2 Estimated Incentive Payment*:* **$440,746**
Year 2 Estimated Outcome Amount *(add incentive payments amounts from each milestone/outcome improvement target)*: **$99,092**	Year 3 Estimated Outcome Amount: **$114,861**	Year 4 Estimated Outcome Amount: **$184,312**	Year 5 Estimated Outcome Amount: **$440,746**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)*: **$839,011**			

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OakBend Medical Center

Pass 2

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Title of Outcome Measure (Improvement Target): IT-8.1 Timeliness of Prenatal/Postnatal Care

Unique RHP Outcome Identification Number(s): 127303903.3.6 / Pass 2

Outcome Measure Description:

The outcome for this measure is the percentage of deliveries of live births for which women receive certain key facets of prenatal and postpartum care.

Rationale:

This project is explicitly tied to postnatal care.

Outcome Measure Valuation:

OBMC values each Category 3 outcome measure based on the specific needs of the community, the projected impact on the health outcomes of the community, the level of advancement to the healthcare delivery system, the time, effort, and clinical resources necessary to affect each outcome. The project will also strive to continuously provide quality service to the population.

In valuing this outcome measure, OBMC took into account the extent to which increases in key areas of prenatal and postnatal care would potentially meet the goals of the Waiver (support the development of a coordinated care delivery system, improve outcomes while containing costs, improve the healthcare infrastructure), the extent to which it will address the community needs, the population served, and the resources and cost necessary to achieve this outcome.

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<table>
<tr><td>127303903.3.6</td><td>3.IT-8.1</td><td colspan="2">Timeliness of Prenatal/Postnatal Care</td></tr>
<tr><td colspan="3">OakBend Medical Center</td><td>127303903</td></tr>
<tr><td>Related Category 1 or 2 Projects:</td><td colspan="3">127303903.2.3</td></tr>
<tr><td>Starting Point/Baseline</td><td colspan="3">July 2012</td></tr>
<tr><th>Year 2

(10/1/2012 – 9/30/2013)</th><th>Year 3

(10/1/2013 – 9/30/2014)</th><th>Year 4

(10/1/2014 – 9/30/2015)</th><th>Year 5

(10/1/2015 – 9/30/2016)</th></tr>
<tr><td>Process Milestone 1 [P-1]: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans.

Data Source: Meeting Agendas, sign-n sheets, conference calls, presentations, email, EHR, claims data

Process Milestone 1 Estimated Incentive Payment: $30,702.45

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

Data Source: Meeting Agendas, sign-n sheets, conference calls, presentations, email, EHR, claims data

Process Milestone 2 Estimated Incentive Payment: $30,702.45</td><td>Outcome Improvement Target 1 [IT-8.1]: Perinatal Outcomes: Timeliness of Prenatal/Postnatal Care

<u>Metric 1</u>:

Rate 1: Received a prenatal care visit as a member of the organization in the first trimester or within 42 days of enrollment in the organization.

Outcome Improvement Target: 20% of patients receive prenatal care visit in the first trimester

Rate 2: Had a postpartum visit for a pelvic exam or postpartum care on or between 21 and 56 days after delivery.

Outcome Improvement Target: 15% of postpartum patients will receive postpartum care on or between 21 and 56 days after delivery.</td><td>Outcome Improvement Target 2 [IT-8.1]: Perinatal Outcomes: Timeliness of Prenatal/Postnatal Care

<u>Metric 1</u>:
Rate 1: Received a prenatal care visit as a member of the organization in the first trimester or within 42 days of enrollment in the organization.

Outcome Improvement Target: 30% of patients receive prenatal care visit in the first trimester

Rate 2: Had a postpartum visit for a pelvic exam or postpartum care on or between 21 and 56 days after delivery.

Outcome Improvement Target: 20% of postpartum patients will receive postpartum care on or between 21 and 56 days after delivery.

Data source: EHR, claims</td><td>Outcome Improvement Target 3 [IT-8.1]: Perinatal Outcomes: Timeliness of Prenatal/Postnatal Care

<u>Metric 1</u>:
Rate 1: Received a prenatal care visit as a member of the organization in the first trimester or within 42 days of enrollment in the organization.

Outcome Improvement Target: 40% of patients receive prenatal care visit in the first trimester

Rate 2: Had a postpartum visit for a pelvic exam or postpartum care on or between 21 and 56 days after delivery.

Outcome Improvement Target: 25% of postpartum patients will receive postpartum care on or between 21 and 56 days after delivery.

Data source: EHR, claims</td></tr>
</table>

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	Data source: EHR, claims Outcome Improvement Target 1 Estimated Incentive Payment*:* $72,744	Outcome Improvement Target 2 Estimated Incentive Payment*:* $118,079	Outcome Improvement Target 3 Estimated Incentive Payment*:* $281,363
Year 2 Estimated Outcome Amount: $61,405	Year 3 Estimated Outcome Amount: $72,744	Year 4 Estimated Outcome Amount: $118,079	Year 5 Estimated Outcome Amount: $281,363
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)*: $533,591			

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Oakbend Medical Center

Pass 3

DRAFT

Title of Outcome Measure (Improvement Target): IT-3.4 Renal Disease 30-Day Readmission Rate

Unique RHP Outcome Identification Number(s): 127303903.3.7 / Pass 2

Outcome Measure Description:

The outcome for this measure is readmissions (for patients 18 years and older), for any cause, within 30 days of discharge from the index renal disease, COPD, Congestive Heart Failure and Diabetes admissions.

Rationale:

OBMC has a relatively large population with the above diseases and part of the wellness program will be specifically targeted to these patients.. In 2011, OBMC had 1,545 patients admitted with one of the above as their primary admitting diagnosis. There are more than triple that number who are admitted with these as a diagnosis secondary. Therefore, measuring the readmission rate for these disease specific illnesses will be a reasonable measure of this project's success.

Outcome Measure Valuation:

OBMC values each Category 3 outcome measure based on the specific needs of the community, the projected impact on the health outcomes of the community, the level of advancement to the healthcare delivery system, and the time, effort, and clinical resources necessary to effect each outcome.

In valuing this outcome measure, OBMC took into account the extent to which the reduction in readmissions for these diagnoses would potentially meet the goals of the Waiver (support the development of a coordinated care delivery system, improve outcomes while containing costs, improve the healthcare infrastructure), the extent to which it will address the community needs, the population served, and the resources and cost necessary to achieve this outcome.

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<table>
<tr><td>127303903.3.7</td><td>3.IT-3.4</td><td colspan="2">Renal Disease 30-Day Readmission Rate</td></tr>
<tr><td colspan="3">OakBend Medical Center</td><td>127303903</td></tr>
<tr><td>Related Category 1 or 2 Projects:</td><td colspan="3">127303903.2.4</td></tr>
<tr><td>Starting Point/Baseline</td><td colspan="3">July 2012</td></tr>
<tr><th>Year 2
(10/1/2012 – 9/30/2013)</th><th>Year 3
(10/1/2013 – 9/30/2014)</th><th>Year 4
(10/1/2014 – 9/30/2015)</th><th>Year 5
(10/1/2015 – 9/30/2016)</th></tr>
<tr><td>Process Milestone 1 [P-1]: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans.

Data Source: Project data; time lines and encounter data; Meeting Agendas, sign-n sheets, conference calls, metrics, presentations, emails with RHP entities and patients.

Process Milestone 1 Estimated Incentive Payment: $89,761.05
Process Milestone 2 [P-2]: Establish baseline rates.
Data Source: EHR, claims
Process Milestone 2 Estimated Incentive Payment: $89,761.05</td><td>Outcome Improvement Target 1 [IT-3.4]: Potentially Preventable Readmissions: Renal Disease 30-Day Readmission Rate (Standalone Measure)

<u>Metric 1</u>:
Renal Disease 30-Day Readmission Rate

Outcome Improvement Target: 2% reduction in preventable readmissions

Data source: EHR, claims

Outcome Improvement Target 1 Estimated Incentive Payment: $215,123.40</td><td>Outcome Improvement Target 2 [IT-3.4]: Potentially Preventable Readmissions: Renal Disease 30-Day Readmission Rate (Standalone Measure)

<u>Metric 1</u>:
Renal Disease 30-Day Readmission Rate

Outcome Improvement Target: 4% reduction in preventable readmissions.

Data source: EHR, claims

Outcome Improvement Target 1 Estimated Incentive Payment: $352,623.00</td><td>Outcome Improvement Target 3 [IT-3.4]: Potentially Preventable Readmissions: Renal Disease 30-Day Readmission Rate (Standalone Measure)

<u>Metric 1</u>:
Renal Disease 30-Day Readmission Rate

Outcome Improvement Target: 5% reduction in preventable readmissions.

Data source: EHR, claims

Outcome Improvement Target 1 Estimated Incentive Payment: $839,439.15</td></tr>
<tr><td>Year 2 Estimated Outcome Amount: $179,522.10</td><td>Year 3 Estimated Outcome Amount: $215,123.40</td><td>Year 4 Estimated Outcome Amount: $352,623.00</td><td>Year 5 Estimated Outcome Amount: $839,439.15</td></tr>
<tr><td colspan="4">TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5): $1,586,708</td></tr>
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Rice Medical Center

Pass 1

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Title of Outcome Measure (Improvement Target): IT-6.1.1 Percent improvement over baseline of patient satisfaction scores establishing patients are getting timely care, appointments and information

Unique RHP outcome identification number: 212060201.3.1

Outcome Measure Description:

Rice will measure patient satisfaction for the patients served in the East Bernard clinic, who will have increased access to an FP/OB under Project 1.1.2. Rice will use the CAHPS survey to establish if patients who use the clinic feel they are receiving timely appointments, care, and information.

Process Milestones

- DY 2: P-1; P-1.1
- DY 3: P-5; P-5.1
- DY 4: P-4; P-4.1
- DY5: I-12.1; I-12.2

Outcome Improvement Target for each year:

- DY4: IT-6.1
- DY5: IT-6.1

Rationale:

The low-income community members residing in East Bernard and the boundaries of the Rice Hospital District are presently underserved by physicians providing primary care and OB services, as is reflected by Colorado County's designation as a HPSA. In seeking to improve access to care, it is important to measure the patients' perspective on how effective efforts toward obtaining that goal have been. If they have been successful, the patient survey scores will apprise Rice of best practices (i.e. using after-hours, having primary care providers who also specialize in a particular type of care). If patient satisfaction with access to timely care, appointments, and information does not increase, then Rice will have learned the lesson that perhaps the infrastructure or administration of the clinic need to change.

Outcome Measure Valuation:

The valuation of each Rice project takes into account the degree to which the project accomplishes the triple-aim of the Waiver, community needs, the population served by the project (both number of people and complexity of patient needs), and investment required to implement the project. This is Rice's most valuable Category 3 project because Rice seeks to improve patient access to primary care through participating in DSRIP, and this outcome will measure how successful Rice's efforts have been. Patient satisfaction leads to increased and earlier use of the health care delivery system, and better overall patient outcomes and quality of life. For these reasons, this outcome is of high value to the community.

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212060201.3.1	*3.IT-6.1*	***Percent improvement over baseline of patient satisfaction scores***	
Rice			*212060201*
Related Category 1 or 2 Outcome Project(s):	*212060201.1.1*		
Starting Point/Baseline:	*To be established DY3.*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-1]: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. Data Source*:* Rice will identify the correct survey instrument, train providers on administering the survey, and begin educating patients on the hospital's initiative to improve patient satisfaction. Process Milestone 1 Estimated Incentive Payment: $7,940	**Milestone 2** [P-2]: Establish baseline rate Data Source: Using the HCAHPS standardized survey instrument, Rice will establish the average East Bernard Clinic patient satisfaction scores for all patients surveyed. Process Milestone 2 Estimated Incentive Payment $9,203	**Outcome Improvement Target 1** [IT 6.1(1)]: Establish if East Bernard Clinic patients are getting timely care, appointments and information. Improvement Target**:** Expect 5% increase of patient satisfaction over baseline Data Source**:** Patient survey Outcome Improvement Target 1 Estimated Incentive Payment: $14,768	**Outcome Improvement Target 2** [IT 6.1(1)]: Establish if East Bernard Clinic patients are getting timely care, appointments and information. Improvement Target: Expect 10% increase of patient satisfaction over baseline Data Source**:** Patient survey Outcome Improvement Target 2 Estimated Incentive Payment: $35,314
Year 2 Estimated Milestone Bundle Amount: $7,940	Year 3 Estimated Milestone Bundle Amount: $9,203	Year 4 Estimated Milestone Bundle Amount: $14,768	Year 5 Estimated Milestone Bundle Amount: $35,314
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)**:*** $67,225			

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Title of Outcome Measure (Improvement Target): IT 6.1(1) – Percent improvement over baseline of patient satisfaction scores - timeliness of appointments, care, and information

Unique RHP outcome identification number: 212060201.3.2

Outcome Measure Description:
Rice will engage in CAHPS patient surveys to measure the satisfaction of patients who have been entered into the ImmTrack system. Through expanding its use of Immunization Tracking, Rice will be able to communicate with patients about their immunization due dates and options. Additionally, Rice can use the data it collects to assure that patients do not receive duplicative immunization shots. This service will remove some of the burden on Rice's hospital and clinic patients to remember when their immunizations are due, and if they have already updated them. Additionally, Rice can target populations that are especially at risk for flu and assure that they are seen early in the flu season (i.e. elderly, children, individuals with weak immune systems), which will improve these patients' overall quality of life and satisfaction with the health care and information they receive from their provider. These improvements are intended to improve patients' satisfaction with the timeliness of their appointments, care, and information from their provider.

Starting Point/Baseline:
Rice does not currently measure patient satisfaction scores in the domain of timeliness of appointments, care and information.

Rationale:
Colorado County has a high rate of preventable hospital stays (higher than Texas and Harris County), a high rate children living in poverty (higher than Texas and Harris County) and a high rate of poor physical health days (higher than Texas and Harris County). Children, the elderly, and those in poor health are especially at risk for being admitted to the hospital for the flu, so tracking who has been immunized in the community may help Rice reach out to those most at risk to assure that they receive their flu shot. According to the Planning Protocol, "Public reporting will serve to enhance public accountability in health care by increasing the transparency of the quality of institutional care provided in return for the public investment."

Project Valuation:
The valuation of each Rice project takes into account the degree to which the project accomplishes the triple-aim of the Waiver, community needs, the population served by the project (both number of people and complexity of patient needs), and investment required to implement the project. This outcome's value is based upon the importance of obtaining patients' perspective on their health care provision and outcomes in our effort to transform the delivery system. Additionally, this project will touch the vast majority of Rice's patients.

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212060201.3.2	*3.IT-6.1(1)*	*PERCENT IMPROVEMENT OVER BASELINE OF PATIENT SATISFACTION SCORES - TIMELINESS OF APPOINTMENTS, CARE, AND INFORMATION*	
Rice			212060201
Related Category 1&2 Projects(s):	*212060201.2.1*		
Starting Point/Baseline:	*To be established in DY3.*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1] Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. Data Source**:** Rice will identify the correct survey instrument, train providers on administering the survey, and begin educating patients on the hospital's initiative to improve patient satisfaction. Process Milestone 1 Estimated Incentive Payment $2,382	**Process Milestone 2** [P-2] Establish baseline rate Data Source**:** Use the relevant CAHPS survey to establish the average patient satisfaction score for patients seen in Colorado County clinics, measuring the timeliness of appointments, care, and information. Process Milestone 2 Estimated Incentive Payment $2,761	**Improvement Milestone 1 [**IT-6.1]1Improve Colorado County clinics' patient satisfaction scores in the domain of timely appointments, care, and information Baseline/Goal: Improve by 10% over baseline Data Source**:** Patient survey Outcome Improvement Target 1 Estimated Incentive Payment: $4,430	**Improvement Milestone 2** IT 6.1.1 Improve Colorado County clinics' patient satisfaction scores in the domain of timely appointments, care, and information Baseline/Goal: Improve by 15% over baseline Data Source**:** Patient survey Outcome Improvement Target 2 Estimated Incentive Payment: $10,594
Year 2 Estimated Milestone Bundle Amount: $2382	Year 3 Estimated Milestone Bundle Amount: $2761	Year 4 Estimated Milestone Bundle Amount: $4430	Year 5 Estimated Milestone Bundle Amount: $10,594
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)**:*** $20,167			

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Title of Outcome Measure (Improvement Target): IT-10.1 Quality of Life

Unique RHP Outcome identification number: 212060201.3.3

Outcome Measure Description:

The outcome of the Chronic Disease Outreach project will be to accomplish improvement in quality of life scores over the life of the Waiver for Rice community members identified as at-risk or suffering from chronic conditions such as diabetes, high blood pressure, and COPD. Expected challenges in attaining this outcome include recruiting staff for the clinic, negotiating space for the clinic, reaching out to traditionally underserved communities, engaging in effective patient education, and doing so with limited resources.

Process Milestones:

- P-1 Project Planning; P-2 Establish baseline

Outcome Improvement Targets for each year:

IT-10.1 Quality of Life - demonstrating annual increase

Rationale:

Colorado County has a high rate of morbidity and mortality (both higher than Harris County), poor physical health days (higher than Texas and Harris County), and premature death (higher than Texas and Harris County). Colorado County residents will benefit from increased quality and quantity of interventions for their chronic diseases. Improved management of these conditions will lead to improved quality of life (as measured by an evidence based and validated assessment tool) for the patients.

Outcome Measure Valuation:

The valuation of each Rice project takes into account the degree to which the project accomplishes the triple-aim of the Waiver, community needs, the population served by the project (both number of people and complexity of patient needs), and investment required to implement the project. This project is valued to reflect the importance of maintaining quality of life for patients suffering from chronic disease, which has a ripple effect of improving their family and friends' quality of life.

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212060201.3.3	*3.IT-10.1*		*QUALITY OF LIFE*
Rice			*212060201*
Related Category 1 or 2 Projects:	*212060201.2.2*		
Starting Point/Baseline:	*To be established in DY3.*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source*:* Identify a valid and evidence-based instrument through which to measure the targeted patients' quality of life (chronic disease sufferers in the 3 areas Rice identifies through Project 2.2.2) Milestone 1 Estimated Incentive Payment: $4,764	**Milestone 2** [P- 2] Establish a - baseline. Data Source**:** Survey results Milestone 2 Estimated Incentive Payment: $5,522	**Outcome Improvement Target 1** [IT 10.1] Quality of Life Goal: Demonstrate improvement in quality of life scores for identified Colorado County patients (5% over baseline) Data Source**:** Survey results Outcome Improvement Target 1 Estimated Incentive Payment: $8,861	**Outcome Improvement Target 2** [IT 10.1] Quality of Life Goal: Demonstrate improvement in quality of life scores for identified Colorado County patients (10% over baseline) Data Source**:** Survey results Outcome Improvement Target 2 Estimated Incentive Payment: $21,288
Year 2 Estimated Milestone Bundle Amount: $4764	Year 3 Estimated Milestone Bundle Amount: $5522	Year 4 Estimated Milestone Bundle Amount: $8861	Year 5 Estimated Milestone Bundle Amount: $21,188
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $ 40,335			

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Title of Outcome Measure (Improvement Target): IT-1.10 Diabetes Care: HbA1c poor control (>9.0%)

Unique RHP Outcome Identification number: 212060201.3.4

Outcome Measure Description:
Rice will implement a Certified Diabetes Teaching Center for patients in Colorado County.

Through implementing a Certified Diabetes Teaching Center, Rice aims to improve the percentage of patients in Colorado County with uncontrolled blood sugar (IT1.10). The Center will accomplish this by educating the diabetic community on diabetes medication and diet management tactics, leading to better control of blood sugar. Patient education, follow-up, and management will result in better overall health outcomes for the targeted population, including increased quality of life, reduced use of acute care, and slower progression of this chronic disease. Achieving this outcome will require Rice to not only communicate with the target population, but to affect their lifestyle choices. Patients will need to reduce poor eating habits, increase physical activity, and manage their medications (when applicable), which Rice cannot force patients to do on a regular basis.

Rice intends to reach out to the community through innovative methods (including social media, creating coalitions, and other methods of community outreach) to create support networks and community engagement in accomplishing this outcome, which is meant to benefit individuals at-risk and the community as a whole.

Process Milestones:

- DY2: P-1; P-1.1
- DY3: P-3; P-3.1

Outcome Improvement Targets for each year:

- DY4: I-6; I-6.1
- DY5: I-8; I-8.1

Rationale:

Colorado County has a high rate of preventable hospital stays (higher than Texas and Harris County) and at least 15% of the county's community does not receive any diabetes screening. Coupled with the high rate of obesity and inactivity in Colorado County (equal to and higher than Texas, respectively), there is good reason to believe that uncontrolled blood sugar for diabetics is a cause of the County's high rate of potentially preventable admissions. Achieving this outcome domain will have positive effects on the health outcomes for patients and the cost of delivering health care for Rice Medical Center.

Outcome Measure Valuation:
The valuation of each Rice project takes into account the degree to which the project accomplishes the triple-aim of the Waiver, community needs, the population served by the project (both number of people and complexity of patient needs), and investment required to implement the project. This particular project is valued as Rice's second highest value outcome due to the importance of controlling blood sugar and preventing hospital admissions for diabetics

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with uncontrolled blood sugar. Hospital admissions reduce a patient’s quality of life, functionality, morale, and short- and long-term health outcomes. Additionally, they create an increased cost burden on the health care delivery system, which affects the entire community. Achieving this outcome will take considerable and concerted effort and investment in infrastructure, but the outcome will justify the expense.

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212060201.3.4	*3.IT-1.10*	**DIABETES CARE: HBAIC POOR CONTROL**	
	Rice		*212060201*
Related Category 1 or 2 Project(s):	***212060201.2.3***		
Starting Point/Baseline:	*To be established in DY3.*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1] Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. (Rice will determine how to give effect to this outcome (increasing blood sugar control among the diabetic population in Colorado County) through the Certified Diabetes Teaching Center, using evidence-based and innovative methods for outreach and engagement.) Data Source**:** Information from discussions/interviews with primary and community health care providers, city and county governments, charities, faith based organizations and other community based helping organizations Process Milestone 1 Estimated Incentive Payment: $4,367	**Process Milestone 2** [P-2] Establish a baseline. Data Source: EHR Process Milestone 2 Estimated Incentive Payment: $5,062	**Outcome Improvement Target 1 –** [IT-1.10] Diabetes Care: HbA1c poor control Improvement Target: Improve HbA1c control > 9% in the Colorado County diabetic population by 5% over baseline Data Source**:** EHR Outcome Improvement Target 1 Estimated Incentive Payment: $8,122	**Outcome Improvement Target 2** [IT-1.10] Diabetes Care: HbA1c poor control Improvement Target: Improve HbA1c control > 9% in the Colorado County diabetic population by 10% over baseline Data Source**:** EHR Outcome Improvement Target 2 Estimated Incentive Payment: $19,422
Year 2 Estimated Milestone Bundle Amount:$4367	Year 3 Estimated Milestone Bundle Amount: $5062	Year 4 Estimated Milestone Bundle Amount: $8122	Year 5 Estimated Milestone Bundle Amount: $19,422
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:** $36,973			

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Rice Medical Center

Pass 3

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Title of Outcome Measure (Improvement Target): IT-6.1 Percent improvement over baseline of patient satisfaction scores: (3) patient's rating of doctor access to specialist.

Unique RHP Outcome ID: 212060201.3.5 / Pass 3

Outcome Measure Description:

By implementing telemedicine in its hospital, Rice will increase its patients' satisfaction with their and their doctors' access to specialists. Rice will measure the satisfaction of all its patients in this domain, with the expected outcome of an increase in satisfaction as the telemedicine program expands.

Starting Point/Baseline:

Rice currently only measures patient satisfaction based on whether the hospital meets all of a patient's healthcare needs.

Rationale:

Colorado County is a rural community. It can be very difficult for patients to access specialists, often having to travel long distances. Likewise, it is difficult for patient's primary care physicians to coordinate with specialists for consultation and referral from a rural community. Patient satisfaction will increase when patients have closer and more immediate access to specialty care for consultations and referrals, especially as this is expected to result in improved patient outcomes.

Project Valuation:

The valuation of each Rice project takes into account the degree to which the project accomplishes the triple-aim of the Waiver, community needs, the population served by the project (both number of people and complexity of patient needs), and investment required to implement the project. The value of this project is based on Rice's belief that patient satisfaction leads to increased and earlier use of the health care delivery system, and better overall patient outcomes and quality of life. The capability to engage in telehealth and telemedicine will allow Rice to provide a broader range of treatment and diagnostic services to its patients, removing the need for those patients to travel to urban areas to access care and allowing for quicker access to often crucial health information. The telemedicine program can continually be expanding as Rice is able to identify additional specialist providers to participate in the program; thus, the potential impact for the satisfaction with their access to information, care, and appointments for patients in Rice's community will only grow over time. For these reasons, this outcome is of high value to the community.

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212060201.3.5	*3.IT-6.1(3)*		*Patient Satisfaction With patients' ratings of their doctor access to specialist.*
Rice			*212060201*
Related Category 1 or 2 Outcome Project(s):	***212060201.1.2***		
Starting Point/Baseline:	To be established in DY3.		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning. Metric 1: Rice will identify the correct survey instrument, train providers on administering the survey, and begin educating patients on the hospital's initiative to improve patient satisfaction. Process Milestone 1 Estimated Incentive Payment: $41,111	**Process Milestone 2** [P-2]: Establish a baseline. Metric 1: Using the HCAHPS standardized survey instrument, Rice will establish the average patient rating concerning their doctor access to specialists. Data Source: Survey results Process Milestone 2 Estimated Incentive Payment: $41,111	**Outcome Improvement Target 1** [IT 6.1(3)] – Percent Improvement Over Baseline Of Patient Satisfaction Scores: Establish an increase in Rice's patients' ratings of their doctor access to specialist. Metric 1: X percent improvement in targeted patient ratings Improvement Target: TBD Data Source: Survey results Outcome Improvement Target 1 Estimated Incentive Payment: $61,667	**Outcome Improvement Target 2** [IT 6.1(3)] – Percent Improvement Over Baseline Of Patient Satisfaction Scores: Establish an increase in Rice's patients' ratings of their doctor access to specialist. Metric 1: X percent improvement in targeted patient ratings Improvement Target: TBD Data Source: Survey results Outcome Improvement Target 2 Estimated Incentive Payment: $135,667
Year 2 Estimated Milestone Bundle Amount: $41,111	Year 3 Estimated Milestone Bundle Amount: $41,111	Year 4 Estimated Milestone Bundle Amount: $61,667	Year 5 Estimated Milestone Bundle Amount: $135,667
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $279,556			

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Title of Outcome Measure (Improvement Target): IT-6.1 Percent improvement over baseline of patient satisfaction scores: (5) patient's overall health status/functional status.

Unique RHP Outcome ID: 212060201.3.6 / Pass 3

Outcome Measure Description:
By establishing a new primary care clinic in Walls, Texas, Rice will increase the overall health and well-being of patient populations in this community. Rice will measure the satisfaction of all its patients in this domain, with the expected outcome of an increase in satisfaction as the primary care clinic is expanded and/or implemented.

Starting Point/Baseline:

Rice is not currently measuring patients' satisfaction with their overall health.

Rationale:

Wallis, Texas is a rural community. It can be very difficult for patients to access primary care, and they often must travel long distances to obtain simple services. Patient satisfaction and overall health will increase when patients have closer and more immediate access to primary care, especially as this is expected to result in improved patient outcomes. Patient satisfaction is important because satisfied patients are more likely to keep regular appointments with their PCPs and heed their providers' advice.

Project Valuation:

The valuation of each Rice project takes into account the degree to which the project accomplishes the triple aim of the Waiver, community needs, the population served by the project (both number of people and complexity of patient needs), and investment required to implement the project. The value of this project is based on Rice's belief that patient satisfaction leads to increased and earlier use of the health care delivery system, and better overall patient outcomes and quality of life. Improved patient outcomes are linked to decreased costs of providing care over the long term, and the savings can be redirected into improving the overall quality and quantity of services in the local community. For these reasons, this outcome is of high value to the community.

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212060201.3.6	*3.IT-.6.1*		*Percent Improvement over Baseline of Patient Satisfaction Scores*
Rice Medical Center			*212060201*
Related Category 1 or 2 Outcome Project(s):	212060201.1.3		
Starting Point/Baseline:	To be established in DY3.		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning. Metric 1: Rice will identify the correct survey instrument, train providers on administering the survey, and begin educating patients on the hospital's initiative to improve patient satisfaction. Process Milestone 1 Estimated Incentive Payment: $82,222	**Process Milestone 2** [P-2]: Establish a baseline. Metric 1: Using the HCAHPS standardized survey instrument, Rice will establish the average patient rating concerning their overall health. Data Source: Survey results Process Milestone 2 Estimated Incentive Payment: $82,222	**Outcome Improvement Target 1** [IT 6.1(5)] – Percent Improvement Over Baseline Of Patient Satisfaction Scores: Establish an increase in Rice's patients' ratings of their overall health. Metric 1: X percent improvement in targeted patient ratings Improvement Target: TBD Data Source: Survey results Outcome Improvement Target 1 Estimated Incentive Payment: $123,333	**Outcome Improvement Target 1** [IT 6.1(5)] – Percent Improvement Over Baseline Of Patient Satisfaction Scores: Establish an increase in Rice's patients' ratings of their overall health. Metric 1: X percent improvement in targeted patient ratings Improvement Target: TBD Data Source: Survey results Outcome Improvement Target 2 Estimated Incentive Payment: $271,333
Year 2 Estimated Milestone Bundle Amount: $82,222	Year 3 Estimated Milestone Bundle Amount: $82,222	Year 4 Estimated Milestone Bundle Amount: $123,333	Year 5 Estimated Milestone Bundle Amount: $271,333
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $559,110			

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Title of Outcome Measure (Improvement Target): IT-9.2: ED Appropriate Utilization

Unique RHP Outcome ID: 212060201.3.7 / Pass 3

Outcome Measure Description:

By establishing an urgent care clinic in its hospital facility at which non-emergent patients can seek time-sensitive care, Rice will reduce inappropriate utilization of its Emergency Department.

Starting Point/Baseline: Approximately 60% of patients presenting for care at Rice's Emergency Department are not truly emergent.

Rationale:

Rice currently experiences serious overutilization of its Emergency Department. This is due in large part to the lack of alternatives for urgent patients who need time-sensitive care, but not the same level of care provided by the Emergency Department. By providing a clearly superior alternative to the Emergency Department, this urgent care clinic project will reduce improper utilization of Rice's Emergency Department. Providing care in the ED is more expensive than in primary care clinics or urgent care clinics, and with over 1 in 5 patients Rice treats annually being Medicaid-eligible or uninsured, the local and regional cost of delivering care will benefit from a reduction in inappropriate ED usage.

Project Valuation:

The valuation of each Rice project takes into account the degree to which the project accomplishes the triple aim of the Waiver, community needs, the population served by the project (both number of people and complexity of patient needs), and investment required to implement the project. The value of this project is based on Rice's belief that appropriate utilization of emergent care will result in better overall patient outcomes and quality of life. Many of the patients Rice treats each year either do not have access to clinic services in the community (due to a provider shortage, an inconvenient work schedule, or inability to travel, for example) or feel that they cannot access affordable care. These patients are often inclined to wait until their conditions worsen to the point of being emergent before seeking care, which is detrimental to their overall health, quality of life, and the systemic cost of delivering. Rice wishes to implement innovative solutions to the problems facing rural, indigent patients, and this urgent care clinic (located conveniently nearby the ED) is one way to provide patients an alternative to accessing care in the ED. For these reasons, this outcome is of high value to the community.

212060201.3.7	*3.IT-9.2*	*ED Appropriate Utilization*	
Rice Medical Center			*212060201*
Related Category 1 or 2 Outcome Project(s):	*212060201.1.4*		
Starting Point/Baseline:	*To be established in DY3.*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning. Metric 1: Documentation of resources identified, stakeholders identified, and implementation plans. Determine best practices for redirecting patients and effecting a reduction in the use of the ED for non-emergent conditions. Process Milestone 1 Estimated Incentive Payment: $61,667	**Process Milestone 2** [P-2]: Establish a baseline. Metric 1: Number of patients treated in the ED (including emergent and those determined to be non-emergent) Process Milestone 2 Estimated Incentive Payment: $61,667	**Outcome Improvement Target 1** [IT-9.2]– Reduce all ED visits. Metric 1: X% reduction Improvement Target: TBD Numerator: ED visits for DY 4 Denominator: ED visits for DY 3 Data Source: EHR; ED records of visits and admits Outcome Improvement Target 1 Estimated Incentive Payment: $92,500	**Outcome Improvement Target 2** [IT-9.2]– Reduce all ED visits. Metric 1: X% reduction Improvement Target: TBD Numerator: ED visits for DY 4 Denominator: ED visits for DY 3 Data Source: EHR; ED records of visits and admits Outcome Improvement Target 2 Estimated Incentive Payment: $203,500
Year 2 Estimated Milestone Bundle Amount: *(add incentive payments amounts from each milestone)* $61,667	Year 3 Estimated Milestone Bundle Amount: $61,667	Year 4 Estimated Milestone Bundle Amount: $92,500	Year 5 Estimated Milestone Bundle Amount: $203,500
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5)***:** $419,334			

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Title of Outcome Measure (Improvement Target): IT-6.1 Percent improvement over baseline of patient satisfaction scores: (3) patient's rating of doctor access to specialist.

Unique RHP Outcome ID: 212060201.3.8 / Pass 3

Outcome Measure Description:
By adding new specialists in its hospital clinic, Rice will increase its patients' satisfaction with their and their doctors' access to specialists. Rice will measure the satisfaction of all its patients in this domain, with the expected outcome of an increase in satisfaction as the specialty services expand.

Starting Point/Baseline:

Rice is not currently measuring patients' satisfaction with their or their doctors' access to specialists.

Rationale:

Colorado County is a rural community. It can be very difficult for patients to access specialists, often having to travel long distances. Likewise, it is difficult for patient's primary care physicians to coordinate with specialists for consultation and referral from a rural community. Patient satisfaction will increase when patients have closer and more immediate access to specialty care for consultations and referrals, especially as this is expected to result in improved patient outcomes.

Project Valuation:

The valuation of each Rice project takes into account the degree to which the project accomplishes the triple aim of the Waiver, community needs, the population served by the project (both number of people and complexity of patient needs), and investment required to implement the project. The value of this project is based on Rice's belief that patient satisfaction leads to increased and earlier use of the health care delivery system, and better overall patient outcomes and quality of life. The ENT is a physician able to treat a myriad of conditions and can examine and refer patients to other providers as needed. An orthopedic specialist is likewise able to diagnose and treat a myriad of conditions, ranging from chronic conditions to severe injuries. Many of the people Rice treats each year through its hospital and/or clinics will benefit from the weekly availability of these providers. For these reasons, this outcome is of high value to the community.

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212060201.3.8	*3.6.1*	*Percent Improvement over Baseline of Patient Satisfaction Scores(3) patient's rating of doctor access to specialist.*	
Rice Medical Center			*212060201*
Related Category 1 or 2 Outcome Project(s):	*212060201.1.5*		
Starting Point/Baseline:	To be established in DY3.		

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning. Metric 1: Rice will identify the correct survey instrument, train providers on administering the survey, and begin educating patients on the hospital's initiative to improve patient satisfaction. Process Milestone 1 Estimated Incentive Payment: $102,778	**Process Milestone 2** [P-2]: Establish a baseline. Metric 1: Using the HCAHPS standardized survey instrument, Rice will establish the average patient rating concerning their doctor access to specialists. Data Source: Survey results Process Milestone 2 Estimated Incentive Payment: $102,778	**Outcome Improvement Target 1** [IT 6.1(3)] – Percent Improvement Over Baseline Of Patient Satisfaction Scores: Establish an increase in Rice's patients' ratings of their doctor access to specialist. Metric 1: X percent improvement in targeted patient ratings Improvement Target: TBD Data Source: Survey results Outcome Improvement Target 1 Estimated Incentive Payment: $154,167	**Outcome Improvement Target 2** [IT 6.1(3)] – Percent Improvement Over Baseline Of Patient Satisfaction Scores: Establish an increase in Rice's patients' ratings of their doctor access to specialist. Metric 1: X percent improvement in targeted patient ratings Improvement Target: TBD Data Source: Survey results Outcome Improvement Target 2 Estimated Incentive Payment: $339,167
Year 2 Estimated Milestone Bundle Amount: $102,778	Year 3 Estimated Milestone Bundle Amount: $102,778	Year 4 Estimated Milestone Bundle Amount: $154,167	Year 5 Estimated Milestone Bundle Amount: $339,167
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over Years 2-5):* $698,890			

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Title of Outcome Measure (Improvement Target): IT-6.1 Percent improvement over baseline of patient satisfaction scores: (1) patients are getting timely care, appointments, and information.

Unique RHP Outcome ID: 212060201.3.9 / Pass 3

Outcome Measure Description:
The outcome of Expanding the East Bernard Clinic will to improve patient satisfaction scores in the domain of timeliness of appointments, care, and information. Rice will measure patient satisfaction of the clinic's patients using the CAHPS survey.

Starting Point/Baseline: Rice is not currently measuring patient satisfaction for the East Bernard Clinic.

Rationale: According to the Planning Protocol, "Public reporting will serve to enhance public accountability in health care by increasing the transparency of the quality of institutional care provided in return for the public investment." Rice intends to improve patient access and patients' perception of their access in East Bernard, which Rice expects will result in improved health outcomes (as patients will engage in preventative care more readily if they feel they have adequate access).

Project Valuation: The valuation of each Rice project takes into account the degree to which the project accomplishes the triple-aim of the Waiver, community needs, the population served by the project (both number of people and complexity of patient needs), and investment required to implement the project. This project is valued to reflect the importance of maintaining patient satisfaction with the provision of primary healthcare so that patients will continue to participate in the system.

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<table>
<tr><td>212060201.3.9</td><td>3.IT-6.1</td><td colspan="2">PERCENT IMPROVEMENT OVER BASELINE OF PATIENT SATISFACTION SCORES: (1) PATIENTS ARE GETTING TIMELY CARE, APPOINTMENTS, AND INFORMATION</td></tr>
<tr><td colspan="3">Rice</td><td>212060201</td></tr>
<tr><td>Related Category 1 or 2 Project(s):</td><td colspan="3">212060201.1.6</td></tr>
<tr><td>Starting Point/Baseline:</td><td colspan="3">To be established in DY3.</td></tr>
<tr><th>Year 2
(10/1/2012 – 9/30/2013)</th><th>Year 3
(10/1/2013 – 9/30/2014)</th><th>Year 4
(10/1/2014 – 9/30/2015)</th><th>Year 5
(10/1/2015 – 9/30/2016)</th></tr>
<tr><td>Process Milestone 1 [P-1]: Project planning.

Metric 1:
Determine the best instrument for measuring patient satisfaction scores, train providers in the East Bernard Clinic to administer the survey, and create system for collecting and reporting the scores.

Process Milestone 1 Estimated Incentive Payment: $82,222</td><td>Process Milestone 2 [P-2]: Establish a baseline.

Metric 1:
Measure the patient satisfaction of the East Bernard Clinic's patients with the timeliness of their appointments, care, and information (using a validated assessment tool)
Data Source: Survey results

Process Milestone 2 Estimated Incentive Payment: $82,222</td><td>Outcome Improvement Target 1
[IT 6.1(1)] – Percent Improvement Over Baseline Of Patient Satisfaction Scores: (1) Patients Are Getting Timely Care, Appointments, And Information

Metric 1: DY4 scores compared with DY3 scores.
Improvement Target: Demonstrate improvement in patient satisfaction scores for East Bernard Clinic patients (5% over baseline).
Data Source: Survey results

Outcome Improvement Target 1 Estimated Incentive Payment: $123,333</td><td>Outcome Improvement Target 2
[IT 6.1(1)] – Percent Improvement Over Baseline Of Patient Satisfaction Scores: (1) Patients Are Getting Timely Care, Appointments, And Information

Metric 1: DY5 scores compared with DY3 scores.
Improvement Target: Demonstrate improvement in patient satisfaction scores for East Bernard Clinic patients (10% over baseline).
Data Source: Survey results

Outcome Improvement Target 2 Estimated Incentive Payment: $271,333</td></tr>
<tr><td>Year 2 Estimated Milestone Bundle Amount: $82,222</td><td>Year 3 Estimated Milestone Bundle Amount: $82,222</td><td>Year 4 Estimated Milestone Bundle Amount: $123,333</td><td>Year 5 Estimated Milestone Bundle Amount: $271,333</td></tr>
<tr><td colspan="4">TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5): $559,110</td></tr>
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Spindletop Center

Pass 1

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Title of Outcome Measure (Improvement Target): OD-6 Patient Satisfaction
IT-6.1 (1) Percent improvement over baseline of patient satisfaction scores-Patients are getting timely care, appointments, and information

Unique RHP Project identification number: 096166602.3.1
Outcome Measure Description:

For demonstration years 3-5, Spindletop has selected improvement outcome measure IT-6.1 (1), percent improvement over baseline of patient satisfaction scores, patients are getting timely care, appointments, and information.

The process milestone selected for demonstration year 2 to prepare for the outcomes is P-2, establish baseline rates. This will involve developing a patient satisfaction survey for the new service to be provided and establishing the satisfaction baseline in year 2.

Rationale:

Since the goal of this project is to provide expanded primary care for our behavioral health clients, measuring the availability and timeliness of physical health care and appointments that meet clients' needs is important. If clients are satisfied with the service, they will be more likely to access primary care that will lead to improved physical health.

Outcome Measure Valuation:
Spindletop considered several factors in valuing this project including reductions in costs associated with emergency room visits and hospitalizations for diseases and illnesses. Improving the physical health of behavioral health clients should reduce the number of ED visits and the occurrences of hospitalizations.

Another valuation factor used for this project is the monetary value for a collaborative primary/behavioral health intervention as measured by quality adjusted life-years multiplied by a life year value. This valuation methodology uses health economic studies to assign a life year value associated with the health intervention.

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<table>
<tr><td>096166602.3.1</td><td>IT-6.1(1)</td><td colspan="2">Percent improvement over baseline of patient satisfaction scores-Patients are getting timely care, appointments, and information</td></tr>
<tr><td colspan="3">Spindletop Center</td><td>096166602</td></tr>
<tr><td>Related Category 1 or 2 Projects:</td><td colspan="3">096166602.2.1</td></tr>
<tr><td>Starting Point/Baseline:</td><td colspan="3">To be established in Year 2</td></tr>
<tr><td>Year 2
(10/1/2012 – 9/30/2013)</td><td>Year 3
(10/1/2013 – 9/30/2014)</td><td>Year 4
(10/1/2014 – 9/30/2015)</td><td>Year 5
(10/1/2015 – 9/30/2016)</td></tr>
<tr><td>Process Milestone 1 P-2:
Establish baseline rates
Data Source: Survey document; survey results

Process Milestone 1 Estimated Incentive Payment: $14,073</td><td>Outcome Improvement Target 1 IT-6-1(1):
Percent improvement over baseline of patient satisfaction scores-Patients are getting timely care, appointments, and information
Improvement Target: TBD
Data Source: Survey results

Outcome Improvement Target 1 Estimated Incentive Payment: $32,623</td><td>Outcome Improvement Target 2 IT-6-1(1):
Percent improvement over baseline of patient satisfaction scores-Patients are getting timely care, appointments, and information
Improvement Target: TBD
Data Source: Survey results

Outcome Improvement Target 2 Estimated Incentive Payment: $34,899</td><td>Outcome Improvement Target 3 IT-6-1(1):
Percent improvement over baseline of patient satisfaction scores-Patients are getting timely care, appointments, and information
Improvement Target: TBD
Data Source: Survey results

Outcome Improvement Target 3 Estimated Incentive Payment: $75,869</td></tr>
<tr><td>Year 2 Estimated Outcome Amount: $14,073</td><td>Year 3 Estimated Outcome Amount: $32,623</td><td>Year 4 Estimated Outcome Amount: $34,899</td><td>Year 5 Estimated Outcome Amount: $75,869</td></tr>
<tr><td colspan="4">TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5): $157,464</td></tr>
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Spindletop Center

Pass 2

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Title of Outcome Measure (Improvement Target): IT-6.2 Other: Percent improvement over baseline of patient satisfaction scores-Patients getting timely healthcare information

Unique RHP outcome identification number(s): 096166602.3.2 / Pass 2
RHP Performing Provider / TPI: Spindletop Center / 096166602

Outcome Measure Description:

The process milestone selected for demonstration year 3 to prepare for the outcomes is P-1, project planning. The process milestone selected for demonstration year 3 is P-2, establish baseline rates. This will involve developing a patient satisfaction survey for the new service to be provided and establishing the satisfaction baseline in year 3.

For demonstration years 4-5, Spindletop has selected improvement outcome measure IT-6.2, percent improvement over baseline of patient satisfaction scores-patients getting timely healthcare information.

Rationale:

Spindletop has selected improvement outcome measure IT-6.2, percent improvement over baseline of patient satisfaction scores, patients getting timely health information. One of the purposes of this project is for clients to have access to their healthcare information and learn skills that allow them to become more self-sufficient and have more control over their physical and behavioral health. The survey will be designed to produce comparable data on the patient's perspective on care that will allow objective and meaningful assessment of the program in meeting the needs of the clients. Public reporting of survey results will serve to enhance accountability in health care by increasing the transparency of the quality of care provided in return for the public investment.

Outcome Measure Valuation:

Spindletop considered several factors in valuing this project including reductions in costs associated with hospitalizations for behavioral and developmental disorders and emergency room visits. Another valuation factor used for this project is the monetary value for a collaborative primary/behavioral health intervention as measured by quality adjusted life-years multiplied by a life year value. This valuation methodology uses health economic studies to assign a life year value associated with the health intervention. Since behavioral health clients have a high incidence of severe illnesses that shorten their life spans by 25 years compared to the general public, any programs that improve their mental and physical health should increase both the length and quality of their lives.

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096166602.3.2	*IT-6.2*	*Other: Percent improvement over baseline of patient satisfaction scores- Patients getting timely healthcare information*	
Spindletop Center			*096166602*
Related Category 1 or 2 Projects:	***096166602.1.1***		
Starting Point/Baseline:	*To be established in Year 3*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Develop project plan Data Source: Plan documentation Process Milestone 1 Estimated Incentive Payment*:* $2,180	**Process Milestone 2** [P-2]: Establish baseline rates Data Source: Survey document; survey results Process Milestone 2 Estimated Incentive Payment*:* $5,165	**Outcome Improvement Target 1** [IT-6.2]: Percent improvement over baseline of patient satisfaction scores- Patients getting timely healthcare information Improvement Target: TBD Data Source: Survey results Outcome Improvement Target 1 Estimated Incentive Payment*:* $5,590	**Outcome Improvement Target 2** [IT-6.2]: Percent improvement over baseline of patient satisfaction scores- Patients getting timely healthcare information Improvement Target: TBD Data Source: Survey results Outcome Improvement Target 2 Estimated Incentive Payment*:* $12,108
Year 2 Estimated Outcome Amount: $2,180	Year 3 Estimated Outcome Amount: $5,165	Year 4 Estimated Outcome Amount: $5,590	Year 5 Estimated Outcome Amount: $12,108
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $25,043			

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St. Joseph Medical Center

Pass 1

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Title of Outcome Measure (Improvement Target): IT-1.18 Follow-Up after Hospitalization for Mental Illness – NQF 0576

Unique RHP outcome identification number(s): 181706601.3.1

Outcome Measure Description:

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. Rate reported will be those patients with follow up visits within 30 days of discharge.

Tracking of recidivism of these patients to either the St. Joseph Behavioral inpatient or PHP program will indicate if the patient has maintained their treatment recommendations subsequent to discharge.

An indicator of patient compliance and treatment adherence is the "no show" rate. We will track the no show rate; along with a number of variables to determine success.

Process Milestones:

- DY2: P-1
- DY3: P-2

Outcome Improvement Targets for each year:

- DY4:
  - IT-1.18 - 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.
    - 25% increase in patients receiving after hospitalization follow-up care based on current discharge data for most common diagnoses
- DY 5:
  - IT-1.18 - 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.
    - 25% increase in patients receiving after hospitalization follow-up care based on DY4 discharge data for most common diagnoses identified above

Rationale:

Improvement Target 1 and Improvement Target 2 were chosen because: we initially need some time to pull together the community information and collect data from the community. Subsequent to that this is considered standard data for most providers and an industry standard to review regarding patient follow up visits and compliance.

Outcome Measure Valuation:

Extensive analysis was performed to value this outcome measure at $1,742,432 over the four years, beginning DY2 – 5. Decrease on recidivism and the cost associated with such things as medication follow-up alone will provide enough value to the community to justify the valuation.

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181706601.3.1	*3.IT-1.18*	*Follow-Up after Hospitalization for Mental Illness – NQF 0576*	
St. Joseph Medical Center			*181706601*
Related Category 1 or 2 Projects:	*181706601.2.1*		
Starting Point/Baseline:	*To be established in DY3.*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Project planning documentation Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $350,000	**Process Milestone 3** [P-2]: Establish baseline rates- Follow-Up after Hospitalization for Mental Illness- 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. Data Source: Medical Record Process Milestone 3 Estimated Incentive Payment: $400,000	**Outcome Improvement Target 1** [IT-1.18]: Follow-Up after Hospitalization for Mental Illness 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. Improvement Target: 25% increase from DY 3 in patients who receive follow up care after hospitalization for Mental Illness Data Source: EHR, Claims, Medical Records Outcome Improvement Target 1 Estimated Incentive Payment*:* $750,000	**Outcome Improvement Target 2** [IT-1.18]: Follow-Up after Hospitalization for Mental Illness 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. Improvement Target: 25% improvement from DY 4 discharge data Data Source: EHR, Claims, Medical Records Outcome Improvement Target 2 Estimated Incentive Payment*:* $1,500,000
Year 2 Estimated Outcome Amount: $350,000	Year 3 Estimated Outcome Amount: $400,000	Year 4 Estimated Outcome Amount: $750,000	Year 5 Estimated Outcome Amount: $1,500,000
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)****:*** $3,000,000			

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Title of outcome measure (improvement target): IT-9.2 ED appropriate utilization

Unique RHP outcome identification number(s): 181706601.3.2

Performing Provider name/TPI: St. Joseph Medical Center (SJMC)/181706601

Outcome Measure Description:

IT-9.2 ED appropriate utilization will measure reduced Emergency Department visits for Behavioral Health/Substance Abuse target conditions at St. Joseph Medical Center.

This measure will help to identify best practices, integrate those best practices into this setting and ensure that St. Joseph's works collaboratively with other providers in the RHP to share data and best practices to enhance the overall service delivery and outcomes within the community.

Process Milestones:

- DY2: P-1
- DY3: P-2

Outcome Improvement Target(s) for each year:

- DY4: IT-9.2 Reduce ED visits for behavioral health or substance abuse (TBD)
- DY5: IT-9.2 Reduce ED visits for behavioral health or substance abuse (TBD)

Rationale:

Process measure P-1 and P-2 were selected to allow for time to ensure that time was allotted to prepare and develop a plan for this program. The other areas were selected to ensure that the program works collaboratively with the other RHP providers to share best practices and enhance outcomes.

Outcome Measure Valuation:

Extensive analysis was performed to value this outcome measure at $1,727,432 over the four years, beginning with DY2 – DY5. Benefits to the community include the increase in available beds in the community to which patients with dual diagnoses (behavioral and medical) can be admitted. This coordinated care in the right setting will reduce readmissions, medical complication rates and overall length of stay, saving the unnecessary burdens of treating these patients.

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181706601.3.2	*IT-9.2*	*ED appropriate utilization*	
St Joseph Medical Center			*181706601*
Related Category 1 or 2 Projects:	*181706601.2.2*		
Starting Point/Baseline:	*TBD in DY 3*		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Milestone 1 [P-1]: Process Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Baseline/Goal: Produce a comprehensive report documenting all points above. To continue Milestone 1 each year. Data Source: Project plan Milestone 1 Estimated Incentive Payment (*maximum amount*): $350,000	**Milestone 2 [P-2]:** Establish baseline rates- ED visits for behavioral health and substance abuse Data Source: Evaluate the electronic health record for co-occurring diagnosis data Milestone 2 Estimated Incentive Payment: $400,000	**Outcome Improvement Target 1 [IT 9.2]:** ED appropriate utilization- Reduce ED visits for behavioral health and substance abuse Improvement target: Reduce ED visits for behavioral health or substance abuse (TBD) Outcome Improvement Target 1 Estimated Incentive Payment: $750,000	**Outcome Improvement Target 2 [IT 9.2]:** ED appropriate utilization- Reduce ED visits for behavioral health and substance abuse Improvement target: Reduce ED visits for behavioral health or substance abuse (TBD) Milestone 5 Estimated Incentive Payment: $1,500,000
Year 2 Estimated Milestone Bundle Amount: (add incentive payments amounts from each milestone): $350,000	Year 3 Estimated Milestone Bundle Amount: $400,000	Year 4 Estimated Milestone Bundle Amount: $750,000	Year 5 Estimated Milestone Bundle Amount: $1,500,000
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add milestone bundle amounts over DYs 2-5)***:** $3,000,000			

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St. Luke's Episcopal Hospital

Pass 1

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Title of Outcome Measure (Improvement Target): IT-3.2 Potentially Preventable Re-Admissions – 30-day Readmission Rates (PPRs)/Congestive Heart Failure 30-day Readmission Rate

Unique RHP outcome identification number: 127300503.3.1

Outcome Measure Description:

The goal of this project is to reduce by 30% the rate of 30-day potentially preventable re-admissions for chronic heart failure (CHF) patients according to the Hospital Compare publically reported data. Currently, St. Luke's experiences a 24.8% re-admission rate for the CHF patients, according to publicly reported data accessed at Hospital Compare. By creating a Transitional Care Clinic for the at-risk, underserved populations, these patients will gain access to timely essential care on a consistent basis. In addition, St. Luke's will work with the St. Luke's Episcopal Health Charities Project Safety Net to identify primary care providers within the patient's local community. The combination of these two services will create a partnership with the patients and provide an opportunity for the patients to discuss health and social concerns. Additionally, patients will have concerns addressed on a timely basis by a care-team provider. This, in turn, will reduce the need for more costly acute, inpatient care.

Over the course of the project, the readmission rate will be reduced by 30%.

Process Milestones:

- DY 2: P-1, P-3
- DY 3: P-2

Outcome Improvement Target for each year:

- DY 4: IT-3.2 Potentially Preventable Readmission Rates - CHF
- DY 5: IT-3.2 Potentially Preventable Readmission Rates - CHF

Rationale:

The process milestones and outcome improvement target of reducing the 30-day potentially preventable re-admission rate was selected because of its impact on the overall health-status of at-risk CHF patients. The creation of a Transitional Care Clinic will provide access to consistent care for at-risk, and underserved patient populations. In addition, St. Luke's will utilize the St. Luke's Episcopal Health Charities Project Safety Net Portal to identify primary care providers within the patient's local community that can serve as an additional health resource. By improving access these patients will receive high-quality care on a consistent basis, which should lead to an improved health status of each of these patients. In addition, the patients will need fewer acute, inpatient admissions and emergency department visits, which will benefit not only the patient but the community at-large by improving efficient utilization of scarce healthcare resources and reducing the overall cost of healthcare.

The data collected through more consistent visits with the at-risk and underserved populations will also lead to identification of health trends within communities and allow for better prioritization of community-health needs. This will allow for more targeted, effective interventions to be created that will improve the overall health status of the community-at-large and reduce regional health-care expenditures.

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Outcome Measure Valuation:

The project scope includes all patients with an index admission of congestive heart failure at St. Luke's Episcopal Hospital. This is anticipated to be approximately 6,000 patients. The intervention begins with education upon admission. The care team will also provide information about the services of the Transitional Care Clinic. Prior to discharge, a follow-up appointment will be scheduled within seven days for each patient. In addition, the care team providers will identify if the patient currently has consistent primary care support. If none is identified, the team will assist the patient in finding stable primary care.

All patients identified with CHF will be supported with this intervention; however, specific-focus will be given to those most at-risk, including the underserved and uninsured.

This addresses a high-priority community need due to the incidence of heart disease. The overall community will benefit by savings achieved by reducing the unnecessary and costly use of acute hospital services.

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127300503.3.1	IT-3.2	Congestive Heart Failure 30 day readmission rate	
Performing Provider: St .Luke's Episcopal Hospital			*127300503*
Related Category 2 Projects	*127300503.2.1*		
Starting Point/Baseline			

Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning – engage stakeholders, identify needed resources, determine timelines, and document implementation plan. Data Source: Committee minutes, finalized plan Process Milestone 1 Estimated Incentive Payment*:* $196,202 **Process Milestone 2 [P-3]** Develop and test data systems. Data Source: Claims and related data. Process Milestone 2 Estimated Incentive Payment*:* $196,202	**Process Milestone 3 [P-2]** Establish baselines. Data Source: Claims, EHR. Process Milestone 3 Estimated Incentive Payment*:* $219,968 **[Outcome Improvement Target 1 [IT-3.2]:**Congestive Heart Failure 30 day readmission rate **Data Source: EHR** **Baseline/Goal**: to be determined in DY3 Outcome Improvement Target 1 Estimated Incentive Payment: $219,967	**Outcome Improvement Target 1 [IT-3.2]:**Congestive Heart Failure 30 day readmission rate **Data Source: EHR** **Goal**: Improve over baseline XX% Outcome Improvement Target 2 Estimated Incentive Payment*:* $643,872	**Outcome Improvement Target 3 [IT-3.2]:**Congestive Heart Failure 30 day readmission rate **Data Source: EHR** **Goal**: Improve over baseline XX% Outcome Improvement Target 3 Estimated Incentive Payment*:* $1,400,563
Year 2: Estimated Milestone Bundle Amounts: $392,404	Year 3: Estimated Milestone Bundle Amounts: $439,935	Year 4: Estimated Milestone Bundle Amounts: $643,872	Year 5: Estimated Milestone Bundle Amounts: $1,400,563
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $2,876,774			

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Title of Outcome Measure (Improvement Target): OD-10 Quality of Life/Functional Status

Unique RHP Outcome Identification Number: 127300503.3.2

Outcome Measure Description:

Quality of life (QOL) is a broad multidimensional concept that usually includes subjective evaluations of the patient's perceptions of mental and physical indicators. Quality of life is a challenging measure in that it is subjective and dependent upon the client's perceptions of each domain. Further, the term "quality of life" has meaning for nearly everyone and every academic discipline, individuals and groups can define it differently.

Process Milestones:

- DY 2: P-1, P-3
- DY 3: P-2

Outcome Improvement Target for each year:

- DY 4: IT-10.1 Quality of Life
- DY 5: IT-10.1 Quality of Life

Rationale:

Chronically ill patients QOL is a major driver to both the pursuit of medical care and adherence to medical therapy. Therefore, we find QOL is a significant indicator of the success of any disease management program.

Outcome Measure Valuation:

In our program we will use CDC HRQOL scores to measure our social and clinical interventions. Through repeated measures of CDC HRQOL we will monitor the patient's experience. Additionally, aggregation of CDC HRQOL data will provide an assessment of efficacy.

The evaluation of CDC HRQOL combined with the readmission rate provides a balanced set of measures to assess effectiveness of our intervention.

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127300503.3.2	**IT-10.1**		**Quality of Life**
Performing Provider: St .Luke's Episcopal Hospital			*127300503*
Related Category 2 Projects	*127300503.2.1*		
Starting Point/Baseline			
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning – engage stakeholders, identify needed resources, determine timelines, and document implementation plan. Data Source: Committee minutes, finalized plan Process Milestone 1 Estimated Incentive Payment: $392,404	**Process Milestone 2 [P-2]** Establish baselines. Data Source: TBD. Process Milestone 2 Estimated Incentive Payment: $219,968 **Outcome Improvement Target 1 [IT-10.1]:**Quality of Life **Data Source: Assessment tool** Baseline/Goal: to be determined in DY3 Outcome Improvement Target 1 Estimated Incentive Payment: $219,967	**Outcome Improvement Target 2 [IT-10.1]:**Quality of Life **Data Source: Assessment tool** **Goal**: Improve over baseline XX% Outcome Improvement Target 2 Estimated Incentive Payment: $643,872	**Outcome Improvement Target 3 [IT-10.1]:**Quality of Life **Data Source: Assessment tool** **Goal**: Improve over baseline XX% Outcome Improvement Target 3 Estimated Incentive Payment: $1,400,563
Year 2: Estimated Milestone Bundle Amounts: $392,404	Year 3: Estimated Milestone Bundle Amounts: $439,935	Year 4: Estimated Milestone Bundle Amounts: $643,872	Year 5: Estimated Milestone Bundle Amounts: $1,400,563
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $2,876,774			

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St. Luke's Episcopal Hospital

Pass 2

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Title of Outcome Measure (Improvement Target): IT-4.1 Improvement in risk adjusted Potentially Preventable Complication rates

Unique RHP Outcome ID: 127300503.3.3 / Pass 2

Outcome Measure Description:
Potentially preventable complications of Hepatitis C include the development of cirrhosis, progressive liver failure and death. Based on estimates of prevalence within the population and the know efficacy of current therapies achieving a 60% cure rate, we plan to prevent progression to active Hepatitis C in at least 444 patients through active screening and effective intervention.

Process Milestones:
- DY2: P-1
- DY3: P-2

Outcome Improvement Target(s) for each year:
- DY3:
  - IT-4.1 Improvement in risk adjusted Potentially Preventable Complication rates
  - Baseline/Goal: 5%
- DY4:
  - IT-4.1 Improvement in risk adjusted Potentially Preventable Complication rates
  - Improve over baseline 10%
- DY5:
  - IT-4.1 Improvement in risk adjusted Potentially Preventable Complication rates
  - Improve over baseline 30%

Rationale:
Outcome improvement targets will determined in DY2.

Outcome Measure Valuation:

In Year 2 as partnerships are developed beyond current relationships, 2000 individuals will be screened. In Years 3 (3500) and 4 (5000) the volume of screening would increase incrementally with the expected volume of screening in Year 5 reaching 8000. As a result of the increased screenings, we would expect to identify additional individuals in the at-risk group. The expected outcome is projected as follows;
- Year 2 – 160
- Year 3 – 280
- Year 4 – 400
- Year 5 - 640

1. Total number of individuals identified with disease over project equals 1480. If approximately 50% of 1480 new patients will be engaged in active community based treatment, we would expect 60% cure rate equaling 444 patients. The lifetime cost of Hepatitis C in the absence of liver transplant is $100,000. With liver transplant, the cost rises to $280,000. Within 5 years of diagnosis, 15-20% of patients with chronic Hepatitis

C develop cirrhosis. Consequently, diagnosis, treatment and cure dramatically lower costs for treatment of a chronic disease. If the epidemiologic estimates are much more modest, assuming cure in only 10% of the potential, the likely cost savings will easily exceed $4.4 million (lifetime cost for one patient with Hepatitis C is $100,000, with liver transplant cost rises to $280,000).

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127300503.3.3	*3.IT-4.1*	*Potentially Preventable Complication rates*	
St .Luke's Episcopal Hospital			*127300503*
Related Category 1 or 2 Projects:	*127300503.2.2*		
Starting Point/Baseline:	*To be established in DY2.*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning – engage stakeholders, identify needed resources, determine timelines, and document implementation plan. Data Source: Committee minutes, finalized plan Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $90,598	**Process Milestone 2** [P-2]: Establish baselines. Data Source: TBD. Process Milestone 2 Estimated Incentive Payment: $ 53,663 **Outcome Improvement Target 1** [IT-4.1]: Potentially Preventable Complication rates Baseline/Goal: 5% reduction in Hepatitis C rate in screened population Data Source: Assessment tool Outcome Improvement Target 1 Estimated Incentive Payment*:* $53,664	**Outcome Improvement Target 2** [IT-4.1]: Potentially Preventable Complication rates Improvement Target 10% reduction in Hepatitis C rate in screened population Data Source: Assessment tool Outcome Improvement Target 2 Estimated Incentive Payment*:* $174,215	**Outcome Improvement Target 3** [IT-4.1]: Potentially Preventable Complication rates Improvement Target: 30% reduction in Hepatitis C rate in screened population Data Source: Assessment tool Outcome Improvement Target 3 Estimated Incentive Payment*:* $415,126
Year 2 Estimated Outcome Amount: $90,598	Year 3 Estimated Outcome Amount: $107,327	Year 4 Estimated Outcome Amount: $174,215	Year 5 Estimated Outcome Amount: $415,126
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $787,266			

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Texana Center

Pass 1

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Title of Outcome Measure: IT-10.1 Quality of Care/Functional Status

Unique RHP outcome identification number: 081522701.3.1

Outcome Measure Description:

This Category 3 Outcome Measure, *Quality of Care,* OD 10, IT-10.1 assesses the effectiveness of the Texana Center Category 1 Project, Option 1.12.2, to enhance service availability of appropriate levels of behavioral health care (applied behavior analysis and speech-language pathology for children diagnosed with autism spectrum disorders) to expand the number of community based settings where behavioral health services may be delivered in underserved areas. The desired outcome of the Category 1.12.2 Project is to increase utilization of community behavioral healthcare (i.e., ABA and SLP services for autism) by adding an additional setting. Expanding the availability of behavioral health services is consistent with the Category 3 Outcome Measure, *Quality of Care.*

Process Milestones:

The following Category 3 Process Measures will define the activities undertaken by Texana Center to prepare for measuring and reporting the improvement targets in DY 4 and DY 5:

1 DY 2 - P-1: Completion of project planning to prepare for reporting
2 DY 2 and 3 - P-2: Establishment of a baseline for measuring and reporting progress
3 DY 3 - P-3: Preparation of data systems
4 DY 3 - P-4: Implementation of continuous quality improvement (CQI) processes for data and reporting (Conduct Plan, Do, Study, Act (PDSA) cycles)

Outcome Improvement Target(s) for each year:

The following Category 3 Improvement Target, IT-10.1, was selected to measure the success of Texana Center's Category 1 Project, Option 1.12.2 during DY 4 and DY 5:

1 Demonstrate improvement in quality of life scores as measured by evidence-based and validated assessment tool(s), for children diagnosed with Autism (standalone measure)

Rationale:

Although much of behavioral healthcare is focused on reducing psychiatric symptoms, this intensive ABA and SLP treatment is specifically designed to improve symptoms and functions, 2 essential components of quality of life. Research indicates that approximately 50% of children that receive 1:1 intensive ABA before the age of 4 for 25-40 hours a week for at least 2 years will no longer meet the diagnostic criteria for an ASD diagnosis (Howard, et al. 2005). Recent research, including the National Standards Project, emphasizes the importance of empirically based Speech Language Pathology (SLP) intervention in addition to the primary mode of intervention of ABA. Effective quality improvement requires relentless focus on patient outcomes. Early intensive ABA treatment results in increased language and communication skills, improved social skills, achievement in pre-academic and academic areas, and decreased problem behaviors (Howard et al. 2005). Early intensive behavior intervention can be costly, exceeding $50,000 per year. This project will improve access to needed behavioral health services for low income families.

Baseline data will be collected during years 2 and 3 using a variety of the below and related assessment tools. One or a combination of 2 or 3 of these tools will be utilized to demonstrate progress during years 3-5 based on baseline data collected during years 2 and 3.

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1 Demonstrated improvement in quality of life scores on evidence-based, validated standardized assessment tools for the target population. Previous instruments used in the Children's Center for Autism include the Pervasive Developmental Disorders Behavior Inventory (PDDBI) and Psychoeducational Profile-3 (PEP-3). Other recommended instruments include the Developmental Profile-Third Edition (DP-3), Peabody Picture Vocabulary Test-Fourth Edition (PPVT-4), Expressive Vocabulary Test-Second Edition (EVT-2), Bayley Scales of Infant Development-Revised (BSID-R), Wechsler Primary Preschool Scales of Intelligence-Revised (WPPSI-R), Differential Abilities Scale (DAS), Developmental Assessment of Young Children (DAYC), Vineland Adaptive Behavior Scales (VABS), Reynell Developmental Language Scales, and the Merrill-Palmer Scale of Mental Tests (Howard, et al. 2005).
2 Demonstrated improvement in quality of life on the Assessment of Basic Language and Learning Skills (ABLLS), Verbal Behavior Milestones Assessment and Placement Program (VB-MAPP), and/or the Assessment of Functional Living Skills (AFLS). Progress can be measured by examining changes in the student's scores from one administration to the next (e.g., Goin-Kochel, Myers, Hendricks, Carr, & Wiley, 2007; Sullivan & Perry, 2006). The ABLLS-R was selected because it is now commonly used by educators, school personnel, and psychologists to assess and monitor skills of children with autism who are receiving behavior therapy (e.g., Bradley-Johnson, Johnson, &Vladescu, 2008; Goin-Kochel et al., 2007; Schwartz, Boulware, McBride, &Sandall, 2001) and, according to Aman et al. (2004), has been selected as an outcome measure by the National Institute of Mental Health Research Units in Pediatric Psychopharmacology and Psychological Intervention Autism Network.

Outcome Measure Valuation:

The Category 3 Outcome Measure, *Quality of Life*, is valued as a subset to the valuation for the Texana Center Category 1.12.2 to enhance service availability of appropriate levels of behavioral health care (applied behavior analysis and speech-language pathology for children diagnosed with autism spectrum disorders) to expand the number of community based settings where behavioral health services may be delivered in underserved areas. The Category 1.12.2 Project, and supporting Category 3 Outcome Measures, addresses a priority need for the population of children diagnosed with autism.

This project addresses a priority need for the autism population to receive intensive ABA services in the community. One of the goals of this project is to avert outcomes such as potentially avoidable inpatient admissions and readmissions in settings including general acute and psychiatric hospitals, state supported living centers, and self-contained special education classrooms; to promote wellness and adherence to treatment; to promote independence in the community/functional status; and to improve quality of life. The vision will be realized throughout the child's lifetime, however, the reduction in the need for self-contained special education classrooms and in some cases the elimination of the need for special education for children served in this project would be realized during the 4 year DSRIP project.

By providing ABA services to children with autism, it allows for cost avoidance. The current project proposes to serve 39 children in years 2-5. In 2007, Chasson et al. results indicated that the state of Texas will save $208,500 *per child across eighteen years of education* with early intensive ABA.

Based on the figures derived from this study, the state of Texas could save $8,131,500 across 18 years of education by providing ABA treatment to these 39 children. In 1998, Jacobson et al. found that cost savings following intensive ABA are estimated to be from $2,439,710 to

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$2,816,535 with inflation to *age 55 per child* served (Jacobson, Mulik, & Green, 1998). Therefore, based on the figures derived from this study, the state of Texas could save $95,148,690 through age 55 for these 39 children by providing early intensive ABA treatment.

Total Five Year Valuation: $1,094,789

Resources:

Aman, M.G., Novotny, S., Samango-Sprouse, C., Lecavalier, L., Leonard, E., Gadow, K., King, B.H., Pearson, D.A., Gernsbacher, M.A., & Chez, M. (2004). Outcome measures for clinical drug trials in autism. *CNS Spectrums, 9*, 36-47.

Bradley-Johnson, S., Johnson, C.M., Vladescu, J.C. (2008).A comprehensive model for assessing the unique characteristics of children with autism.*Journal of Psychoeducational Assessment, 26,* 325-338.

Chasson, G. S., Harris, G. E., & Neely, W. J., (2007). Cost comparison of Early Intensive Behavioral Intervention and Special Education for Children, Journal of Child and Family Studies, 2007.

Goin-Kochel, R.P., Myers, B.J., Hendricks, D.R., Carr, S.E., & Wiley, S.B. (2007). Early responsiveness to intensive behavioral interventions predicts outcomes among preschool children with autism. *International Journal of Disability, Development and Education, 54,* 154-175.

Howard, J.S., Sparkman, C.R., Cohen, H.G., Green, G., & Stanislaw, H. (2005). A comparison of

intensive behavior analytic and eclectic treatments for young children with autism, Research in Developmental Disabilities.

Jacobson, J., Mulik, J., and Green, G (1998). Cost–benefit estimates for early intensive behavioral intervention for young children with autism—general model and single state case. *Behavioral Interventions*, 13(4), 201-226).

Schwartz, I.S., Boulware, G. I., McBride, B.M. &Sandall, S.R. (2001).Functional assessment strategies for young children with autism.*Focus on Autism and Other Developmental Disabilities, 16,* 222-227.

Sullivan, A. & Perry, A. (November, 2006). Developmental trajectories of typically developing children captured by the ABLLS. Poster presented at the 14th Annual Ontario Association for Behavioural Analysis Conference, Toronto, Ontario, Canada.

081522701.3.1	*3.IT-10.1*	*Quality of Life/Functional Status*	
Texana Center			081522701
Related Category 1 or 2 Projects:	*081522701.1.1*		
Starting Point/Baseline:	*Baseline TBD in DY 2 and 3*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Process planning engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Project Documentation Process Milestone 1Estimated Incentive Payment *(maximum amount):* N/A. Captured in Category 1 milestones. **Process Milestone 2** [P-3]: Establish baseline data Data Source: Project Documentation Process Milestone 2 Estimated Incentive Payment: N/A. Captured in Category 1 milestones.	**Process Milestone 3** [P-3]: Establish baseline data Data Source: Project Documentation Process Milestone 3 Estimated Incentive Payment: $91,232.33 **Process Milestone 4** [P-3]: Develop and test data systems. Data Source: Project Documentation Process Milestone 4 Estimated Incentive Payment: $91,232.33 **Process Milestone 5** [P-4]: Conduct Plan, Do, Study, Act (PDSA) cycles to improve data collection and intervention activities. Data Source: Project Documentation Process Milestone 5 Estimated Incentive Payment: $ 91,232.33	**Outcome Improvement Target 1** [IT-10.1]: Demonstrate improvement in quality of life scores as measured by evidence-based and validated assessment tool(s), for children diagnosed with Autism (standalone measure) Data Source: TBD (see narrative) Outcome Improvement Target 1 Estimated Incentive Payment*:* $273,697	**Outcome Improvement Target 2** [IT-10.1]: Demonstrate improvement in quality of life scores as measured by evidence-based and validated assessment tool(s), for children diagnosed with Autism (standalone measure) Data Source: TBD (see narrative) Outcome Improvement Target 2 Estimated Incentive Payment*:* $547,395

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Title of the Outcome Measure (Improvement Target): TBD
Unique RHP Project Identification Number: 081522701.3.2

Outcome Measure Description: TBD

Rationale:

Currently, the Category 3 Outcome Measure to be chosen falls within OD-2-Potentially Preventable Admissions and/or OD-3 Potentially Preventable Re-Admissions – 30 day Readmission Rates (PPRs). Texana Center needs to identify data sources (hospitals) and processes to obtain the data in order to make a data-driven decision for a specific outcome measure. By focusing on these outcome measures, low income populations with no funding source for these services will have a place to go in the local community which will allow them to remain close to natural supports and other outpatient services which will help prevent admissions and readmissions into psychiatric hospitals.

Within OD-2 – Potentially Preventable Admissions, we are trying to identify data sources and baselines for IT-2.4 Behavioral Health/Substance Abuse (BH/SA) Admission Rate and within OD-3 Potentially Preventable Re-Admissions – 30 day Readmission Rates (PPRs), we are trying to identify data sources and baselines as well. Since both of these are stand-alone measures, we will be choosing the measure with the greater need for improvement.

Outcome Measure Valuation:

This project addresses a major need in the community---a "place" for individuals to go other than the hospital emergency rooms and jails and to avoid inpatient stays in psychiatric hospitals. This project was valued using a medical economists' analysis to determine average savings per acute per year care episode for individuals treated in a residential setting as opposed to a hospital. The study was completed by the UT Houston School of Public Health and the UT Austin Center for Social Work Research. Based on this analysis, the value of the program, per acute care episode is $17,504 or $1,750,392 per 100 persons served. The study also indicates that additional cost savings may be expected. Based on this and the projected volume over three years of 1,800 persons served, the valuation for this project is $31,507,056 which is significantly more than twice the value placed on this project.

Since a final decision has not been made on the outcome measure to be used, Texana Center valued this category based on the overall valuation for the project and the percentage requirements of the overall valuation for this category.

Plan for Learning Collaborative: We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 3, Harris Health System. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system.

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081522701.3.2	TBD	***TBD***	
Texana Center			081522701
Related Category 1 or 2 Projects:	*081522701.1.2*		
Starting Point/Baseline:	*TBD*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-2]: Establish baseline rates Data Source: Identified data sources Process Milestone 2 Estimated Incentive Payment: $0	**Process Milestone 2 [P-3]:** Develop and test data systems Data Source: Identified claims data, encounter data Process Milestone 3 Estimated Incentive Payment: $287,906	**Outcome Improvement Target 2** [IT-1.1]: **TBD** Improvement Target: Data Source: Outcome Improvement Target 2 Estimated Incentive Payment: $338,777	**Outcome Improvement Target 3** [IT-1.1]: **TBD** Improvement Target: Data Source: Outcome Improvement Target 3 Estimated Incentive Payment: $813,219
Year 2 Estimated Outcome Amount: **$0**	Year 3 Estimated Outcome Amount: **$287,906**	Year 4 Estimated Outcome Amount: **$338,777**	Year 5 Estimated Outcome Amount: **$813,219**
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $1,439,902			

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Title of Outcome Measure (Improvement Target): 3.IT 9.4- Other Outcome Improvement Target- Mental health (IDD/SPMI or Challenging Behaviors) admissions and readmissions to state institutions (state mental hospitals and State Supported Living Centers)

Unique RHP outcome identification number: 081522701.3.3

Outcome Measure Description:

This Category 3 Outcome Measure, *Right Care, Right Setting*, assesses the effectiveness of the Texana Center Category 2 Project, Option 2.13.1, for the implementation of a crisis stabilization intervention for the dually diagnosed population (i.e., persons with intellectual and developmental disabilities (IDD) with a co-occurring serious and persistent mental illness (SPMI) and/or serious behavioral challenges). The desired outcome of the Category 2.13.1 Project is to prevent, for this dually diagnosed population, unnecessary use of services in criminal justice settings, emergency rooms, and state institutions (i.e., mental hospitals and State Supported Living Centers). Prevention of services in these more restrictive settings is consistent with the Category 3 Outcome Measure, *Right Care, Right Setting*.

As a solution to the cyclic pattern of long term support and acute crisis intervention for the dually diagnosed IDD/SPMI population, the Texana Center Category 2.13.1 Project proposes the development of a crisis behavioral healthcare team, expanded out-of-home respite care to respond to acute behavior crisis events, and on-going supports to avert crisis and establish stable living environments. The selection of this Outcome, *Right Care, Right Setting*, is consistent with community needs assessment (RHP 3: CN2), which identified insufficient access to behavioral health care services resulting in delivery of inappropriate care (e.g., emergency departments or state institutional care) and increased demand on the criminal justice system.

Process Milestones:

The following Category 3 Process Measures will define the activities undertaken by Texana Center to prepare for measuring and reporting the improvement targets in DY 4 and DY 5:

- DY 2 - P-1: Completion of project planning to prepare for reporting
- DY 2 - P-2: Establishment of a baseline for measuring and reporting progress
- DY 3 - P-3: Preparation of data systems
- DY 3 - P-4: Implementation of continuous quality improvement processes for data and reporting

Outcome Improvement Target(s) for each year:

The following Category 3 Improvement Target is selected to measure the success of Texana Center's crisis stabilization interventions for the dually diagnosed IDD/SPMI population (Category 2 Project, Option 2.13.1) during DY 4 and DY 5:

- Decrease in admissions and readmissions to state facilities (state hospitals and State Supported Living Centers) for the dually diagnosed IDD/SPMI population

Rationale:

Currently, data for tracking individuals with IDD/SPMI seeking crisis interventions is across multiple agencies, multiple data systems and varied reporting requirements. The data is present, but not in an easily accessed and meaningful reporting format. The Category 3 process milestones will allow for planning and the development of systems for identifying, accessing, analyzing and disseminating data that will be used to report progress for the above improvement

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targets in DY 4 and DY 5. Additionally, once the data sources are in place, a baseline will be determined in order to measure improvement from the project's starting point. Consistent with the regional goal for developing a culture of ongoing transformation and innovation, a continuous quality improvement milestone is included in the Category 3 process measures.

When responding to individuals with IDD/SPMI or challenging behaviors in crisis, Texana Center, as the Local ID Authority, may assist the individual with limited emergency respite, admission to a state facility, admission to an ICF/ID facility, or admission to a State Supported Living Center. These options are further limited by resources (funding) and bed availability. When the crisis is one of pending criminal charges, Texana Center is challenged to help the individual avoid further involvement in the criminal justice system. The intent of the Category 2 Project is to provide the option of emergency behavior supports and out of home respite as 'right care, right setting' alternative. Consider the following reasons for Texana Center selecting these Category 3 Improvement Targets to support the crisis stabilization interventions for this targeted population:

- Decrease in admissions and readmissions to state facilities (state hospitals and State Supported Living Centers) for the dually diagnosed IDD/SPMI population
  - Current state and federal initiatives, including community living options supported by the *1999 Olmstead*decision, are based on evidence that patient-centered care in the most cost-effective manner is in non-institutional settings.

Outcome Measure Valuation:

The Category 3 Outcome Measure, *Right Care, Right Setting*, is valued as a subset to the valuation for the Texana Center Category2.13.1Project for the implementation of a crisis stabilization intervention for the dually diagnosed population (i.e., persons with intellectual and developmental disabilities (IDD) with a co-occurring serious and persistent mental illness (SPMI) and/or serious behavioral challenges). The Category2.13.1Project, and supporting Category 3 Outcome Measures, addresses a priority need for the IDD/SPMI population to receive the *right care* (intensive crisis stabilization services) in the *right setting* (their home and community). By doing so, it also allows for cost avoidance, supporting individuals in the community at a lesser cost than institutional care in state hospitals and State Supported Living Centers, and avoiding costs in the criminal justice system and emergency rooms.

Category 2.13.1 Project, and supporting Category 3 Outcome Measures, was valued based on two studies completed by the UT Houston School of Public Health and the UT Austin Center for Social Work Research: "Valuing the Program to Create an Assertive Community Treatment (ACT) Team for People with Intellectual and Developmental Disabilities (IDD)" and "Valuing the Crisis Respite for Children Program". These studies were completed through a contract with Center for Health Care Services, and were based on cost-utility analysis measures and quality-adjusted life-years analysis.

For DY 2, the processes in Category 3 will be completed concurrently with those in Category 2, and the value for these activities is in Category 2 only. For DY 3, the processes in Category 3 were considered to be 10% of the value of the Category 2.13.1 Project. For DY 4, the Improvement Targets in Category 3 were considered to be 10% of the value of Category 2.13.1 Project. For DY 5, the Improvement Targets in Category 3 were considered to be 20% of the value of Category 2.13.1

Total Five Year Valuation: $670,170

081522701.3.3	*3.IT 9.4*	*Other Outcome Improvement Target-Mental health (IDD/SPMI or Challenging Behaviors) admissions and readmissions to state institutions (state mental hospitals and State Supported Living Centers)*	
Texana Center			*081522701*
Related Category 1 or 2 Projects:	*081522701.2.1*		
Starting Point/Baseline:	*Baseline for potentially preventable admission and readmission to state institutions (state hospitals and State Supported Living Centers) is to be determined in DY 2.*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Process planning engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans. Data Source: Project Documentation Process Milestone 1Estimated Incentive Payment *(maximum amount):* N/A. Captured in Category 2 milestones. **Process Milestone2** [P-2]: Establish baseline data. Data Source: Project Documentation Process Milestone 2 Estimated Incentive Payment: N/A. Captured in Category 2 milestones.	**Process Milestone 3** [P-3]: Develop and test data systems. Data Source: Project Documentation Process Milestone 3 Estimated Incentive Payment: $83,771.50 **Process Milestone4**[P-4]: Conduct Plan, Do, Study, Act (PDSA) cycles to improve data collection and intervention activities. Data Source: Project Documentation Process Milestone 4 Estimated Incentive Payment: $ 83,771.50	**Outcome Improvement Target 1** [IT-9.4]: Decrease by 10% in mental health (IDD/SPMI or Challenging Behaviors) admissions and readmissions to state institutions (state mental hospitals and State Supported Living Centers). Numerator: The number of individuals receiving project interventions who had a potentially preventable admission/readmission to a State Supported Living Center within the measurement period. Denominator: The number of individuals receiving project interventions. Data Source: TBD Outcome Improvement Target 3 Estimated Incentive Payment*:* $167,543	**Outcome Improvement Target 6** [IT-9.4]: Decrease by 20% in mental health (IDD/SPMI or Challenging Behaviors) admissions and readmissions to state institutions (state mental hospitals and State Supported Living Centers). Numerator: The number of individuals receiving project interventions who had a potentially preventable admission/readmission to a State Supported Living Center within the measurement period. Denominator: The number of individuals receiving project interventions. Data Source: TBD Outcome Improvement Target 6 Estimated Incentive Payment*:* $335.085
Year 2 Estimated Outcome Amount: $0	Year 3 Estimated Outcome Amount: $167,543	Year 4 Estimated Outcome Amount: $ 167,543	Year 5 Estimated Outcome Amount: $335,085
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:**$670,171			

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Texana Center

Pass 2

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Title of Outcome Measure (Improvement Target): IT-2.13 Other: Potentially Preventable Admissions

Unique RHP Outcome ID: 081522701.3.4 / Pass 2

Performing Provider / TPI: Texana Center / 081522701

Outcome Measure Description:

This Category 3 Outcome Measure, Potentially Preventable Admissions, OD 2, IT-2.13 assesses the effectiveness of the Texana Center Category 1 Project, Option 1.9.2, to establish or expand initiatives to increase the availability of targeted specialty care providers for infants and toddlers 0-3 years old who exhibit mild developmental delays or have a recognized risk factor that puts them at risk of developmental delay. The desired outcome of the Category 1.9.2 project is to minimize the impact of established risk factors on developmental progress and/or to enable children with developmental delays achieve a functional status at, or near, age appropriate levels, decreasing or eliminating potential eligibility for IDEA Part B special education services. Expanding access to specialty care (OT, PT, ST, behavior analysis/therp;y) is consistent with the Category 3 Outcome Measure, Potentially Preventable Admission.

The following Category 3 Process Measures will define the activities undertaken by Texana Center to prepare for measuring and reporting the improvement targets in DY 3,4,and 5:

- DY 2 - P-1: Completion of project planning to prepare for reporting
- DY 2 and 3 - P-2: Establishment of a baseline for measuring and reporting progress
- DY 3 - P-3: Preparation of data systems
- DY 3 - P-4: Implementation of continuous quality improvement (CQI) processes for data and reporting (Conduct Plan, Do, Study, Act (PDSA) cycles)

The following Category 3 Improvement Target, IT-2.13, was selected to measure the success of Texana Center's Category 1 Project, Option 1.9.2 during DY 4 and 5.

- Demonstrate developmental functioning at, or approaching, age expectations as evidenced by scores on a standardized, evidence-based and validated assessment tool.

Rationale:

In 2010–11, children with delays or disabilities who received (therapeutic) services…showed greater than expected developmental progress. Many children exited the program functioning within age expectations, and almost all made progress.[302] Comparison of entry and exit scores will evaluate the effectiveness of therapeutic interventions for each individual child.

School districts administer standardized tests to determine eligibility for special education services for children not having other eligibility determinations.[303] Examination of exit scores will provide a reliable indicator of potential eligibility for special education services and measure

[302] Early Childhood Outcomes Center, July 2012

[303] It's a New Idea, the manual for parents and students about special education services in Texas. The ARC of Texas; Advocacy, Incorporated. 2007.

progress toward the project goal of increasing school readiness and decreasing the need for special education services at age 3.

Data collected in DY 2 and 3 on entry and exit test scores will establish a baseline on which to base improvement targets to be implemented in DY 4.

- This project proposes to use the Battelle Developmental Inventory 2nd Edition (BDI-2) to establish eligibility for enrollment and an individual baseline score on each child on entry into services. The developmental test will be administered a second time prior to exiting services. The BDI-2 provides a measure of progress during the preschool years and has been designed to help assess the effects of various intervention strategies for individual children and for groups of children.[304]
- Data collected will be categorized using criteria established by the Early Childhood Outcomes Center to measure progress toward established goals:
  - Maintained typical development
  - Achieved typical development
  - Made sufficient progress to move closer to typical development but did not achieve it
  - Made progress but did not move closer to typical development
  - Did not make progress[305]

Outcome Measure Valuation:

The Category 3 Outcome Measure, Potentially Preventable Admissions, is valued as a subset to the valuation for the Texana Center Category 1.9.2 to expand access to specialty care (OT, PT, ST) to infants and toddlers. The Category 1.9.2 Project, and supporting Category 3 Outcome Measures, address a priority need for the population of children with mild to moderate developmental delay or with established risk factors for delay.

One of the goals of this project is to avert outcomes such as potentially avoidable special education services and to promote independence in the community. The vision will be realized throughout the child's lifetime, however, the reduction in the need for special education for children served in this project would be realized during the 4 year DSRIP project.

[304] Newborg, J, (2005) *Battelle Developmental Inventory 2nd Edition, Examiner's Manual. Rolling Meadows, IL: Riverside Publishing.*
[305] Early Childhood Outcomes Center

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081522701.3.4	*3.IT-2.13.*	*Other: Potentially Preventable Admissions*	
Texana Center			081522701
Related Category 1 or 2 Projects:	*081522701.1.3*		
Starting Point/Baseline:	*Baseline TBD in DY 2 and 3*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Process planning engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Project Documentation Process Milestone 1 Estimated Incentive Payment *(maximum amount):* N/A. Captured in Category 1 milestones. **Process Milestone 2** [P-3]: Establish baseline data Data Source: Project Documentation Process Milestone 2 Estimated Incentive Payment: N/A. Captured in Category 1 milestones.	**Process Milestone 3** [P-3]: Establish baseline data Data Source: Project Documentation Process Milestone 3 Estimated Incentive Payment: $38,482 **Process Milestone 4** [P-3]: Develop and test data systems. Data Source: Project Documentation Process Milestone 4 Estimated Incentive Payment: $38,482 **Process Milestone 5**[P-4]: Conduct Plan, Do, Study, Act (PDSA) cycles to improve data collection and intervention activities. Data Source: Project Documentation Process Milestone 5 Estimated Incentive Payment: $38,482	**Outcome Improvement Target 1** [IT-2.13]: Other Admissions Rate: Special Education Qualification Rate Improvement Target: < 30% of children discharging from the waiver program Data Source: Standardized test results on exit from waiver program Numerator: number of children discharging from waiver program that potentially qualify for special education Denominator: number of children discharging from the waiver program Outcome Improvement Target 1 Estimated Incentive Payment*: $124,929*	**Outcome Improvement Target 2** [IT-2.13]: Other Admissions Rate: Special Education Qualification Rate Improvement Target: < 20% of children discharging from the waiver program Data Source: Standardized test results on exit from waiver program Outcome Improvement Target 2 Estimated Incentive Payment*: $270,624*
Year 2 Estimated Outcome Amount: $0	Year 3 Estimated Outcome Amount: $115,447	Year 4 Estimated Outcome Amount: $124,929	Year 5 Estimated Outcome Amount: $270,624
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $511,000			

Texana Center

Pass 3

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<u>Title of Outcome Measure:</u> IT-10.1 Quality of Care/Functional Status

<u>Unique RHP outcome identification number</u>: 081522701.3.5 / Pass 3

<u>Outcome Measure Description:</u>

This Category 3 Outcome Measure, *Quality of Care,* OD 10, IT-10.1 assesses the effectiveness of the Texana Center Category 1 Project, Option 1.12.2, to enhance service availability of appropriate levels of behavioral health care (applied behavior analysis and speech-language pathology for children diagnosed with autism spectrum disorders) to expand the number of community based settings where behavioral health services may be delivered in underserved areas. The desired outcome of the Category 1.12.2 Project is to increase utilization of community behavioral healthcare (i.e., ABA and SLP services for autism) by adding one additional setting (a third setting to the original setting and Waiver pass 1 proposed setting). Expanding the availability of behavioral health services is consistent with the Category 3 Outcome Measure, *Quality of Care.*

Process Milestones:

The following Category 3 Process Measures will define the activities undertaken by Texana Center to prepare for measuring and reporting the improvement targets in DY 4 and DY 5:

- DY 2 and DY 3 - P-1: Completion of project planning to prepare for reporting
- DY 3 and 4 - P-2: Establishment of a baseline for measuring and reporting progress
- DY 3 and 4 - P-3: Preparation of data systems
- DY 3 - P-4: Implementation of continuous quality improvement (CQI) processes for data and reporting (Conduct Plan, Do, Study, Act (PDSA) cycles)

Outcome Improvement Target(s) for each year:

The following Category 3 Improvement Target, IT-10.1, was selected to measure the success of Texana Center's Category 1 Project, Option 1.12.2 during DY 4 and DY 5:

- Demonstrate improvement in quality of life scores as measured by evidence-based and validated assessment tool(s), for children diagnosed with Autism (standalone measure).

<u>Rationale:</u>

Although much of behavioral healthcare is focused on reducing psychiatric symptoms, this intensive ABA and SLP treatment is specifically designed to improve symptoms and functions, 2 essential components of quality of life. Research indicates that approximately 50% of children that receive 1:1 intensive ABA before the age of 4 for 25-40 hours a week for at least 2 years will no longer meet the diagnostic criteria for an ASD diagnosis (Howard, et al. 2005). Recent research, including the National Standards Project, emphasizes the importance of empirically based Speech Language Pathology (SLP) intervention in addition to the primary mode of intervention of ABA. Effective quality improvement requires relentless focus on patient outcomes. Early intensive ABA treatment results in increased language and communication skills, improved social skills, achievement in pre-academic and academic areas, and decreased problem behaviors (Howard et al. 2005). Early intensive behavior intervention can be costly, exceeding $50,000 per year per child. This project will improve access to needed behavioral health services for low income families.

Baseline data will be collected during years 2 and 3 using a variety of the below and related assessment tools. One or a combination of 2 or 3 of these tools will be utilized to demonstrate progress during years 4-5 based on baseline data collected during years 3 and 4.

- Demonstrated improvement in quality of life scores on evidence-based, validated standardized assessment tools for the target population. Previous instruments used in the Children's Center for Autism include the Pervasive Developmental Disorders Behavior Inventory (PDDBI) and Psychoeducational Profile-3 (PEP-3). Other recommended instruments include the Developmental Profile-Third Edition (DP-3), Peabody Picture Vocabulary Test-Fourth Edition (PPVT-4), Expressive Vocabulary Test-Second Edition (EVT-2), Bayley Scales of Infant Development-Revised (BSID-R), Wechsler Primary Preschool Scales of Intelligence-Revised (WPPSI-R), Differential Abilities Scale (DAS), Developmental Assessment of Young Children (DAYC), Vineland Adaptive Behavior Scales (VABS), Reynell Developmental Language Scales, and the Merrill-Palmer Scale of Mental Tests (Howard, et al. 2005).
- Demonstrated improvement in quality of life on the Assessment of Basic Language and Learning Skills (ABLLS), Verbal Behavior Milestones Assessment and Placement Program (VB-MAPP), and/or the Assessment of Functional Living Skills (AFLS). Progress can be measured by examining changes in the student's scores from one administration to the next (e.g., Goin-Kochel, Myers, Hendricks, Carr, & Wiley, 2007; Sullivan & Perry, 2006). The ABLLS-R was selected because it is now commonly used by educators, school personnel, and psychologists to assess and monitor skills of children with autism who are receiving behavior therapy (e.g., Bradley-Johnson, Johnson, &Vladescu, 2008; Goin-Kochel et al., 2007; Schwartz, Boulware, McBride, &Sandall, 2001) and, according to Aman et al. (2004), has been selected as an outcome measure by the National Institute of Mental Health Research Units in Pediatric Psychopharmacology and Psychological Intervention Autism Network.

Outcome Measure Valuation:

The Category 3 Outcome Measure, *Quality of Life*, is valued as a subset to the valuation for the Texana Center Category 1.12.2 to enhance service availability of appropriate levels of behavioral health care (applied behavior analysis and speech-language pathology for children diagnosed with autism spectrum disorders) to expand the number of community based settings where behavioral health services may be delivered in underserved areas. The Category 1.12.2 Project, and supporting Category 3 Outcome Measures, addresses a priority need for the population of children diagnosed with autism.

This project addresses a priority need for the autism population to receive intensive ABA services in the community. One of the goals of this project is to avert outcomes such as potentially avoidable inpatient admissions and readmissions in settings including general acute and psychiatric hospitals, state supported living centers, and self-contained special education classrooms; to promote wellness and adherence to treatment; to promote independence in the community/functional status; and to improve quality of life. The vision will be realized throughout the child's lifetime, however, the reduction in the need for self-contained special education classrooms and in some cases the elimination of the need for special education for children served in this project would be realized during the 4 year DSRIP project.

By providing ABA services to children with autism, it allows for cost avoidance. The current project proposes to serve 20 children in years 3-5. In 2007, results of a study by Chasson et al. indicated that the state of Texas will save $208,500 *per child across eighteen years of*

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education with early intensive ABA. Based on the figures derived from this study, the state of Texas could save $4,170,000 across 18 years of education by providing ABA treatment to these 20 children. In 1998, Jacobson et al. found that cost savings following intensive ABA are estimated to be from $2,439,710 to $2,816,535 with inflation to *age 55 per child* served (Jacobson, Mulik, & Green, 1998). Therefore, based on the figures derived from this study, the state of Texas could save $48,794,200 through age 55 for these 20 children by providing early intensive ABA treatment.

Total Five Year Valuation: $541,379

Resources:

Aman, M.G., Novotny, S., Samango-Sprouse, C., Lecavalier, L., Leonard, E., Gadow, K., King, B.H., Pearson, D.A., Gernsbacher, M.A., & Chez, M. (2004). Outcome measures for clinical drug trials in autism. *CNS Spectrums, 9*, 36-47.

Bradley-Johnson, S., Johnson, C.M., Vladescu, J.C. (2008).A comprehensive model for assessing the unique characteristics of children with autism.*Journal of Psychoeducational Assessment, 26,* 325-338.

Chasson, G. S., Harris, G. E., & Neely, W. J., (2007). Cost comparison of Early Intensive Behavioral Intervention and Special Education for Children, Journal of Child and Family Studies, 2007.

Goin-Kochel, R.P., Myers, B.J., Hendricks, D.R., Carr, S.E., & Wiley, S.B. (2007). Early responsiveness to intensive behavioral interventions predicts outcomes among preschool children with autism. *International Journal of Disability, Development and Education, 54,* 154-175.

Howard, J.S., Sparkman, C.R., Cohen, H.G., Green, G., & Stanislaw, H. (2005). A comparison of

intensive behavior analytic and eclectic treatments for young children with autism, Research in Developmental Disabilities.

Jacobson, J., Mulik, J., and Green, G (1998). Cost–benefit estimates for early intensive behavioral intervention for young children with autism—general model and single state case. *Behavioral Interventions*, 13(4), 201-226).

Schwartz, I.S., Boulware, G. I., McBride, B.M. &Sandall, S.R. (2001).Functional assessment strategies for young children with autism.*Focus on Autism and Other Developmental Disabilities, 16,* 222-227.

Sullivan, A. & Perry, A. (November, 2006). Developmental trajectories of typically developing children captured by the ABLLS. Poster presented at the 14th Annual Ontario Association for Behavioural Analysis Conference, Toronto, Ontario, Canada.

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081522701.3.5	*3.IT-10.1*	*Quality of Life/Functional Status*	
Texana Center			081522701
Related Category 1 or 2 Projects:	*081522701.1.4*		
Starting Point/Baseline:	*Baseline TBD in DY 2 and 3*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Process planning engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Project Documentation Process Milestone 1Estimated Incentive Payment *(maximum amount):* N/A. Captured in Category 1 milestones. **Process Milestone 2** [P-3]: Establish baseline data Data Source: Project Documentation Process Milestone 2 Estimated Incentive Payment: N/A. Captured in Category 1 milestones.	**Process Milestone 3** [P-3]: Establish baseline data Data Source: Project Documentation Process Milestone 3 Estimated Incentive Payment: $40,482 **Process Milestone 4** [P-3]: Develop and test data systems. Data Source: Project Documentation Process Milestone 4 Estimated Incentive Payment: $40,483 **Process Milestone 5** [P-4]: Conduct Plan, Do, Study, Act (PDSA) cycles to improve data collection and intervention activities. Data Source: Project Documentation Process Milestone 5 Estimated Incentive Payment: $ 40,483	**Outcome Improvement Target 1** [IT-10.1]: Demonstrate improvement in quality of life scores as measured by evidence-based and validated assessment tool(s), for children diagnosed with Autism (standalone measure) Data Source: TBD (see narrative) Outcome Improvement Target 1 Estimated Incentive Payment*:* $132,716	**Outcome Improvement Target 2** [IT-10.1]: Demonstrate improvement in quality of life scores as measured by evidence-based and validated assessment tool(s), for children diagnosed with Autism (standalone measure) Data Source: TBD (see narrative) Outcome Improvement Target 2 Estimated Incentive Payment*:* $287,215
Year 2 Estimated Outcome Amount: $0	Year 3 Estimated Outcome Amount: $121,448	Year 4 Estimated Outcome Amount: $132,716	Year 5 Estimated Outcome Amount: $287,215
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:**$541,379			

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Texas Children's Hospital

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Title of Outcome Measure (Improvement Target): OD-5: Cost of Care

Unique RHP outcome identification number: 139135109.3.1

Outcome Measure Description:

OD-5: Cost of Care

IT-5.1 Improved cost savings

Process milestone:

DY 2 P-1; P-3

DY3 P-4; P-5

Outcome Improvement Targets for each year:

DY 4 IT-5.1;

DY 5 IT-5.1

Rationale:

Process milestones P-1, P-3, and P-4 were chosen due to the lack of accurate reports and resources currently available to measure and monitor the cost of care for this population. P-1 and P-3 must be approached in DY 2 and DY3. In DY 3 we will establish a baseline percentage. P-5 will be approached in DY 3 after the initial gap assessment is completed. Lessons learned will be shared with the region and all stakeholders. Improvement targets were placed in DY4 and DY 5 based on the timeline allowed to put in place the proper resources and processes needed to collect data. Improvement target goals will be determined after baseline percentage is set in DY3. The baseline percentage, whether high or low, will dictate an appropriate improvement target goal.

Outcome Measure Valuation:

All projects are valued for cost avoidance of medical expenses and improved quality of life. For example, increased provider capacity leads to reduction in emergency room visits and reduction in inpatient hospital visits.[306] Our valuation includes an increase in the patient's quality of life. We used a conservative Quality Adjusted Life Year ("QALY") per year and a percentage of that QALY for the pediatric population.[307] The QALY is used as a one-time improvement in the quality of life, even though we know the patient's quality of life will be improved for many years. We recognize that this is a government funded waiver and thus we chose to have conservative valuations out of respect for the taxpayer funded program. We have academic literature citing the link between access to appropriate pediatric subspecialty care and decrease in hospital visits, both inpatient and emergency room.[3]

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[306] Smith, John T, Price, Christopher, Stevens Peter M., Masters, Kevin S., and Young, Mark. "Selected Topics - Does Pediatric Orthopedic Subspecialization Affect Hospital Utilization and Charges?" *Journal of Pediatric Orthopedics*. 19.4 (1999): 553-555.

[307] Brannon, Ike. "Risk - What Is a Life Worth? Despite Its Prima Facie Callousness, Determining the Value of a Human Life Is Necessary for Good Public Policy." *Regulation*. 27.4 (2004): 60-63.

139135109.3.1	*IT- 5.1*	Cost of Care	
	Texas Children's Hospital		*139135109*
Related Category 1 or 2 Projects:	*139135109.1.1*		
Starting Point/Baseline:	*TBD in DY 3*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1[P-1] Project Planning – Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: EHR/Business Intelligence Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $42,132.50 **Process Milestone 2 [P-3]: Test Data System** Data Source**:** Enterprise Data Warehouse reports Process Milestone 2 Estimated Incentive Payment: $42,132.50	**Process Milestone 3 [P-4**] Conduct PDSA by subspecialty clinic Data Source: Advanced Quality Improvement (AQI) projects Process Milestone 3 Estimated Incentive Payment: *$48,837* **Process Milestone 4 [P-5]:** Disseminate findings, including lessons learned and best practices, to stakeholders Data Source: Reports and participation in learning collaboratives Process Milestone 4 Estimated Incentive Payment*: $48,837*	**Outcome Improvement Target 1** [**IT-5.1]** Improved cost savings: Demonstrate cost savings in care delivery Improvement Target: TBD Data Source: EPIC Medical Record Outcome Improvement Target 1 Estimated Incentive Payment*:* $156,731	**Outcome Improvement Target 1** [**IT-5.1]** Improved cost savings: Demonstrate cost savings in care delivery Improvement Target: TBD Data Source: EPIC Medical Record Outcome Improvement Target 1 Estimated Incentive Payment*:* $374,794
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $84,265	Year 3 Estimated Outcome Amount: $97,674	Year 4 Estimated Outcome Amount: $156,731	Year 5 Estimated Outcome Amount: $374,794
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $713,463			

Title of Outcome Measure (Improvement Target): OD-5: Cost of Care

Unique RHP outcome identification number: 139135109.3.2
Outcome Measure Description:
OD-5: Cost of Care
IT-5.2 Per Episode of Care

Process milestone:
DY 2 P-1; P-3
DY3 P-4; P-5

Outcome Improvement Targets for each year:
DY 4 IT-5.2;
DY 5 IT-5.2

Rationale:
Process milestones P-1, P-3, and P-4 were chosen due to the lack of accurate reports and resources currently available to measure and monitor the cost of care for this population. P-1 and P-3 must be approached in DY 2 and DY3. In DY 3 we will establish a baseline percentage. P-5 will be approached in DY 3 after the initial gap assessment is completed. Lessons learned will be shared with the region and all stakeholders. Improvement targets were placed in DY4 and DY 5 based on the timeline allowed to put in place the proper resources and processes needed to collect data. Improvement target goals will be determined after baseline percentage is set in DY3. The baseline percentage, whether high or low, will dictate an appropriate improvement target goal.

Outcome Measure Valuation:
All projects are valued for cost avoidance of medical expenses and improved quality of life. For example, increased provider capacity leads to reduction in emergency room visits and reduction in inpatient hospital visits.[308] Our valuation includes an increase in the patient's quality of life. We used a conservative Quality Adjusted Life Year ("QALY") per year and a percentage of that QALY for the pediatric population.[309] The QALY is used as a one-time improvement in the quality of life, even though we know the patient's quality of life will be improved for many years. We recognize that this is a government funded waiver and thus we chose to have conservative valuations out of respect for the taxpayer funded program. We have academic literature citing the link between access to appropriate pediatric subspecialty care and decrease in hospital visits, both inpatient and emergency room.[3]

[308] Smith, John T, Price, Christopher, Stevens Peter M., Masters, Kevin S., and Young, Mark. "Selected Topics - Does Pediatric Orthopedic Subspecialization Affect Hospital Utilization and Charges?" *Journal of Pediatric Orthopedics*. 19.4 (1999): 553-555.
[309] Brannon, Ike. "Risk - What Is a Life Worth? Despite Its Prima Facie Callousness, Determining the Value of a Human Life Is Necessary for Good Public Policy." *Regulation*. 27.4 (2004): 60-63.

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139135109.3.2	*IT- 5.2*	Cost of Care	
Texas Children's Hospital			*139135109*
Related Category 1 or 2 Projects:	*139135109.1.1*		
Starting Point/Baseline:	*TBD in DY 3*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1[P-1] Project Planning – Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: EHR/Business Intelligence Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $42,132.50 **Process Milestone 2 [P-3]: Test Data System** Data Source**:** Enterprise Data Warehouse reports Process Milestone 2 Estimated Incentive Payment: $42,132.50	**Process Milestone 3 [P-4**] Conduct PDSA by subspecialty clinic Data Source: Advanced Quality Improvement (AQI) projects Process Milestone 3 Estimated Incentive Payment: *$48,837* **Process Milestone 4 [P-5]:** Disseminate findings, including lessons learned and best practices, to stakeholders Data Source: Reports and participation in learning collaboratives Process Milestone 4 Estimated Incentive Payment*: $48,837*	**Outcome Improvement Target 2** [**IT-5.2]** Per episode cost of care Improvement Target: TBD Data Source: EPIC Medical Record Outcome Improvement Target 2 Estimated Incentive Payment*:* $156,731	**Outcome Improvement Target 2** [**IT-5.2]** Per episode cost of care Improvement Target: TBD Data Source: EPIC Medical Record Outcome Improvement Target 2 Estimated Incentive Payment*:* $374,794
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $84,265	Year 3 Estimated Outcome Amount: $97,674	Year 4 Estimated Outcome Amount: $156,731	Year 5 Estimated Outcome Amount: $374,794
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $713,463			

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Title of Outcome Measure (Improvement Target): OD-5: Cost of Care

Unique RHP outcome identification number: 139135109.3.3

Outcome Measure Description:

OD-5: Cost of Care

IT-5.3 Length of Stay

Process milestone:

DY 2 P-1; P-3

DY3 P-4; P-5

Outcome Improvement Targets for each year:

DY 4 IT-5.3;

DY 5 IT-5.3

Rationale:

Process milestones P-1, P-3, and P-4 were chosen due to the lack of accurate reports and resources currently available to measure and monitor the cost of care for this population. P-1 and P-3 must be approached in DY 2 and DY3. In DY 3 we will establish a baseline percentage. P-5 will be approached in DY 3 after the initial gap assessment is completed. Lessons learned will be shared with the region and all stakeholders. Improvement targets were placed in DY4 and DY 5 based on the timeline allowed to put in place the proper resources and processes needed to collect data. Improvement target goals will be determined after baseline percentage is set in DY3. The baseline percentage, whether high or low, will dictate an appropriate improvement target goal.

Outcome Measure Valuation:

All projects are valued for cost avoidance of medical expenses and improved quality of life. For example, increased provider capacity leads to reduction in emergency room visits and reduction in inpatient hospital visits.[310] Our valuation includes an increase in the patient's quality of life. We used a conservative Quality Adjusted Life Year ("QALY") per year and a percentage of that QALY for the pediatric population.[311] The QALY is used as a one-time improvement in the quality of life, even though we know the patient's quality of life will be improved for many years. We recognize that this is a government funded waiver and thus we chose to have conservative valuations out of respect for the taxpayer funded program. We have academic literature citing the link between access to appropriate pediatric subspecialty care and decrease in hospital visits, both inpatient and emergency room.[3]

[310] Smith, John T, Price, Christopher, Stevens Peter M., Masters, Kevin S., and Young, Mark. "Selected Topics - Does Pediatric Orthopedic Subspecialization Affect Hospital Utilization and Charges?" *Journal of Pediatric Orthopedics*. 19.4 (1999): 553-555.

[311] Brannon, Ike. "Risk - What Is a Life Worth? Despite Its Prima Facie Callousness, Determining the Value of a Human Life Is Necessary for Good Public Policy." *Regulation*. 27.4 (2004): 60-63.

139135109.3.3	*IT- 5.3*	Cost of Care	
Texas Children's Hospital			*139135109*
Related Category 1 or 2 Projects:	*139135109.1.1*		
Starting Point/Baseline:	*TBD in DY 3*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1[P-1] Project Planning – Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: EHR/Business Intelligence Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $42,132.50 **Process Milestone 2 [P-3]: Test Data System** Data Source**:** Enterprise Data Warehouse reports Process Milestone 2 Estimated Incentive Payment: $42,132.50	**Process Milestone 3 [P-4**] Conduct PDSA by subspecialty clinic Data Source: Advanced Quality Improvement (AQI) projects Process Milestone 3 Estimated Incentive Payment: *$48,837* **Process Milestone 4 [P-5]:** Disseminate findings, including lessons learned and best practices, to stakeholders Data Source: Reports and participation in learning collaboratives Process Milestone 4 Estimated Incentive Payment*: $48,837*	**Outcome Improvement Target 3 [IT-5.3]** Length of Stay Improvement Target: TBD Data Source: EPIC Medical Record Outcome Improvement Target 3 Estimated Incentive Payment*:* $156,731	**Outcome Improvement Target 3 [IT-5.3]** Length of Stay Improvement Target: TBD Data Source: EPIC Medical Record Outcome Improvement Target 3 Estimated Incentive Payment*:* $374,794
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $84,265	Year 3 Estimated Outcome Amount: $97,674	Year 4 Estimated Outcome Amount: $156,731	Year 5 Estimated Outcome Amount: $374,794
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $713,463			

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Title of Outcome Measure (Improvement Target): OD-5: Cost of Care

Unique RHP outcome identification number: 139135109.3.4
Outcome Measure Description: Cost of Care
IT-5.1 Improved cost savings:

Process milestone:
DY 2 P-1; P-3
DY3 P-4; P-5

Outcome Improvement Targets for each year:
DY 4 IT-5.1;
DY 5 IT-5.1

Rationale: Process milestones P-1, P-3, and P-4 were chosen due to the lack of accurate reports and resources currently available to measure and monitor the cost of care for this population. P-1 and P-3 must be approached in DY 2 and DY3. In DY 3 we will establish a baseline percentage. P-5 will be approached in DY 3 after the initial gap assessment is completed. Lessons learned will be shared with the region and all stakeholders.
Improvement targets were placed in DY4 and DY 5 based on the timeline allowed to put in place the proper resources and processes needed to collect data. Improvement target goals will be determined after baseline percentage is set in DY3. The baseline percentage, whether high or low, will dictate an appropriate improvement target goal.

Outcome Measure Valuation: All projects are valued for cost avoidance of medical expenses and improved quality of life. For example, increased provider capacity leads to reduction in emergency room visits and reduction in inpatient hospital visits.[312] Our valuation includes an increase in the patient's quality of life. We used a conservative Quality Adjusted Life Year ("QALY") per year and a percentage of that QALY for the pediatric population.[313] The QALY is used as a one-time improvement in the quality of life, even though we know the patient's quality of life will be improved for many years. We recognize that this is a government funded waiver and thus we chose to have conservative valuations out of respect for the taxpayer funded program. We have academic literature citing the link between access to appropriate pediatric subspecialty care and decrease in hospital visits, both inpatient and emergency room.[3]

[312] Smith, John T, Price, Christopher, Stevens Peter M., Masters, Kevin S., and Young, Mark. "Selected Topics - Does Pediatric Orthopedic Subspecialization Affect Hospital Utilization and Charges?" *Journal of Pediatric Orthopedics*. 19.4 (1999): 553-555.
[313] Brannon, Ike. "Risk - What Is a Life Worth? Despite Its Prima Facie Callousness, Determining the Value of a Human Life Is Necessary for Good Public Policy." *Regulation*. 27.4 (2004): 60-63.

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139135109.3.4	*IT- 5.1*	Cost of Care	
Texas Children's Hospital			*139135109*
Related Category 1 or 2 Projects:	*139135109.1.2*		
Starting Point/Baseline:	*TBD in DY 3*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1[P-1] Project Planning – Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: EHR/Business Intelligence Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $25,820 **Process Milestone 2 [P-3]: Test Data System** Data Source: Enterprise Data Warehouse reports Process Milestone 2 Estimated Incentive Payment: $25,820	**Process Milestone 3 [P-4] Conduct PDSA by subspecialty clinic** Data Source: Advanced Quality Improvement (AQI) projects Process Milestone 3 Estimated Incentive Payment: *$29,928.50* **Process Milestone 4 [P-5]:** Disseminate findings, including lessons learned and best practices, to stakeholders Data Source: Reports and participation in learning collaboratives Process Milestone 4 Estimated Incentive Payment*:* *$29,928.50*	**Outcome Improvement Target 1 [IT-5.1]** Improved cost savings: Demonstrate cost savings in care delivery Improvement Target: TBD Data Source: EPIC Medical Record Outcome Improvement Target 1 Estimated Incentive Payment*:* $96,050	**Outcome Improvement Target 1 [IT-5.1]** Improved cost savings: Demonstrate cost savings in care delivery Improvement Target: TBD Data Source: EPIC Medical Record Outcome Improvement Target 1 Estimated Incentive Payment*:* $229,684
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $51,640	Year 3 Estimated Outcome Amount: $59,857	Year 4 Estimated Outcome Amount: $96,050	Year 5 Estimated Outcome Amount: $229,684
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $437,230			

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Title of Outcome Measure (Improvement Target): OD-5: Cost of Care

Unique RHP outcome identification number: 139135109.3.5
Outcome Measure Description: Cost of Care
IT-5.2 Per Episode of Care:

Process milestone:
DY 2 P-1; P-3
DY3 P-4; P-5

Outcome Improvement Targets for each year:
DY 4 IT-5.2;
DY 5 IT-5.2

Rationale: Process milestones P-1, P-3, and P-4 were chosen due to the lack of accurate reports and resources currently available to measure and monitor the cost of care for this population. P-1 and P-3 must be approached in DY 2 and DY3. In DY 3 we will establish a baseline percentage. P-5 will be approached in DY 3 after the initial gap assessment is completed. Lessons learned will be shared with the region and all stakeholders.
Improvement targets were placed in DY4 and DY 5 based on the timeline allowed to put in place the proper resources and processes needed to collect data. Improvement target goals will be determined after baseline percentage is set in DY3. The baseline percentage, whether high or low, will dictate an appropriate improvement target goal.

Outcome Measure Valuation: All projects are valued for cost avoidance of medical expenses and improved quality of life. For example, increased provider capacity leads to reduction in emergency room visits and reduction in inpatient hospital visits.[314] Our valuation includes an increase in the patient's quality of life. We used a conservative Quality Adjusted Life Year ("QALY") per year and a percentage of that QALY for the pediatric population.[315] The QALY is used as a one-time improvement in the quality of life, even though we know the patient's quality of life will be improved for many years. We recognize that this is a government funded waiver and thus we chose to have conservative valuations out of respect for the taxpayer funded program. We have academic literature citing the link between access to appropriate pediatric subspecialty care and decrease in hospital visits, both inpatient and emergency room.[3]

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[314] Smith, John T, Price, Christopher, Stevens Peter M., Masters, Kevin S., and Young, Mark. "Selected Topics - Does Pediatric Orthopedic Subspecialization Affect Hospital Utilization and Charges?" *Journal of Pediatric Orthopedics*. 19.4 (1999): 553-555.
[315] Brannon, Ike. "Risk - What Is a Life Worth? Despite Its Prima Facie Callousness, Determining the Value of a Human Life Is Necessary for Good Public Policy." *Regulation*. 27.4 (2004): 60-63.

139135109.3.5	*IT- 5.2*	Cost of Care	
	Texas Children's Hospital		*139135109*
Related Category 1 or 2 Projects:	*139135109.1.2*		
Starting Point/Baseline:	*TBD in DY 3*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1[P-1] Project Planning – Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: EHR/Business Intelligence Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $25,820 **Process Milestone 2 [P-3]: Test Data System** Data Source: Enterprise Data Warehouse reports Process Milestone 2 Estimated Incentive Payment: $25,820	**Process Milestone 3 [P-4] Conduct PDSA by subspecialty clinic** Data Source: Advanced Quality Improvement (AQI) projects Process Milestone 3 Estimated Incentive Payment: *$29,928.50* **Process Milestone 4 [P-5]:** Disseminate findings, including lessons learned and best practices, to stakeholders Data Source: Reports and participation in learning collaboratives Process Milestone 4 Estimated Incentive Payment*: $29,928.50*	**Outcome Improvement Target 2** [**IT-5.2]** Per episode cost of care Improvement Target: TBD Data Source: EPIC Medical Record Outcome Improvement Target 2 Estimated Incentive Payment*:* $96,050	**Outcome Improvement Target 2** [**IT-5.2]** Per episode cost of care Improvement Target: TBD Data Source: EPIC Medical Record Outcome Improvement Target 2 Estimated Incentive Payment*:* $229,684
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $51,640	Year 3 Estimated Outcome Amount: $59,857	Year 4 Estimated Outcome Amount: $96,050	Year 5 Estimated Outcome Amount: $229,684
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)*: $437,230			

Title of Outcome Measure (Improvement Target): OD-5: Cost of Care

Unique RHP outcome identification number: 139135109.3.6
Outcome Measure Description: Cost of Care
IT-5.3 Length of Stay
Process milestone:
DY 2 P-1; P-3
DY3 P-4; P-5

Outcome Improvement Targets for each year:
DY 4 IT-5.3;
DY 5 IT-5.3

Rationale: Process milestones P-1, P-3, and P-4 were chosen due to the lack of accurate reports and resources currently available to measure and monitor the cost of care for this population. P-1 and P-3 must be approached in DY 2 and DY3. In DY 3 we will establish a baseline percentage. P-5 will be approached in DY 3 after the initial gap assessment is completed. Lessons learned will be shared with the region and all stakeholders.
Improvement targets were placed in DY4 and DY 5 based on the timeline allowed to put in place the proper resources and processes needed to collect data. Improvement target goals will be determined after baseline percentage is set in DY3. The baseline percentage, whether high or low, will dictate an appropriate improvement target goal.

Outcome Measure Valuation: All projects are valued for cost avoidance of medical expenses and improved quality of life. For example, increased provider capacity leads to reduction in emergency room visits and reduction in inpatient hospital visits.[316] Our valuation includes an increase in the patient's quality of life. We used a conservative Quality Adjusted Life Year ("QALY") per year and a percentage of that QALY for the pediatric population.[317] The QALY is used as a one-time improvement in the quality of life, even though we know the patient's quality of life will be improved for many years. We recognize that this is a government funded waiver and thus we chose to have conservative valuations out of respect for the taxpayer funded program. We have academic literature citing the link between access to appropriate pediatric subspecialty care and decrease in hospital visits, both inpatient and emergency room.

[316] Smith, John T, Price, Christopher, Stevens Peter M., Masters, Kevin S., and Young, Mark. "Selected Topics - Does Pediatric Orthopedic Subspecialization Affect Hospital Utilization and Charges?" *Journal of Pediatric Orthopedics*. 19.4 (1999): 553-555.
[317] Brannon, Ike. "Risk - What Is a Life Worth? Despite Its Prima Facie Callousness, Determining the Value of a Human Life Is Necessary for Good Public Policy." *Regulation*. 27.4 (2004): 60-63.

139135109.3.6	*IT- 5.3*	Cost of Care	
Texas Children's Hospital			*139135109*
Related Category 1 or 2 Projects:	*139135109.1.2*		
Starting Point/Baseline:	*TBD in DY 3*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1[P-1] Project Planning – Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: EHR/Business Intelligence Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $25,820 **Process Milestone 2 [P-3]: Test Data System** Data Source: Enterprise Data Warehouse reports Process Milestone 2 Estimated Incentive Payment: $25,820	**Process Milestone 3 [P-4] Conduct PDSA by subspecialty clinic** Data Source: Advanced Quality Improvement (AQI) projects Process Milestone 3 Estimated Incentive Payment: *$29,928.50* **Process Milestone 4 [P-5]:** Disseminate findings, including lessons learned and best practices, to stakeholders Data Source: Reports and participation in learning collaboratives Process Milestone 4 Estimated Incentive Payment*: $29,928.50*	**Outcome Improvement Target 3 [IT-5.3]** Length of Stay Improvement Target: TBD Data Source: EPIC Medical Record Outcome Improvement Target 3 Estimated Incentive Payment*:* $96,050	**Outcome Improvement Target 3 [IT-5.3]** Length of Stay Improvement Target: TBD Data Source: EPIC Medical Record Outcome Improvement Target 3 Estimated Incentive Payment*:* $229,684
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $51,640	Year 3 Estimated Outcome Amount: $59,857	Year 4 Estimated Outcome Amount: $96,050	Year 5 Estimated Outcome Amount: $229,684
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $437,230			

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Title of Outcome Measure (Improvement Target): OD-5: Cost of Care

Unique RHP outcome identification number: 139135109.3.7

Outcome Measure Description:
OD-5: Cost of Care
IT-5.1 Improved cost savings

Process milestone:
DY 2 P-1; P-3
DY3 P-4; P-5

Outcome Improvement Targets for each year:
DY 4 IT-5.1;
DY 5 IT-5.1

Rationale: Process milestones P-1, P-3, and P-4 were chosen due to the lack of accurate reports and resources currently available to measure and monitor the cost of care for this population. P-1 and P-3 must be approached in DY 2 and DY3. In DY 3 we will establish a baseline percentage. P-5 will be approached in DY 3 after the initial gap assessment is completed. Lessons learned will be shared with the region and all stakeholders. Improvement targets were placed in DY4 and DY 5 based on the timeline allowed to put in place the proper resources and processes needed to collect data. Improvement target goals will be determined after baseline percentage is set in DY3. The baseline percentage, whether high or low, will dictate an appropriate improvement target goal. The overall success of this project is dependent upon the compliance rate of ours patients and primary care takers arriving for their appointments. If the compliance rate is poor, it will be a challenge to realize a reduction in the cost of care.

Outcome Measure Valuation: All projects are valued for cost avoidance of medical expenses and improved quality of life. For example, increased provider capacity leads to reduction in emergency room visits and reduction in inpatient hospital visits.[318] Our valuation includes an increase in the patient's quality of life. We used a conservative Quality Adjusted Life Year ("QALY") per year and a percentage of that QALY for the pediatric population.[319] The QALY is used as a one-time improvement in the quality of life, even though we know the patient's quality of life will be improved for many years. We recognize that this is a government funded waiver and thus we chose to have conservative valuations out of respect for the taxpayer funded program.

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[318] Smith, John T, Price, Christopher, Stevens Peter M., Masters, Kevin S., and Young, Mark. "Selected Topics - Does Pediatric Orthopedic Subspecialization Affect Hospital Utilization and Charges?" *Journal of Pediatric Orthopedics*. 19.4 (1999): 553-555.
[319] Brannon, Ike. "Risk - What Is a Life Worth? Despite Its Prima Facie Callousness, Determining the Value of a Human Life Is Necessary for Good Public Policy." *Regulation*. 27.4 (2004): 60-63.

139135109.3.7	*IT-5.1*	*Potentially Preventable Admissions*	
Texas Children's Hospital			*139135109*
Related Category 1 or 2 Projects:	*139135109*.1.3		
Starting Point/Baseline:	*TBD in DY 3*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1[P-1] Project Planning – Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: EHR/Business Intelligence Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $19,736 **Process Milestone 2 [P-3]: Test Data System** Data Source: Enterprise Data Warehouse reports Process Milestone 2 Estimated Incentive Payment: $19,736	**Process Milestone 1[P-1] Project Planning –** Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: EHR/Business Intelligence Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $22,876.50 **Process Milestone 2 [P-3]:** Test Data System Data Source: Enterprise Data Warehouse reports Process Milestone 2 Estimated Incentive Payment: $22,876.50	**Outcome Improvement Target [IT-5.1]** Improved cost savings: Demonstrate cost savings in care delivery Improvement Target: TBD Data Source: EHR, Claims Estimated Incentive Payment*:* $73,417	**Outcome Improvement Target [IT-5.1]** Improved cost savings: Demonstrate cost savings in care delivery Improvement Target: TBD Data Source: EHR, Claims Estimated Incentive Payment*:* $175,563
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $39,472	Year 3 Estimated Outcome Amount: $45,753	Year 4 Estimated Outcome Amount: $73,417	Year 5 Estimated Outcome Amount: $175,563
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $334,205			

DRAFT

Title of Outcome Measure (Improvement Target): OD-5: Cost of Care

Unique RHP outcome identification number: 139135109.3.8

Outcome Measure Description:
OD-5: Cost of Care
IT-5.2 Per Episode of Care

Process milestone:
DY 2 P-1; P-3
DY3 P-4; P-5

Outcome Improvement Targets for each year:
DY 4 IT-5.2;
DY 5 IT-5.2

Rationale: Process milestones P-1, P-3, and P-4 were chosen due to the lack of accurate reports and resources currently available to measure and monitor the cost of care for this population. P-1 and P-3 must be approached in DY 2 and DY3. In DY 3 we will establish a baseline percentage. P-5 will be approached in DY 3 after the initial gap assessment is completed. Lessons learned will be shared with the region and all stakeholders. Improvement targets were placed in DY4 and DY 5 based on the timeline allowed to put in place the proper resources and processes needed to collect data. Improvement target goals will be determined after baseline percentage is set in DY3. The baseline percentage, whether high or low, will dictate an appropriate improvement target goal. The overall success of this project is dependent upon the compliance rate of ours patients and primary care takers arriving for their appointments. If the compliance rate is poor, it will be a challenge to realize a reduction in the cost of care.

Outcome Measure Valuation: All projects are valued for cost avoidance of medical expenses and improved quality of life. For example, increased provider capacity leads to reduction in emergency room visits and reduction in inpatient hospital visits.[320] Our valuation includes an increase in the patient's quality of life. We used a conservative Quality Adjusted Life Year ("QALY") per year and a percentage of that QALY for the pediatric population.[321] The QALY is used as a one-time improvement in the quality of life, even though we know the patient's quality of life will be improved for many years. We recognize that this is a government funded waiver and thus we chose to have conservative valuations out of respect for the taxpayer funded program.

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[320] Smith, John T, Price, Christopher, Stevens Peter M., Masters, Kevin S., and Young, Mark. "Selected Topics - Does Pediatric Orthopedic Subspecialization Affect Hospital Utilization and Charges?" *Journal of Pediatric Orthopedics*. 19.4 (1999): 553-555.
[321] Brannon, Ike. "Risk - What Is a Life Worth? Despite Its Prima Facie Callousness, Determining the Value of a Human Life Is Necessary for Good Public Policy." *Regulation*. 27.4 (2004): 60-63.

139135109.3.8	*IT-5.2*	*Potentially Preventable Admissions*	
Texas Children's Hospital			*139135109*
Related Category 1 or 2 Projects:	*139135109.1.3*		
Starting Point/Baseline:	*TBD in DY 3*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1[P-1] Project Planning – Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: EHR/Business Intelligence Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $19,736 **Process Milestone 2 [P-3]: Test Data System** Data Source: Enterprise Data Warehouse reports Process Milestone 2 Estimated Incentive Payment: $19,736	**Process Milestone 1[P-1] Project Planning –** Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: EHR/Business Intelligence Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $22,876.50 **Process Milestone 2 [P-3]:** Test Data System Data Source: Enterprise Data Warehouse reports Process Milestone 2 Estimated Incentive Payment: $22,876.50	**Outcome Improvement Target 2** [**IT-5.2]** Per episode cost of care Improvement Target: TBD Data Source: HER, Claims Outcome Improvement Target 2 Estimated Incentive Payment*:* $73,417	**Outcome Improvement Target 2** [**IT-5.2]** Per episode cost of care Improvement Target: TBD Data Source: HER, Claims Outcome Improvement Target 2 Estimated Incentive Payment*:* $175,563
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $39,472	Year 3 Estimated Outcome Amount: $45,753	Year 4 Estimated Outcome Amount: $73,417	Year 5 Estimated Outcome Amount: $175,563
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $334,205			

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Title of Outcome Measure (Improvement Target): OD-5: Cost of Care

Unique RHP outcome identification number: 139135109.3.9

Outcome Measure Description:
OD-5: Cost of Care
IT-5.3 Length of Stay

Process milestone:
DY 2 P-1; P-3
DY3 P-4; P-5

Outcome Improvement Targets for each year:
DY 4 IT-5.3;
DY 5 IT-5.3

Rationale: Process milestones P-1, P-3, and P-4 were chosen due to the lack of accurate reports and resources currently available to measure and monitor the cost of care for this population. P-1 and P-3 must be approached in DY 2 and DY3. In DY 3 we will establish a baseline percentage. P-5 will be approached in DY 3 after the initial gap assessment is completed. Lessons learned will be shared with the region and all stakeholders. Improvement targets were placed in DY4 and DY 5 based on the timeline allowed to put in place the proper resources and processes needed to collect data. Improvement target goals will be determined after baseline percentage is set in DY3. The baseline percentage, whether high or low, will dictate an appropriate improvement target goal. The overall success of this project is dependent upon the compliance rate of ours patients and primary care takers arriving for their appointments. If the compliance rate is poor, it will be a challenge to realize a reduction in the cost of care.

Outcome Measure Valuation: All projects are valued for cost avoidance of medical expenses and improved quality of life. For example, increased provider capacity leads to reduction in emergency room visits and reduction in inpatient hospital visits.[322] Our valuation includes an increase in the patient's quality of life. We used a conservative Quality Adjusted Life Year ("QALY") per year and a percentage of that QALY for the pediatric population.[323] The QALY is used as a one-time improvement in the quality of life, even though we know the patient's quality of life will be improved for many years. We recognize that this is a government funded waiver and thus we chose to have conservative valuations out of respect for the taxpayer funded program.

[322] Smith, John T, Price, Christopher, Stevens Peter M., Masters, Kevin S., and Young, Mark. "Selected Topics - Does Pediatric Orthopedic Subspecialization Affect Hospital Utilization and Charges?" *Journal of Pediatric Orthopedics*. 19.4 (1999): 553-555.
[323] Brannon, Ike. "Risk - What Is a Life Worth? Despite Its Prima Facie Callousness, Determining the Value of a Human Life Is Necessary for Good Public Policy." *Regulation*. 27.4 (2004): 60-63.

139135109.3.9	*IT-5.3,*	*Potentially Preventable Admissions*	
Texas Children's Hospital			*139135109*
Related Category 1 or 2 Projects:	*139135109.1.3*		
Starting Point/Baseline:	*TBD in DY 3*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1[P-1] Project Planning – Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: EHR/Business Intelligence Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $$19,736 **Process Milestone 2 [P-3]: Test Data System** Data Source: Enterprise Data Warehouse reports Process Milestone 2 Estimated Incentive Payment: $19,736	**Process Milestone 1[P-1] Project Planning –** Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: EHR/Business Intelligence Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $22,876.50 **Process Milestone 2 [P-3]:** Test Data System Data Source: Enterprise Data Warehouse reports Process Milestone 2 Estimated Incentive Payment: $22,876.50	**Outcome Improvement Target 3 [IT-5.3]** Length of Stay Improvement Target: TBD Data Source: HER, Claims Outcome Improvement Target 3 Estimated Incentive Payment*:* $73,417	**Outcome Improvement Target 3 [IT-5.3]** Length of Stay Improvement Target: TBD Data Source: HER, Claims Outcome Improvement Target 3 Estimated Incentive Payment*:* $175,563
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $39,472	Year 3 Estimated Outcome Amount: $45,753	Year 4 Estimated Outcome Amount: $73,417	Year 5 Estimated Outcome Amount: $175,563
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $334,205			

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Title of Outcome Measure (Improvement Target): Cost of Care
Unique RHP outcome identification number: 139135109.3.10

Outcome Measure Description: Cost of Care
IT-5.1 Improved cost savings:

Process milestone:
DY 2 P-1; P-3
DY3 P-4; P-5

Outcome Improvement Targets for each year:
DY 4 IT-5.1;
DY 5 IT-5.1

Rationale:
Process milestones P-1, P-3, and P-4 were chosen due to the lack of accurate reports and resources currently available to measure and monitor the cost of care for this population. P-1 and P-3 must be approached in DY 2 and DY3. In DY 3 we will establish a baseline percentage. P-5 will be approached in DY 3 after the initial gap assessment is completed. Lessons learned will be shared with the region and all stakeholders. Improvement targets were placed in DY4 and DY 5 based on the timeline allowed to put in place the proper resources and processes needed to collect data. Improvement target goals will be determined after baseline percentage is set in DY3. The baseline percentage, whether high or low, will dictate an appropriate improvement target goal.

Outcome Measure Valuation:
All projects are valued for cost avoidance of medical expenses and improved quality of life. For example, increased provider capacity leads to reduction in emergency room visits and reduction in inpatient hospital visits.[324] Our valuation includes an increase in the patient's quality of life. We used a conservative Quality Adjusted Life Year ("QALY") per year and a percentage of that QALY for the pediatric population.[325] The QALY is used as a one-time improvement in the quality of life, even though we know the patient's quality of life will be improved for many years. We recognize that this is a government funded waiver and thus we chose to have conservative valuations out of respect for the taxpayer funded program.

[324] Smith, John T, Price, Christopher, Stevens Peter M., Masters, Kevin S., and Young, Mark. "Selected Topics - Does Pediatric Orthopedic Subspecialization Affect Hospital Utilization and Charges?" *Journal of Pediatric Orthopedics*. 19.4 (1999): 553-555.
[325] Brannon, Ike. "Risk - What Is a Life Worth? Despite Its Prima Facie Callousness, Determining the Value of a Human Life Is Necessary for Good Public Policy." *Regulation*. 27.4 (2004): 60-63.

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139135109.3.10	*IT- 5.1,*	*Cost of Care*	
Texas Children's Hospital			*139135109*
Related Category 1 or 2 Projects:	*139135109.1.4*		
Starting Point/Baseline:	*TBD in DY 3*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1[P-1] Project Planning – Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: EHR/Business Intelligence Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $21,451.50 **Process Milestone 2 [P-3]:** Test Data System Data Source**:** Enterprise Data Warehouse reports Process Milestone 2 Estimated Incentive Payment: $21,451.50	**Process Milestone 3 [P-4] Conduct PDSA by subspecialty clinic** **Data Source:** Advanced Quality Improvement (AQI) projects Process Milestone 3 Estimated Incentive Payment: *$24,865* **Process Milestone 4 [P-5]:** Disseminate findings, including lessons learned and best practices, to stakeholders Data Source: Reports and participation in learning collaboratives Process Milestone 4 Estimated Incentive Payment*: $24,865*	**Outcome Improvement Target 1** [**IT-5.1**] Improved cost savings: Demonstrate cost savings in care delivery Improvement Target: TBD Data Source: EPIC Medical Record Outcome Improvement Target 1 Estimated Incentive Payment*:* $79,799	**Outcome Improvement Target 1** [**IT-5.1**] Improved cost savings: Demonstrate cost savings in care delivery Improvement Target: TBD Data Source: EPIC Medical Record Outcome Improvement Target 1 Estimated Incentive Payment*:* $190,824
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $42,903	Year 3 Estimated Outcome Amount: $49,730	Year 4 Estimated Outcome Amount: $79,799	Year 5 Estimated Outcome Amount: $190,824
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $363,255			

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Title of Outcome Measure (Improvement Target): Cost of Care
Unique RHP outcome identification number: 139135109.3.11

Outcome Measure Description: Cost of Care
IT-5.2 Per Episode of Care:

Process milestone:
DY 2 P-1; P-3
DY3 P-4; P-5

Outcome Improvement Targets for each year:
DY 4 IT-5.2;
DY 5 IT-5.2

Rationale:
Process milestones P-1, P-3, and P-4 were chosen due to the lack of accurate reports and resources currently available to measure and monitor the cost of care for this population. P-1 and P-3 must be approached in DY 2 and DY3. In DY 3 we will establish a baseline percentage. P-5 will be approached in DY 3 after the initial gap assessment is completed. Lessons learned will be shared with the region and all stakeholders. Improvement targets were placed in DY4 and DY 5 based on the timeline allowed to put in place the proper resources and processes needed to collect data. Improvement target goals will be determined after baseline percentage is set in DY3. The baseline percentage, whether high or low, will dictate an appropriate improvement target goal.

Outcome Measure Valuation:
All projects are valued for cost avoidance of medical expenses and improved quality of life. For example, increased provider capacity leads to reduction in emergency room visits and reduction in inpatient hospital visits.[326] Our valuation includes an increase in the patient's quality of life. We used a conservative Quality Adjusted Life Year ("QALY") per year and a percentage of that QALY for the pediatric population.[327] The QALY is used as a one-time improvement in the quality of life, even though we know the patient's quality of life will be improved for many years. We recognize that this is a government funded waiver and thus we chose to have conservative valuations out of respect for the taxpayer funded program.

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[327] Brannon, Ike. "Risk - What Is a Life Worth? Despite Its Prima Facie Callousness, Determining the Value of a Human Life Is Necessary for Good Public Policy." *Regulation*. 27.4 (2004): 60-63.

139135109.3.11	*IT- 5.2*	*Cost of Care*	
Texas Children's Hospital			*139135109*
Related Category 1 or 2 Projects:	*139135109.1.4*		
Starting Point/Baseline:	*TBD in DY 3*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1[P-1] Project Planning – Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: EHR/Business Intelligence Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $$21,451.50 **Process Milestone 2 [P-3]:** Test Data System Data Source**:** Enterprise Data Warehouse reports Process Milestone 2 Estimated Incentive Payment: $21,451.50	**Process Milestone 3 [P-4] Conduct PDSA by subspecialty clinic** **Data Source:** Advanced Quality Improvement (AQI) projects Process Milestone 3 Estimated Incentive Payment: *$24,865* **Process Milestone 4 [P-5]:** Disseminate findings, including lessons learned and best practices, to stakeholders Data Source: Reports and participation in learning collaboratives Process Milestone 4 Estimated Incentive Payment*: $24,865*	**Outcome Improvement Target 2** [**IT-5.2]** Per episode cost of care Improvement Target: TBD Data Source: EPIC Medical Record Outcome Improvement Target 2 Estimated Incentive Payment: $79,799	**Outcome Improvement Target 2** [**IT-5.2]** Per episode cost of care Improvement Target: TBD Data Source: EPIC Medical Record Outcome Improvement Target 2 Estimated Incentive Payment*:* $190,824
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $42,903	Year 3 Estimated Outcome Amount: $49,730	Year 4 Estimated Outcome Amount: $79,799	Year 5 Estimated Outcome Amount: $190,824
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $363,255			

Title of Outcome Measure (Improvement Target): Cost of Care
Unique RHP outcome identification number: 139135109.3.12

Outcome Measure Description: Cost of Care
IT-5.3 Length of Stay:

Process milestone:
DY 2 P-1; P-3
DY3 P-4; P-5

Outcome Improvement Targets for each year:
DY 4 IT-5.3;
DY 5 IT-5.3

Rationale:
Process milestones P-1, P-3, and P-4 were chosen due to the lack of accurate reports and resources currently available to measure and monitor the cost of care for this population. P-1 and P-3 must be approached in DY 2 and DY3. In DY 3 we will establish a baseline percentage. P-5 will be approached in DY 3 after the initial gap assessment is completed. Lessons learned will be shared with the region and all stakeholders. Improvement targets were placed in DY4 and DY 5 based on the timeline allowed to put in place the proper resources and processes needed to collect data. Improvement target goals will be determined after baseline percentage is set in DY3. The baseline percentage, whether high or low, will dictate an appropriate improvement target goal.

Outcome Measure Valuation:
All projects are valued for cost avoidance of medical expenses and improved quality of life. For example, increased provider capacity leads to reduction in emergency room visits and reduction in inpatient hospital visits.[328] Our valuation includes an increase in the patient's quality of life. We used a conservative Quality Adjusted Life Year ("QALY") per year and a percentage of that QALY for the pediatric population.[329] The QALY is used as a one-time improvement in the quality of life, even though we know the patient's quality of life will be improved for many years. We recognize that this is a government funded waiver and thus we chose to have conservative valuations out of respect for the taxpayer funded program.

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[329] Brannon, Ike. "Risk - What Is a Life Worth? Despite Its Prima Facie Callousness, Determining the Value of a Human Life Is Necessary for Good Public Policy." *Regulation*. 27.4 (2004): 60-63.

139135109.3.12	*IT- 5.3*	*Cost of Care*	
Texas Children's Hospital			*139135109*
Related Category 1 or 2 Projects:	*139135109.1.4*		
Starting Point/Baseline:	*TBD in DY 3*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1[P-1] Project Planning – Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: EHR/Business Intelligence Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $21,451.50 **Process Milestone 2 [P-3]:** Test Data System Data Source**:** Enterprise Data Warehouse reports Process Milestone 2 Estimated Incentive Payment: $21,451.50	**Process Milestone 3 [P-4] Conduct PDSA by subspecialty clinic** **Data Source:** Advanced Quality Improvement (AQI) projects Process Milestone 3 Estimated Incentive Payment: *$24,865* **Process Milestone 4 [P-5]:** Disseminate findings, including lessons learned and best practices, to stakeholders Data Source: Reports and participation in learning collaboratives Process Milestone 4 Estimated Incentive Payment*: $24,865*	**Outcome Improvement Target 3 [IT-5.3]** Length of Stay Improvement Target: TBD Data Source: EPIC Medical Record Outcome Improvement Target 3 Estimated Incentive Payment*:* $79,799	**Outcome Improvement Target 3 [IT-5.3]** Length of Stay Improvement Target: TBD Data Source: EPIC Medical Record Outcome Improvement Target 3 Estimated Incentive Payment*:* $190,824
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $42,903	Year 3 Estimated Outcome Amount: $49,730	Year 4 Estimated Outcome Amount: $79,799	Year 5 Estimated Outcome Amount: $190,824
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $363,255			

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Title of Outcome Measure (Improvement Target): Cost of Care
Unique RHP outcome identification number: 139135109.3.13

Outcome Measure Description:
OD-5: Cost of Care
IT-5.1 Improved cost savings

Process milestone:
DY 2 P-1; P-3
DY3 P-4; P-5

Outcome Improvement Targets for each year:
DY 4 IT-5.1;
DY 5 IT-5.1

Rationale: Process milestones P-1, P-3, and P-4 were chosen due to the lack of accurate reports and resources currently available to measure and monitor the cost of care for this population. P-1 and P-3 must be approached in DY 2 and DY3. In DY 3 we will establish a baseline percentage. P-5 will be approached in DY 3 after the initial gap assessment is completed. Lessons learned will be shared with the region and all stakeholders. Improvement targets were placed in DY4 and DY 5 based on the timeline allowed to put in place the proper resources and processes needed to collect data. Improvement target goals will be determined after baseline percentage is set in DY3. The baseline percentage, whether high or low, will dictate an appropriate improvement target goal. The overall success of this project is dependent upon the compliance rate of ours patients and primary care takers arriving for their appointments. If the compliance rate is poor, it will be a challenge to realize a reduction in the cost of care. We recognize that while increasing access to care we need to continue to focus on delivering quality, efficient and cost effective care. Medicaid is an entitlement program, but there is only a finite amount of money. The affordable Care Act focused on the triple aim- improving quality, reducing costs and improving access. This project strives to meet those same goals. We agree that increased access should be coupled with controlling unnecessary costs.

Outcome Measure Valuation: All projects are valued for cost avoidance of medical expenses and improved quality of life. For example, increased provider capacity leads to reduction in emergency room visits and reduction in inpatient hospital visits.[330] Our valuation includes an increase in the patient's quality of life. We used a conservative Quality Adjusted Life Year ("QALY") per year and a percentage of that QALY for the pediatric population.[331] The QALY is used as a one-time improvement in the quality of life, even though we know the patient's quality of life will be improved for many years. We recognize that this is a government funded waiver and thus we chose to have conservative valuations out of respect for the taxpayer funded program.

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[331] Brannon, Ike. "Risk - What Is a Life Worth? Despite Its Prima Facie Callousness, Determining the Value of a Human Life Is Necessary for Good Public Policy." *Regulation*. 27.4 (2004): 60-63.

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139135109.3.13	*IT- 5.1*	Cost of Care	
Texas Children's Hospital			*139135109*
Related Category 1 or 2 Projects:	*139135109.1.5*		
Starting Point/Baseline:	*TBD in DY 3*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1[P-1] Project Planning – Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: EHR/Business Intelligence Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $21,175 **Process Milestone 2 [P-3]: Test Data System** Data Source: Enterprise Data Warehouse reports Process Milestone 2 Estimated Incentive Payment: $21,175	**Process Milestone 3 [P-4] Conduct PDSA by subspecialty clinic** Data Source: Advanced Quality Improvement (AQI) projects Process Milestone 3 Estimated Incentive Payment: *$24,544.50* **Process Milestone 4 [P-5]:** Disseminate findings, including lessons learned and best practices, to stakeholders Data Source: Reports and participation in learning collaboratives Process Milestone 4 Estimated Incentive Payment*: $24,544.50*	**Outcome Improvement Target 1 [IT-5.1]** Improved cost savings: Demonstrate cost savings in care delivery Improvement Target: TBD Data Source: EPIC Medical Record Outcome Improvement Target 1 Estimated Incentive Payment*:* $78,771	**Outcome Improvement Target 1 [IT-5.1]** Improved cost savings: Demonstrate cost savings in care delivery Improvement Target: TBD Data Source: EPIC Medical Record Outcome Improvement Target 1 Estimated Incentive Payment*:* $188,366
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $42,350	Year 3 Estimated Outcome Amount: $49,089	Year 4 Estimated Outcome Amount: $78,771	Year 5 Estimated Outcome Amount: $188,366
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $358,576			

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Title of Outcome Measure (Improvement Target): Cost of Care

Unique RHP outcome identification number: 139135109.3.14

Outcome Measure Description:
OD-5: Cost of Care IT-5.2 Per Episode of Care

Process milestone:
DY 2 P-1; P-3
DY3 P-4; P-5

Outcome Improvement Targets for each year:
DY 4 IT-5.2;
DY 5 IT-5.2

Rationale: Process milestones P-1, P-3, and P-4 were chosen due to the lack of accurate reports and resources currently available to measure and monitor the cost of care for this population. P-1 and P-3 must be approached in DY 2 and DY3. In DY 3 we will establish a baseline percentage. P-5 will be approached in DY 3 after the initial gap assessment is completed. Lessons learned will be shared with the region and all stakeholders. Improvement targets were placed in DY4 and DY 5 based on the timeline allowed to put in place the proper resources and processes needed to collect data. Improvement target goals will be determined after baseline percentage is set in DY3. The baseline percentage, whether high or low, will dictate an appropriate improvement target goal. The overall success of this project is dependent upon the compliance rate of ours patients and primary care takers arriving for their appointments. If the compliance rate is poor, it will be a challenge to realize a reduction in the cost of care. We recognize that while increasing access to care we need to continue to focus on delivering quality, efficient and cost effective care. Medicaid is an entitlement program, but there is only a finite amount of money. The affordable Care Act focused on the triple aim- improving quality, reducing costs and improving access. This project strives to meet those same goals. We agree that increased access should be coupled with controlling unnecessary costs.

Outcome Measure Valuation: All projects are valued for cost avoidance of medical expenses and improved quality of life. For example, increased provider capacity leads to reduction in emergency room visits and reduction in inpatient hospital visits.[332] Our valuation includes an increase in the patient's quality of life. We used a conservative Quality Adjusted Life Year ("QALY") per year and a percentage of that QALY for the pediatric population.[333] The QALY is used as a one-time improvement in the quality of life, even though we know the patient's quality of life will be improved for many years. We recognize that this is a government funded waiver and thus we chose to have conservative valuations out of respect for the taxpayer funded program.

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[332] Smith, John T, Price, Christopher, Stevens Peter M., Masters, Kevin S., and Young, Mark. "Selected Topics - Does Pediatric Orthopedic Subspecialization Affect Hospital Utilization and Charges?" *Journal of Pediatric Orthopedics*. 19.4 (1999): 553-555.

[333] Brannon, Ike. "Risk - What Is a Life Worth? Despite Its Prima Facie Callousness, Determining the Value of a Human Life Is Necessary for Good Public Policy." *Regulation*. 27.4 (2004): 60-63.

139135109.3.14	*IT-5.2*	Cost of Care	
Texas Children's Hospital			*139135109*
Related Category 1 or 2 Projects:	*139135109.1.5*		
Starting Point/Baseline:	*TBD in DY 3*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1[P-1] Project Planning – Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: EHR/Business Intelligence Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $21,175 **Process Milestone 2 [P-3]: Test Data System** Data Source: Enterprise Data Warehouse reports Process Milestone 2 Estimated Incentive Payment: $21,175	**Process Milestone 3 [P-4] Conduct PDSA by subspecialty clinic** Data Source: Advanced Quality Improvement (AQI) projects Process Milestone 3 Estimated Incentive Payment: *$24,544.50* **Process Milestone 4 [P-5]:** Disseminate findings, including lessons learned and best practices, to stakeholders Data Source: Reports and participation in learning collaboratives Process Milestone 4 Estimated Incentive Payment*:* *$24,544.50*	**Outcome Improvement Target 2 [IT-5.2] Per episode cost of care** Improvement Target: TBD Data Source: EPIC Medical Record Outcome Improvement Target 2 Estimated Incentive Payment*:* $78,771	**Outcome Improvement Target 2 [IT-5.2] Per episode cost of care** Improvement Target: TBD Data Source: EPIC Medical Record Outcome Improvement Target 2 Estimated Incentive Payment*:* $188,366
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $42,350	Year 3 Estimated Outcome Amount: $49,089.34	Year 4 Estimated Outcome Amount: $78,771	Year 5 Estimated Outcome Amount: $188,366
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $358,576			

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Title of Outcome Measure (Improvement Target): Cost of Care

Unique RHP outcome identification number: 139135109.3.15

Outcome Measure Description:
OD-5: Cost of Care IT-5.3 Length of Stay

Process milestone:
DY 2 P-1; P-3
DY3 P-4; P-5

Outcome Improvement Targets for each year:
DY 4 IT-5.3;
DY 5 IT-5.3

Rationale: Process milestones P-1, P-3, and P-4 were chosen due to the lack of accurate reports and resources currently available to measure and monitor the cost of care for this population. P-1 and P-3 must be approached in DY 2 and DY3. In DY 3 we will establish a baseline percentage. P-5 will be approached in DY 3 after the initial gap assessment is completed. Lessons learned will be shared with the region and all stakeholders. Improvement targets were placed in DY4 and DY 5 based on the timeline allowed to put in place the proper resources and processes needed to collect data. Improvement target goals will be determined after baseline percentage is set in DY3. The baseline percentage, whether high or low, will dictate an appropriate improvement target goal. The overall success of this project is dependent upon the compliance rate of ours patients and primary care takers arriving for their appointments. If the compliance rate is poor, it will be a challenge to realize a reduction in the cost of care. We recognize that while increasing access to care we need to continue to focus on delivering quality, efficient and cost effective care. Medicaid is an entitlement program, but there is only a finite amount of money. The affordable Care Act focused on the triple aim- improving quality, reducing costs and improving access. This project strives to meet those same goals. We agree that increased access should be coupled with controlling unnecessary costs.

Outcome Measure Valuation: All projects are valued for cost avoidance of medical expenses and improved quality of life. For example, increased provider capacity leads to reduction in emergency room visits and reduction in inpatient hospital visits.[334] Our valuation includes an increase in the patient's quality of life. We used a conservative Quality Adjusted Life Year ("QALY") per year and a percentage of that QALY for the pediatric population.[335] The QALY is used as a one-time improvement in the quality of life, even though we know the patient's quality of life will be improved for many years. We recognize that this is a government funded waiver and thus we chose to have conservative valuations out of respect for the taxpayer funded program.

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<table>
<tr><td>139135109.3.15</td><td>IT-5.3</td><td colspan="2">Cost of Care</td></tr>
<tr><td colspan="3">Texas Children's Hospital</td><td>139135109</td></tr>
<tr><td>Related Category 1 or 2 Projects:</td><td colspan="3">139135109.1.5</td></tr>
<tr><td>Starting Point/Baseline:</td><td colspan="3">TBD in DY 3</td></tr>
<tr><th>Year 2
(10/1/2012 – 9/30/2013)</th><th>Year 3
(10/1/2013 – 9/30/2014)</th><th>Year 4
(10/1/2014 – 9/30/2015)</th><th>Year 5
(10/1/2015 – 9/30/2016)</th></tr>
<tr><td>Process Milestone 1[P-1] Project Planning – Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
Data Source: EHR/Business Intelligence

Process Milestone 1 Estimated Incentive Payment (maximum amount): $21,175

Process Milestone 2 [P-3]: Test Data System
Data Source: Enterprise Data Warehouse reports

Process Milestone 2 Estimated Incentive Payment: $21,175</td><td>Process Milestone 3 [P-4] Conduct PDSA by subspecialty clinic
Data Source: Advanced Quality Improvement (AQI) projects

Process Milestone 3 Estimated Incentive Payment: $24,544.50

Process Milestone 4 [P-5]: Disseminate findings, including lessons learned and best practices, to stakeholders
Data Source: Reports and participation in learning collaboratives

Process Milestone 4 Estimated Incentive Payment: $24,544.50</td><td>Outcome Improvement Target 3 [IT-5.3] Length of Stay
Improvement Target: TBD
Data Source: EPIC Medical Record

Outcome Improvement Target 3 Estimated Incentive Payment: $78,771</td><td>Outcome Improvement Target 3 [IT-5.3] Length of Stay
Improvement Target: TBD
Data Source: EPIC Medical Record

Outcome Improvement Target 3 Estimated Incentive Payment: $188,366</td></tr>
<tr><td>Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $42,350</td><td>Year 3 Estimated Outcome Amount: $49,089.34</td><td>Year 4 Estimated Outcome Amount: $78,771</td><td>Year 5 Estimated Outcome Amount: $188,366</td></tr>
<tr><td colspan="4">TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5): $358,576</td></tr>
</table>

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Title of Outcome Measure (Improvement Target): OD-5: Cost of Care

Unique RHP outcome identification number: 139135109.3.16

Outcome Measure Description:
IT-5.1 Improved cost savings:

Process milestone:
DY 2 P-1; P-3
DY3 P-4; P-5

Outcome Improvement Targets for each year:
DY 4 IT-5.1;
DY 5 IT-5.1

Rationale: Process milestones P-1, P-3, and P-4 were chosen due to the lack of accurate reports and resources currently available to measure and monitor the cost of care for this population. P-1 and P-3 must be approached in DY 2 and DY3. In DY 3 we will establish a baseline percentage. P-5 will be approached in DY 3 after the initial gap assessment is completed. Lessons learned will be shared with the region and all stakeholders.

Improvement targets were placed in DY4 and DY 5 based on the timeline allowed to put in place the proper resources and processes needed to collect data. Improvement target goals will be determined after baseline percentage is set in DY3. The baseline percentage, whether high or low, will dictate an appropriate improvement target goal. We recognize that while increasing access to care we need to continue to focus on delivering quality, efficient and cost effective care. Medicaid is an entitlement program, but there is only a finite amount of money. The affordable Care Act focused on the triple aim- improving quality, reducing costs and improving access. This project strives to meet those same goals. We agree that increased access should be coupled with controlling unnecessary costs.

Outcome Measure Valuation: All projects are valued for cost avoidance of medical expenses and improved quality of life. For example, increased provider capacity leads to reduction in emergency room visits and reduction in inpatient hospital visits.[336] Our valuation includes an increase in the patient's quality of life. We used a conservative Quality Adjusted Life Year ("QALY") per year and a percentage of that QALY for the pediatric population.[337] The QALY is used as a one-time improvement in the quality of life, even though we know the patient's quality of life will be improved for many years. We recognize that this is a government funded waiver and thus we chose to have conservative valuations out of respect for the taxpayer funded program.

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139135109.3.16	*IT- 5.1*	Cost of Care	
Texas Children's Hospital			*139135109*
Related Category 1 or 2 Projects:	*139135109.1.6*		
Starting Point/Baseline:	*TBD in DY 3*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1[P-1] Project Planning – Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: EHR/Business Intelligence Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $24,109 **Process Milestone 2 [P-3]: Test Data System** Data Source: Enterprise Data Warehouse reports Process Milestone 2 Estimated Incentive Payment: $24,109	**Process Milestone 3 [P-4] Conduct PDSA by subspecialty clinic** Data Source: Advanced Quality Improvement (AQI) projects Process Milestone 3 Estimated Incentive Payment: *$27,945.50* **Process Milestone 4 [P-5]:** Disseminate findings, including lessons learned and best practices, to stakeholders Data Source: Reports and participation in learning collaboratives Process Milestone 4 Estimated Incentive Payment*: $27,945.50*	**Outcome Improvement Target 1 [IT-5.1]** Improved cost savings: Demonstrate cost savings in care delivery Improvement Target: TBD Data Source: EPIC Medical Record Outcome Improvement Target 1 Estimated Incentive Payment*:* $89,686	**Outcome Improvement Target 1 [IT-5.1]** Improved cost savings: Demonstrate cost savings in care delivery Improvement Target: TBD Data Source: EPIC Medical Record Outcome Improvement Target 1 Estimated Incentive Payment*:* $214,466
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $48,218	Year 3 Estimated Outcome Amount: $55,891	Year 4 Estimated Outcome Amount: $89,686	Year 5 Estimated Outcome Amount: $214,466
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $408,260			

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Title of Outcome Measure (Improvement Target): OD-5: Cost of Care

Unique RHP outcome identification number: 139135109.3.17

Outcome Measure Description:
IT-5.2 Per Episode of Care

Process milestone:
DY 2 P-1; P-3
DY3 P-4; P-5

Outcome Improvement Targets for each year:
DY 4 IT-5.2;
DY 5 IT-5.2

Rationale: Process milestones P-1, P-3, and P-4 were chosen due to the lack of accurate reports and resources currently available to measure and monitor the cost of care for this population. P-1 and P-3 must be approached in DY 2 and DY3. In DY 3 we will establish a baseline percentage. P-5 will be approached in DY 3 after the initial gap assessment is completed. Lessons learned will be shared with the region and all stakeholders.

Improvement targets were placed in DY4 and DY 5 based on the timeline allowed to put in place the proper resources and processes needed to collect data. Improvement target goals will be determined after baseline percentage is set in DY3. The baseline percentage, whether high or low, will dictate an appropriate improvement target goal. We recognize that while increasing access to care we need to continue to focus on delivering quality, efficient and cost effective care. Medicaid is an entitlement program, but there is only a finite amount of money. The affordable Care Act focused on the triple aim- improving quality, reducing costs and improving access. This project strives to meet those same goals. We agree that increased access should be coupled with controlling unnecessary costs.

Outcome Measure Valuation: All projects are valued for cost avoidance of medical expenses and improved quality of life. For example, increased provider capacity leads to reduction in emergency room visits and reduction in inpatient hospital visits.[338] Our valuation includes an increase in the patient's quality of life. We used a conservative Quality Adjusted Life Year ("QALY") per year and a percentage of that QALY for the pediatric population.[339] The QALY is used as a one-time improvement in the quality of life, even though we know the patient's quality of life will be improved for many years. We recognize that this is a government funded waiver and thus we chose to have conservative valuations out of respect for the taxpayer funded program.

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139135109.3.17	*IT- 5.2*	Cost of Care	
Texas Children's Hospital			*139135109*
Related Category 1 or 2 Projects:	*139135109.1.6*		
Starting Point/Baseline:	*TBD in DY 3*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1[P-1] Project Planning – Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: EHR/Business Intelligence Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $24,109 **Process Milestone 2 [P-3]: Test Data System** Data Source: Enterprise Data Warehouse reports Process Milestone 2 Estimated Incentive Payment: $24,109	**Process Milestone 3 [P-4] Conduct PDSA by subspecialty clinic** Data Source: Advanced Quality Improvement (AQI) projects Process Milestone 3 Estimated Incentive Payment: *$27,945.50* **Process Milestone 4 [P-5]:** Disseminate findings, including lessons learned and best practices, to stakeholders Data Source: Reports and participation in learning collaboratives Process Milestone 4 Estimated Incentive Payment*: $27,945.50*	**Outcome Improvement Target 2** [**IT-5.2]** Per episode cost of care Improvement Target: TBD Data Source: EPIC Medical Record Outcome Improvement Target 2 Estimated Incentive Payment*:* $89,686	**Outcome Improvement Target 2** [**IT-5.2]** Per episode cost of care Improvement Target: TBD Data Source: EPIC Medical Record Outcome Improvement Target 2 Estimated Incentive Payment*:* $214,466
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $48,218	Year 3 Estimated Outcome Amount: $55,891	Year 4 Estimated Outcome Amount: $89,686	Year 5 Estimated Outcome Amount: $214,466
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)*: $408,260			

DRAFT

Title of Outcome Measure (Improvement Target): OD-5: Cost of Care

Unique RHP outcome identification number: 139135109.3.18

Outcome Measure Description:
IT-5.3 Length of Stay

Process milestone:

DY 2 P-1; P-3
DY3 P-4; P-5

Outcome Improvement Targets for each year:

DY 4 IT-5.3;
DY 5 IT-5.3

Rationale: Process milestones P-1, P-3, and P-4 were chosen due to the lack of accurate reports and resources currently available to measure and monitor the cost of care for this population. P-1 and P-3 must be approached in DY 2 and DY3. In DY 3 we will establish a baseline percentage. P-5 will be approached in DY 3 after the initial gap assessment is completed. Lessons learned will be shared with the region and all stakeholders.

Improvement targets were placed in DY4 and DY 5 based on the timeline allowed to put in place the proper resources and processes needed to collect data. Improvement target goals will be determined after baseline percentage is set in DY3. The baseline percentage, whether high or low, will dictate an appropriate improvement target goal. We recognize that while increasing access to care we need to continue to focus on delivering quality, efficient and cost effective care. Medicaid is an entitlement program, but there is only a finite amount of money. The affordable Care Act focused on the triple aim- improving quality, reducing costs and improving access. This project strives to meet those same goals. We agree that increased access should be coupled with controlling unnecessary costs.

Outcome Measure Valuation: All projects are valued for cost avoidance of medical expenses and improved quality of life. For example, increased provider capacity leads to reduction in emergency room visits and reduction in inpatient hospital visits.[340] Our valuation includes an increase in the patient's quality of life. We used a conservative Quality Adjusted Life Year ("QALY") per year and a percentage of that QALY for the pediatric population.[341] The QALY is used as a one-time improvement in the quality of life, even though we know the patient's quality of life will be improved for many years. We recognize that this is a government funded waiver and thus we chose to have conservative valuations out of respect for the taxpayer funded program.

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139135109.3.18	*IT- 5.3*	Cost of Care	
Texas Children's Hospital			*139135109*
Related Category 1 or 2 Projects:	*139135109.1.6*		
Starting Point/Baseline:	*TBD in DY 3*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1[P-1] Project Planning – Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: EHR/Business Intelligence Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $24,109 **Process Milestone 2 [P-3]: Test Data System** Data Source: Enterprise Data Warehouse reports Process Milestone 2 Estimated Incentive Payment: $24,109	**Process Milestone 3 [P-4] Conduct PDSA by subspecialty clinic** Data Source: Advanced Quality Improvement (AQI) projects Process Milestone 3 Estimated Incentive Payment: *$27,945.50* **Process Milestone 4 [P-5]:** Disseminate findings, including lessons learned and best practices, to stakeholders Data Source: Reports and participation in learning collaboratives Process Milestone 4 Estimated Incentive Payment*: $27,945.50*	**Outcome Improvement Target 3 [IT-5.3]** Length of Stay Improvement Target: TBD Data Source: EPIC Medical Record Outcome Improvement Target 3 Estimated Incentive Payment*:* $89,686	**Outcome Improvement Target 3 [IT-5.3]** Length of Stay Improvement Target: TBD Data Source: EPIC Medical Record Outcome Improvement Target 3 Estimated Incentive Payment*:* $214,466
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $48,218	Year 3 Estimated Outcome Amount: $55,891	Year 4 Estimated Outcome Amount: $89,686	Year 5 Estimated Outcome Amount: $214,466
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $408,260			

Title of Outcome Measure (Improvement Target): Cost of Care

Unique RHP outcome identification number: 139135109.3.19

Outcome Measure Description: OD-5: Cost of Care
IT-5.1 Improved cost savings

Process milestone:
DY 2 P-1; P-3
DY3 P-4; P-5

Outcome Improvement Targets for each year:
DY 4 IT-5.1;
DY 5 IT-5.1

Rationale: Process milestones P-1, P-3, and P-4 were chosen due to the lack of accurate reports and resources currently available to measure and monitor the cost of care for this population. P-1 and P-3 must be approached in DY 2 and DY3. In DY 3 we will establish a baseline percentage. P-5 will be approached in DY 3 after the initial gap assessment is completed. Lessons learned will be shared with the region and all stakeholders. Improvement targets were placed in DY4 and DY 5 based on the timeline allowed to put in place the proper resources and processes needed to collect data. Improvement target goals will be determined after baseline percentage is set in DY3. The baseline percentage, whether high or low, will dictate an appropriate improvement target goal. The overall success of this project is dependent upon the compliance rate of ours patients and primary care takers arriving for their appointments. If the compliance rate is poor, it will be a challenge to realize a reduction in the cost of care.

Outcome Measure Valuation: All projects are valued for cost avoidance of medical expenses and improved quality of life. For example, increased provider capacity leads to reduction in emergency room visits and reduction in inpatient hospital visits.[342] Our valuation includes an increase in the patient's quality of life. We used a conservative Quality Adjusted Life Year ("QALY") per year and a percentage of that QALY for the pediatric population.[343] The QALY is used as a one-time improvement in the quality of life, even though we know the patient's quality of life will be improved for many years. We recognize that this is a government funded waiver and thus we chose to have conservative valuations out of respect for the taxpayer funded program. We have academic literature citing the link between access to appropriate pediatric subspecialty care and decrease in hospital visits, both inpatient and emergency room.[3]

[342] Smith, John T, Price, Christopher, Stevens Peter M., Masters, Kevin S., and Young, Mark. "Selected Topics - Does Pediatric Orthopedic Subspecialization Affect Hospital Utilization and Charges?" *Journal of Pediatric Orthopedics*. 19.4 (1999): 553-555.
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139135109.3.19	*IT- 5.1*	Cost of Care	
Texas Children's Hospital			*139135109*
Related Category 1 or 2 Projects:	*139135109.1.7*		
Starting Point/Baseline:	*TBD in DY 3*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1[P-1] Project Planning **–** Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: EHR/Business Intelligence Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $42,132.33 **Process Milestone 2 [P-3]:** Test Data System Data Source**:** Enterprise Data Warehouse reports Process Milestone 2 Estimated Incentive Payment: $42,132.34	**Process Milestone 3 [P-4] Conduct PDSA by subspecialty clinic** **Data Source:** Advanced Quality Improvement (AQI) projects Process Milestone 3 Estimated Incentive Payment: *$48.836.83* **Process Milestone 4 [P-5]:** Disseminate findings, including lessons learned and best practices, to stakeholders Data Source: Reports and participation in learning collaboratives Process Milestone 4 Estimated Incentive Payment*: $48.836.83*	**Outcome Improvement Target 1** [**IT-5.1]** Improved cost savings: Demonstrate cost savings in care delivery Improvement Target: TBD Data Source: EPIC Medical Record Outcome Improvement Target 1 Estimated Incentive Payment*:* $156,731	**Outcome Improvement Target 1** [**IT-5.1]** Improved cost savings: Demonstrate cost savings in care delivery Improvement Target: TBD Data Source: EPIC Medical Record Outcome Improvement Target 1 Estimated Incentive Payment*:* $708,127
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $84,264.66	Year 3 Estimated Outcome Amount: $97,673.66	Year 4 Estimated Outcome Amount: $156,732	Year 5 Estimated Outcome Amount: $708,127
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $1,046,797			

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Title of Outcome Measure (Improvement Target): Cost of Care

Unique RHP outcome identification number: 139135109.3.20

Outcome Measure Description: OD-5: Cost of Care
IT-5.2 Per episode of care

Process milestone:
DY 2 P-1; P-3
DY3 P-4; P-5

Outcome Improvement Targets for each year:
DY 4 IT5.2
DY 5 IT-5.2

Rationale: Process milestones P-1, P-3, and P-4 were chosen due to the lack of accurate reports and resources currently available to measure and monitor the cost of care for this population. P-1 and P-3 must be approached in DY 2 and DY3. In DY 3 we will establish a baseline percentage. P-5 will be approached in DY 3 after the initial gap assessment is completed. Lessons learned will be shared with the region and all stakeholders. Improvement targets were placed in DY4 and DY 5 based on the timeline allowed to put in place the proper resources and processes needed to collect data. Improvement target goals will be determined after baseline percentage is set in DY3. The baseline percentage, whether high or low, will dictate an appropriate improvement target goal. The overall success of this project is dependent upon the compliance rate of ours patients and primary care takers arriving for their appointments. If the compliance rate is poor, it will be a challenge to realize a reduction in the cost of care.

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139135109.3.20	*IT-5.2*	Cost of Care	
Texas Children's Hospital			*139135109*
Related Category 1 or 2 Projects:	*139135109.1.7*		
Starting Point/Baseline:	*TBD in DY 3*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1[P-1] Project Planning **–** Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: EHR/Business Intelligence Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $42,132.33 **Process Milestone 2 [P-3]:** Test Data System Data Source**:** Enterprise Data Warehouse reports Process Milestone 2 Estimated Incentive Payment: $42,132.33	**Process Milestone 3 [P-4] Conduct PDSA by subspecialty clinic** **Data Source:** Advanced Quality Improvement (AQI) projects Process Milestone 3 Estimated Incentive Payment: *$48.836.83* **Process Milestone 4 [P-5]:** Disseminate findings, including lessons learned and best practices, to stakeholders Data Source: Reports and participation in learning collaboratives Process Milestone 4 Estimated Incentive Payment*: $48.836.83*	**Outcome Improvement Target 2** [**IT-5.2]** Per episode cost of care Improvement Target: TBD Data Source: EPIC Medical Record Outcome Improvement Target 2 Estimated Incentive Payment*:* $156,731	**Outcome Improvement Target 2** [**IT-5.2]** Per episode cost of care Improvement Target: TBD Data Source: EPIC Medical Record Outcome Improvement Target 2 Estimated Incentive Payment*:* $708,127
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $84,264.66	Year 3 Estimated Outcome Amount: $97,673.66	Year 4 Estimated Outcome Amount: $156,732	Year 5 Estimated Outcome Amount: $708,127
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $1,046,797			

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<u>Title of Outcome Measure (Improvement Target):</u> Cost of Care

<u>Unique RHP outcome identification number:</u> 139135109.3.21

Outcome Measure Description: OD-5: Cost of Care
IT-5.3 Length of stay

Process milestone:
DY 2 P-1; P-3
DY3 P-4; P-5

Outcome Improvement Targets for each year:
DY 4 IT-5.3
DY 5 IT-5.3

<u>Rationale</u>: Process milestones P-1, P-3, and P-4 were chosen due to the lack of accurate reports and resources currently available to measure and monitor the cost of care for this population. P-1 and P-3 must be approached in DY 2 and DY3. In DY 3 we will establish a baseline percentage. P-5 will be approached in DY 3 after the initial gap assessment is completed. Lessons learned will be shared with the region and all stakeholders. Improvement targets were placed in DY4 and DY 5 based on the timeline allowed to put in place the proper resources and processes needed to collect data. Improvement target goals will be determined after baseline percentage is set in DY3. The baseline percentage, whether high or low, will dictate an appropriate improvement target goal. The overall success of this project is dependent upon the compliance rate of ours patients and primary care takers arriving for their appointments. If the compliance rate is poor, it will be a challenge to realize a reduction in the cost of care.

<u>Outcome Measure Valuation:</u> All projects are valued for cost avoidance of medical expenses and improved quality of life. For example, increased provider capacity leads to reduction in emergency room visits and reduction in inpatient hospital visits.[346] Our valuation includes an increase in the patient's quality of life. We used a conservative Quality Adjusted Life Year ("QALY") per year and a percentage of that QALY for the pediatric population.[347] The QALY is used as a one-time improvement in the quality of life, even though we know the patient's quality of life will be improved for many years. We recognize that this is a government funded waiver and thus we chose to have conservative valuations out of respect for the taxpayer funded program. We have academic literature citing the link between access to appropriate pediatric subspecialty care and decrease in hospital visits, both inpatient and emergency room.[3]

[346] Smith, John T, Price, Christopher, Stevens Peter M., Masters, Kevin S., and Young, Mark. "Selected Topics - Does Pediatric Orthopedic Subspecialization Affect Hospital Utilization and Charges?" *Journal of Pediatric Orthopedics*. 19.4 (1999): 553-555.
[347] Brannon, Ike. "Risk - What Is a Life Worth? Despite Its Prima Facie Callousness, Determining the Value of a Human Life Is Necessary for Good Public Policy." *Regulation*. 27.4 (2004): 60-63.

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139135109.3.21	*IT-5.3*	Cost of Care	
Texas Children's Hospital			*139135109*
Related Category 1 or 2 Projects:	*139135109.1.7*		
Starting Point/Baseline:	*TBD in DY 3*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1[P-1] Project Planning **–** Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: EHR/Business Intelligence Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $126,397 **Process Milestone 2 [P-3]:** Test Data System Data Source**:** Enterprise Data Warehouse reports Process Milestone 2 Estimated Incentive Payment: $126,397	**Process Milestone 3 [P-4] Conduct PDSA by subspecialty clinic** **Data Source:** Advanced Quality Improvement (AQI) projects Process Milestone 3 Estimated Incentive Payment: *$48.836.83* **Process Milestone 4 [P-5]:** Disseminate findings, including lessons learned and best practices, to stakeholders Data Source: Reports and participation in learning collaboratives Process Milestone 4 Estimated Incentive Payment*: $48.836.83*	**Outcome Improvement Target 3 [IT-5.3] Length of Stay** Improvement Target: TBD Data Source: EPIC Medical Record Outcome Improvement Target 3 Estimated Incentive Payment*:* $156,731	**Outcome Improvement Target 3 [IT-5.3] Length of Stay** Improvement Target: TBD Data Source: EPIC Medical Record Outcome Improvement Target 3 Estimated Incentive Payment*:* $718,128
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $84,264.66	Year 3 Estimated Outcome Amount: $97,673.66	Year 4 Estimated Outcome Amount: $156,732	Year 5 Estimated Outcome Amount: $718,128
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $1,056,798			

Title of Outcome Measure (Improvement Target): OD-5: Cost of Care

Unique RHP outcome identification number: 139135109.3.22

Outcome Measure Description:
OD-5: Cost of Care
IT-5.1 Improved cost savings

Process milestone:
DY 2 P-1; P-3
DY3 P-4; P-5

Outcome Improvement Targets for each year:
DY 4 IT-5.1
DY 5 IT-5.1

Rationale: Process milestones P-1, P-3, and P-4 were chosen due to the lack of accurate reports and resources currently available to measure and monitor the cost of care for this population. P-1 and P-3 must be approached in DY 2 and DY3. In DY 3 we will establish a baseline percentage. P-5 will be approached in DY 3 after the initial gap assessment is completed. Lessons learned will be shared with the region and all stakeholders. Improvement targets were placed in DY4 and DY 5 based on the timeline allowed to put in place the proper resources and processes needed to collect data. Improvement target goals will be determined after baseline percentage is set in DY3. The baseline percentage, whether high or low, will dictate an appropriate improvement target goal. The overall success of this project is dependent upon the compliance rate of ours patients and primary care takers arriving for their appointments. If the compliance rate is poor, it will be a challenge to realize a reduction in the cost of care.

Outcome Measure Valuation: All projects are valued for cost avoidance of medical expenses and improved quality of life. For example, increased provider capacity leads to reduction in emergency room visits and reduction in inpatient hospital visits.[348] Our valuation includes an increase in the patient's quality of life. We used a conservative Quality Adjusted Life Year ("QALY") per year and a percentage of that QALY for the pediatric population.[349] The QALY is used as a one-time improvement in the quality of life, even though we know the patient's quality of life will be improved for many years. We recognize that this is a government funded waiver and thus we chose to have conservative valuations out of respect for the taxpayer funded program. We have academic literature citing the link between access to appropriate pediatric subspecialty care and decrease in hospital visits, both inpatient and emergency room.[3]

[348] Smith, John T, Price, Christopher, Stevens Peter M., Masters, Kevin S., and Young, Mark. "Selected Topics - Does Pediatric Orthopedic Subspecialization Affect Hospital Utilization and Charges?" *Journal of Pediatric Orthopedics*. 19.4 (1999): 553-555.

[349] Brannon, Ike. "Risk - What Is a Life Worth? Despite Its Prima Facie Callousness, Determining the Value of a Human Life Is Necessary for Good Public Policy." *Regulation*. 27.4 (2004): 60-63.

139135109.3.22	*IT- 5.1*	Cost of Care	
	Texas Children's Hospital		*139135109*
Related Category 1 or 2 Projects:	*139135109.1.8*		
Starting Point/Baseline:	*TBD in DY 3*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1[P-1] Project Planning – Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans **Data Source: EHR/Business Intelligence** Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $42,132.50 **Process Milestone 2 [P-3]: Test Data System** **Data Source:** Enterprise Data Warehouse reports Process Milestone 2 Estimated Incentive Payment: $42,132.50	**Process Milestone 3 [P-4] Conduct PDSA by subspecialty clinic** **Data Source:** Advanced Quality Improvement (AQI) projects Process Milestone 3 Estimated Incentive Payment: *$48,837* **Process Milestone 4 [P-5]:** Disseminate findings, including lessons learned and best practices, to stakeholders **Data Source: Reports and participation in learning collaboratives** Process Milestone 4 Estimated Incentive Payment*: $48,837*	**Outcome Improvement Target 1 [IT-5.1] Improved cost savings: Demonstrate cost savings in care delivery** Improvement Target: TBD Data Source: EPIC Medical Record Outcome Improvement Target 1 Estimated Incentive Payment*:* $156,732	**Outcome Improvement Target 1 [IT-5.1] Improved cost savings: Demonstrate cost savings in care delivery** Improvement Target: TBD Data Source: EPIC Medical Record Outcome Improvement Target 1 Estimated Incentive Payment*:* $374,794
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $84,265	Year 3 Estimated Outcome Amount: $97,674	Year 4 Estimated Outcome Amount: $156,732	Year 5 Estimated Outcome Amount: $374,794
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $713,464			

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Title of Outcome Measure (Improvement Target): Cost of Care

Unique RHP outcome identification number: 139135109.3.23

Outcome Measure Description: OD-5: Cost of Care
IT-5.2 Per Episode of Care

Process milestone:
DY 2 P-1; P-3
DY3 P-4; P-5

Outcome Improvement Targets for each year:
DY 4 IT5.2
DY 5 IT-5.2

Rationale: Process milestones P-1, P-3, and P-4 were chosen due to the lack of accurate reports and resources currently available to measure and monitor the cost of care for this population. P-1 and P-3 must be approached in DY 2 and DY3. In DY 3 we will establish a baseline percentage. P-5 will be approached in DY 3 after the initial gap assessment is completed. Lessons learned will be shared with the region and all stakeholders. Improvement targets were placed in DY4 and DY 5 based on the timeline allowed to put in place the proper resources and processes needed to collect data. Improvement target goals will be determined after baseline percentage is set in DY3. The baseline percentage, whether high or low, will dictate an appropriate improvement target goal. The overall success of this project is dependent upon the compliance rate of ours patients and primary care takers arriving for their appointments. If the compliance rate is poor, it will be a challenge to realize a reduction in the cost of care.

Outcome Measure Valuation: All projects are valued for cost avoidance of medical expenses and improved quality of life. For example, increased provider capacity leads to reduction in emergency room visits and reduction in inpatient hospital visits.[350] Our valuation includes an increase in the patient's quality of life. We used a conservative Quality Adjusted Life Year ("QALY") per year and a percentage of that QALY for the pediatric population.[351] The QALY is used as a one-time improvement in the quality of life, even though we know the patient's quality of life will be improved for many years. We recognize that this is a government funded waiver and thus we chose to have conservative valuations out of respect for the taxpayer funded program. We have academic literature citing the link between access to appropriate pediatric subspecialty care and decrease in hospital visits, both inpatient and emergency room.[3]

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[351] Brannon, Ike. "Risk - What Is a Life Worth? Despite Its Prima Facie Callousness, Determining the Value of a Human Life Is Necessary for Good Public Policy." *Regulation*. 27.4 (2004): 60-63.

139135109.3.23	IT-5.2	Cost of Care	
Texas Children's Hospital			139135109
Related Category 1 or 2 Projects:	139135109.1.8		
Starting Point/Baseline:	TBD in DY 3		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1[P-1] Project Planning – Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans **Data Source: EHR/Business Intelligence** Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $$42,132.50 **Process Milestone 2 [P-3]: Test Data System** **Data Source:** Enterprise Data Warehouse reports Process Milestone 2 Estimated Incentive Payment: $42,132.50	**Process Milestone 3 [P-4] Conduct PDSA by subspecialty clinic** **Data Source:** Advanced Quality Improvement (AQI) projects Process Milestone 3 Estimated Incentive Payment: *$48,837* **Process Milestone 4 [P-5]:** Disseminate findings, including lessons learned and best practices, to stakeholders **Data Source: Reports and participation in learning collaboratives** Process Milestone 4 Estimated Incentive Payment: *$48,837*	**Outcome Improvement Target 2 [IT-5.2] Per episode cost of care** Improvement Target: TBD Data Source: EPIC Medical Record Outcome Improvement Target 2 Estimated Incentive Payment: $156,732	**Outcome Improvement Target 2 [IT-5.2] Per episode cost of care** Improvement Target: TBD Data Source: EPIC Medical Record Outcome Improvement Target 2 Estimated Incentive Payment: $374,794
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $84,265	Year 3 Estimated Outcome Amount: $97,674	Year 4 Estimated Outcome Amount: $156,732	Year 5 Estimated Outcome Amount: $374,794
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $713,464			

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Title of Outcome Measure (Improvement Target): Cost of Care

Unique RHP outcome identification number: 139135109.3.24

Outcome Measure Description: OD-5: Cost of Care
IT-5.3 Length of Stay

Process milestone:
DY 2 P-1; P-3
DY3 P-4; P-5

Outcome Improvement Targets for each year:
DY 4 IT-5.3;
DY 5 IT-5.3

Rationale: Process milestones P-1, P-3, and P-4 were chosen due to the lack of accurate reports and resources currently available to measure and monitor the cost of care for this population. P-1 and P-3 must be approached in DY 2 and DY3. In DY 3 we will establish a baseline percentage. P-5 will be approached in DY 3 after the initial gap assessment is completed. Lessons learned will be shared with the region and all stakeholders. Improvement targets were placed in DY4 and DY 5 based on the timeline allowed to put in place the proper resources and processes needed to collect data. Improvement target goals will be determined after baseline percentage is set in DY3. The baseline percentage, whether high or low, will dictate an appropriate improvement target goal. The overall success of this project is dependent upon the compliance rate of ours patients and primary care takers arriving for their appointments. If the compliance rate is poor, it will be a challenge to realize a reduction in the cost of care.

Outcome Measure Valuation: All projects are valued for cost avoidance of medical expenses and improved quality of life. For example, increased provider capacity leads to reduction in emergency room visits and reduction in inpatient hospital visits.[352] Our valuation includes an increase in the patient's quality of life. We used a conservative Quality Adjusted Life Year ("QALY") per year and a percentage of that QALY for the pediatric population.[353] The QALY is used as a one-time improvement in the quality of life, even though we know the patient's quality of life will be improved for many years. We recognize that this is a government funded waiver and thus we chose to have conservative valuations out of respect for the taxpayer funded program. We have academic literature citing the link between access to appropriate pediatric subspecialty care and decrease in hospital visits, both inpatient and emergency room.[3]

[352] Smith, John T, Price, Christopher, Stevens Peter M., Masters, Kevin S., and Young, Mark. "Selected Topics - Does Pediatric Orthopedic Subspecialization Affect Hospital Utilization and Charges?" *Journal of Pediatric Orthopedics*. 19.4 (1999): 553-555.
[353] Brannon, Ike. "Risk - What Is a Life Worth? Despite Its Prima Facie Callousness, Determining the Value of a Human Life Is Necessary for Good Public Policy." *Regulation*. 27.4 (2004): 60-63.

139135109.3.24	*IT-5.3*	Cost of Care	
Texas Children's Hospital			*139135109*
Related Category 1 or 2 Projects:	*139135109.1.8*		
Starting Point/Baseline:	*TBD in DY 3*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1[P-1] Project Planning – Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans **Data Source: EHR/Business Intelligence** Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $42,132.33 **Process Milestone 2 [P-3]: Test Data System** **Data Source:** Enterprise Data Warehouse reports Process Milestone 2 Estimated Incentive Payment: $42,132.33	**Process Milestone 3 [P-4] Conduct PDSA by subspecialty clinic** **Data Source:** Advanced Quality Improvement (AQI) projects Process Milestone 3 Estimated Incentive Payment: *$48,836.83* **Process Milestone 4 [P-5]:** Disseminate findings, including lessons learned and best practices, to stakeholders **Data Source: Reports and participation in learning collaboratives** Process Milestone 4 Estimated Incentive Payment*: $48,836.83*	**Outcome Improvement Target 3 [IT-5.3]** Length of Stay Improvement Target: TBD Data Source: EPIC Medical Record Outcome Improvement Target 3 Estimated Incentive Payment*:* $156,732	**Outcome Improvement Target 3 [IT-5.3]** Length of Stay Improvement Target: TBD Data Source: EPIC Medical Record Outcome Improvement Target 3 Estimated Incentive Payment*:* $374,794
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $84,265	Year 3 Estimated Outcome Amount: $97,674	Year 4 Estimated Outcome Amount: $156,732	Year 5 Estimated Outcome Amount: $374,794
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $713,464			

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Title of Outcome Measure (Improvement Target): OD- 10 Quality Of Life/ Functional Status IT-10.1 Quality of Life

Unique RHP outcome identification number: 139135109.3.25

Outcome Measure Description:
OD- 10 Quality Of Life/ Functional Status
IT-10.1 Quality of Life

Process milestone:

DY 2 P-1; P-3
DY3 P-4; P-5

Outcome Improvement Targets for each year:

DY 4 IT- Increase patient visits by 5% from baseline
DY 5 IT- Increase patient visits by 10% from baseline

Rationale: Process milestones P-1, P-3, and P-4 were chosen due to the lack of accurate reports and resources currently available to measure and monitor patient access for the specific population within Texas Children's Hospital system. P-1 and P-3 must be approached in DY 2 and DY3. In DY 3 we will establish a baseline percentage. P-5 will be approached in DY 3 after the initial gap assessment is completed. Lessons learned will be shared with the region and all stakeholders.
Improvement targets were placed in DY4 and DY 5 based on the timeline allowed to put in place the proper resources and processes needed to collect data. Improvement target goals will be determined after baseline percentage is set in DY3. The baseline percentage, whether high or low, will dictate an appropriate improvement target goal. Given the national shortage of Developmental Pediatricians, loss of providers could prevent TCH from reaching target as replacement providers often take multiple years to recruit.

Outcome Measure Valuation: All projects are valued for cost avoidance of medical expenses and improved quality of life. For example, increased provider capacity leads to reduction in emergency room visits and reduction in inpatient hospital visits.[354] Our valuation includes an increase in the patient's quality of life. We used a conservative Quality Adjusted Life Year ("QALY") per year and a percentage of that QALY for the pediatric population.[355] The QALY is used as a one-time improvement in the quality of life, even though we know the patient's quality of life will be improved for many years. We recognize that this is a government funded waiver and thus we chose to have conservative valuations out of respect for the taxpayer funded program. We have academic literature citing the link between access to appropriate pediatric subspecialty care and decrease in hospital visits, both inpatient and emergency room.[3]

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[354] Smith, John T, Price, Christopher, Stevens Peter M., Masters, Kevin S., and Young, Mark. "Selected Topics - Does Pediatric Orthopedic Subspecialization Affect Hospital Utilization and Charges?" *Journal of Pediatric Orthopedics*. 19.4 (1999): 553-555.
[355] Brannon, Ike. "Risk - What Is a Life Worth? Despite Its Prima Facie Callousness, Determining the Value of a Human Life Is Necessary for Good Public Policy." *Regulation*. 27.4 (2004): 60-63.

<table>
<tr><td>139135109.3.25</td><td>IT- 10.1</td><td colspan="2">Quality of Life</td></tr>
<tr><td colspan="3">Texas Children's Hospital</td><td>139135109</td></tr>
<tr><td>Related Category 1 or 2 Projects:</td><td colspan="3">139135109.1.9</td></tr>
<tr><td>Starting Point/Baseline:</td><td colspan="3">TBD in DY 3</td></tr>
<tr><th>Year 2
(10/1/2012 – 9/30/2013)</th><th>Year 3
(10/1/2013 – 9/30/2014)</th><th>Year 4
(10/1/2014 – 9/30/2015)</th><th>Year 5
(10/1/2015 – 9/30/2016)</th></tr>
<tr><td>Process Milestone 1[P-1] Project Planning – Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
Data Source: EHR/Business Intelligence

Process Milestone 1 Estimated Incentive Payment (maximum amount): $29,448

Process Milestone 2 [P-3]: Test Data System
Data Source: Enterprise Data Warehouse reports

Process Milestone 2 Estimated Incentive Payment: $29,448</td><td>Process Milestone 3 [P-4] Establish baseline
Data Source: Advanced Quality Improvement (AQI) projects

Process Milestone 3 Estimated Incentive Payment: $34,134

Process Milestone 4 [P-5]: Disseminate findings, including lessons learned and best practices, to stakeholders
Data Source: Reports and participation in learning collaboratives

Process Milestone 4 Estimated Incentive Payment: $34,134</td><td>Outcome Improvement Target IT-10.1 Quality of Life
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: TBD
Improvement Target: TBD
Data Source: TBD

Estimated Incentive Payment: $109,546</td><td>Outcome Improvement Target IT-10.1 Quality of Life
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: TBD
Improvement Target: TBD
Data Source: TBD

Estimated Incentive Payment: $261,958</td></tr>
<tr><td>Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $58,896</td><td>Year 3 Estimated Outcome Amount: $68,268</td><td>Year 4 Estimated Outcome Amount: $109,546</td><td>Year 5 Estimated Outcome Amount: $261,958</td></tr>
<tr><td colspan="4">TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5): $498,668</td></tr>
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Title of Outcome Measure (Improvement Target): OD- 10 Quality of Life/ Functional Status

Unique RHP outcome identification number: 139135109.3.26

Outcome Measure Description:
OD- 10 Quality of Life/ Functional Status
IT-10.1 Quality of Life

Process milestone:
DY 2 P-1; P-3
DY3 P-4; P-5

Outcome Improvement Targets for each year:
DY 4 IT-10.1
DY 5 IT- 10.1

Rationale: Process milestones P-1, P-3, and P-4 were chosen due to the lack of accurate reports and resources currently available to measure and monitor the quality of life for the specific population of Developmental Pediatrics within Texas Children's Hospital system. P-1 and P-3 must be approached in DY 2 and DY3. In DY 3 we will establish a baseline percentage. P-5 will be approached in DY 3 after the initial gap assessment is completed. Lessons learned will be shared with the region and all stakeholders.

Improvement targets were placed in DY4 and DY 5 based on the timeline allowed to put in place the proper resources and processes needed to collect data. Improvement target goals will be determined after baseline percentage is set in DY3. The baseline percentage, whether high or low, will dictate an appropriate improvement target goal. Given the national shortage of Developmental Pediatricians, loss of providers could prevent TCH from reaching target as replacement providers often take multiple years to recruit.

Outcome Measure Valuation: All projects are valued for cost avoidance of medical expenses and improved quality of life. For example, increased provider capacity leads to reduction in emergency room visits and reduction in inpatient hospital visits.[356] Our valuation includes an increase in the patient's quality of life. We used a conservative Quality Adjusted Life Year ("QALY") per year and a percentage of that QALY for the pediatric population.[357] The QALY is used as a one-time improvement in the quality of life, even though we know the patient's quality of life will be improved for many years. We recognize that this is a government funded waiver and thus we chose to have conservative valuations out of respect for the taxpayer funded program.

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[356] Smith, John T, Price, Christopher, Stevens Peter M., Masters, Kevin S., and Young, Mark. "Selected Topics - Does Pediatric Orthopedic Subspecialization Affect Hospital Utilization and Charges?" *Journal of Pediatric Orthopedics*. 19.4 (1999): 553-555.
[357] Brannon, Ike. "Risk - What Is a Life Worth? Despite Its Prima Facie Callousness, Determining the Value of a Human Life Is Necessary for Good Public Policy." *Regulation*. 27.4 (2004): 60-63.

<table>
<tr><td>139135109.3.26</td><td>IT- 10.1</td><td colspan="2">Quality of Life</td></tr>
<tr><td colspan="3">Texas Children’s Hospital</td><td>139135109</td></tr>
<tr><td>Related Category 1 or 2 Projects:</td><td colspan="3">139135109.1.10</td></tr>
<tr><td>Starting Point/Baseline:</td><td colspan="3">TBD in DY 3</td></tr>
<tr><th>Year 2
(10/1/2012 – 9/30/2013)</th><th>Year 3
(10/1/2013 – 9/30/2014)</th><th>Year 4
(10/1/2014 – 9/30/2015)</th><th>Year 5
(10/1/2015 – 9/30/2016)</th></tr>
<tr><td>Process Milestone 1[P-1] Project Planning – Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
Data Source: EHR/Business Intelligence

Process Milestone 1 Estimated Incentive Payment (maximum amount): $49,008.50

Process Milestone 2 [P-3]: Test Data System
Data Source: Enterprise Data Warehouse reports

Process Milestone 2 Estimated Incentive Payment: $49,008.50</td><td>Process Milestone 3 [P-4] Establish baseline
Data Source: Advanced Quality Improvement (AQI) projects

Process Milestone 3 Estimated Incentive Payment: $56,807

Process Milestone 4 [P-5]: Disseminate findings, including lessons learned and best practices, to stakeholders
Data Source: Reports and participation in learning collaboratives

Process Milestone 4 Estimated Incentive Payment: $56,807</td><td>Outcome Improvement Target IT-10.1 Quality of Life
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: TBD
Improvement Target: TBD
Data Source: TBD

Estimated Incentive Payment: $182,311</td><td>Outcome Improvement Target IT-10.1 Quality of Life
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: TBD
Improvement Target: TBD
Data Source: TBD

Estimated Incentive Payment: $435,961</td></tr>
<tr><td>Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $98,017</td><td>Year 3 Estimated Outcome Amount: $113,614</td><td>Year 4 Estimated Outcome Amount: $182,311</td><td>Year 5 Estimated Outcome Amount: $435,961</td></tr>
<tr><td colspan="4">TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5): $829,903</td></tr>
</table>

<u>Title of Outcome Measure (Improvement Target):</u> OD-5: Cost of Care

<u>Unique RHP outcome identification number</u>: 139135109.3.27

<u>Outcome Measure Description:</u>
OD-5: Cost of Care
IT-5.1 Improved cost savings

Process milestone:
DY 2 P-1; P-3
DY3 P-4; P-5

Outcome Improvement Targets for each year:
DY 4 IT-5.1;
DY 5 IT-5.1

<u>Rationale</u>: Process milestones P-1, P-3, and P-4 were chosen due to the lack of accurate reports and resources currently available to measure and monitor the cost of care for this population. P-1 and P-3 must be approached in DY 2 and DY3. In DY 3 we will establish a baseline percentage. P-5 will be approached in DY 3 after the initial gap assessment is completed. Lessons learned will be shared with the region and all stakeholders. Improvement targets were placed in DY4 and DY 5 based on the timeline allowed to put in place the proper resources and processes needed to collect data. Improvement target goals will be determined after baseline percentage is set in DY3. The baseline percentage, whether high or low, will dictate an appropriate improvement target goal. The overall success of this project is dependent upon the compliance rate of ours patients and primary care takers arriving for their appointments. If the compliance rate is poor, it will be a challenge to realize a reduction in the cost of care.

<u>Outcome Measure Valuation:</u> All projects are valued for cost avoidance of medical expenses and improved quality of life. For example, increased provider capacity leads to reduction in emergency room visits and reduction in inpatient hospital visits.[358] Our valuation includes an increase in the patient's quality of life. We used a conservative Quality Adjusted Life Year ("QALY") per year and a percentage of that QALY for the pediatric population.[359] The QALY is used as a one-time improvement in the quality of life, even though we know the patient's quality of life will be improved for many years. We recognize that this is a government funded waiver and thus we chose to have conservative valuations out of respect for the taxpayer funded program.

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[358] Smith, John T, Price, Christopher, Stevens Peter M., Masters, Kevin S., and Young, Mark. "Selected Topics - Does Pediatric Orthopedic Subspecialization Affect Hospital Utilization and Charges?" *Journal of Pediatric Orthopedics*. 19.4 (1999): 553-555.
[359] Brannon, Ike. "Risk - What Is a Life Worth? Despite Its Prima Facie Callousness, Determining the Value of a Human Life Is Necessary for Good Public Policy." *Regulation*. 27.4 (2004): 60-63.

<table>
<tr><td>139135109.3.27</td><td>IT- 5.1</td><td colspan="2">Cost of Care</td></tr>
<tr><td colspan="3">Texas Children's Hospital</td><td>139135109</td></tr>
<tr><td>Related Category 1 or 2 Projects:</td><td colspan="3">139135109.1.11</td></tr>
<tr><td>Starting Point/Baseline:</td><td colspan="3">TBD in DY 3</td></tr>
<tr><th>Year 2
(10/1/2012 – 9/30/2013)</th><th>Year 3
(10/1/2013 – 9/30/2014)</th><th>Year 4
(10/1/2014 – 9/30/2015)</th><th>Year 5
(10/1/2015 – 9/30/2016)</th></tr>
<tr><td>Process Milestone 1[P-1] Project Planning – Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
Data Source: EHR/Business Intelligence

Process Milestone 1 Estimated Incentive Payment (maximum amount): $18,167.50

Process Milestone 2 [P-3]: Test Data System
Data Source: Enterprise Data Warehouse reports

Process Milestone 2 Estimated Incentive Payment: $18,167.50</td><td>Process Milestone 3 [P-4] Conduct PDSA by subspecialty clinic
Data Source: Advanced Quality Improvement (AQI) projects

Process Milestone 3 Estimated Incentive Payment: $21,058

Process Milestone 4 [P-5]: Disseminate findings, including lessons learned and best practices, to stakeholders
Data Source: Reports and participation in learning collaboratives

Process Milestone 4 Estimated Incentive Payment: $21,058</td><td>Outcome Improvement Target 1 [IT-5.1] Improved cost savings: Demonstrate cost savings in care delivery
Improvement Target: TBD
Data Source: EPIC Medical Record

Outcome Improvement Target 1 Estimated Incentive Payment: $67,582</td><td>Outcome Improvement Target 1 [IT-5.1] Improved cost savings: Demonstrate cost savings in care delivery
Improvement Target: TBD
Data Source: EPIC Medical Record

Outcome Improvement Target 1 Estimated Incentive Payment: $161,610</td></tr>
<tr><td>Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $36,335</td><td>Year 3 Estimated Outcome Amount: $42,116</td><td>Year 4 Estimated Outcome Amount: $67,582</td><td>Year 5 Estimated Outcome Amount: $161,610</td></tr>
<tr><td colspan="4">TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5): $307,643</td></tr>
</table>

<u>Title of Outcome Measure (Improvement Target):</u> OD-5: Cost of Care

<u>Unique RHP outcome identification number</u>: 139135109.3.28

<u>Outcome Measure Description:</u>
OD-5: Cost of Care
IT-5.2 Per Episode of Care

Process milestone:
DY 2 P-1; P-3
DY3 P-4; P-5

Outcome Improvement Targets for each year:
DY 4 IT-5.2;
DY 5 IT-5.2

<u>Rationale</u>: Process milestones P-1, P-3, and P-4 were chosen due to the lack of accurate reports and resources currently available to measure and monitor the cost of care for this population. P-1 and P-3 must be approached in DY 2 and DY3. In DY 3 we will establish a baseline percentage. P-5 will be approached in DY 3 after the initial gap assessment is completed. Lessons learned will be shared with the region and all stakeholders. Improvement targets were placed in DY4 and DY 5 based on the timeline allowed to put in place the proper resources and processes needed to collect data. Improvement target goals will be determined after baseline percentage is set in DY3. The baseline percentage, whether high or low, will dictate an appropriate improvement target goal. The overall success of this project is dependent upon the compliance rate of ours patients and primary care takers arriving for their appointments. If the compliance rate is poor, it will be a challenge to realize a reduction in the cost of care.

<u>Outcome Measure Valuation:</u> All projects are valued for cost avoidance of medical expenses and improved quality of life. For example, increased provider capacity leads to reduction in emergency room visits and reduction in inpatient hospital visits.[360] Our valuation includes an increase in the patient's quality of life. We used a conservative Quality Adjusted Life Year ("QALY") per year and a percentage of that QALY for the pediatric population.[361] The QALY is used as a one-time improvement in the quality of life, even though we know the patient's quality of life will be improved for many years. We recognize that this is a government funded waiver and thus we chose to have conservative valuations out of respect for the taxpayer funded program.

[360] Smith, John T, Price, Christopher, Stevens Peter M., Masters, Kevin S., and Young, Mark. "Selected Topics - Does Pediatric Orthopedic Subspecialization Affect Hospital Utilization and Charges?" *Journal of Pediatric Orthopedics*. 19.4 (1999): 553-555.
[361] Brannon, Ike. "Risk - What Is a Life Worth? Despite Its Prima Facie Callousness, Determining the Value of a Human Life Is Necessary for Good Public Policy." *Regulation*. 27.4 (2004): 60-63.

139135109.3.28	*IT- 5.2*	Cost of Care	
Texas Children's Hospital			*139135109*
Related Category 1 or 2 Projects:	*139135109.1.11*		
Starting Point/Baseline:	*TBD in DY 3*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1[P-1] Project Planning – Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: EHR/Business Intelligence Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $18167.50 **Process Milestone 2 [P-3]: Test Data System** Data Source: Enterprise Data Warehouse reports Process Milestone 2 Estimated Incentive Payment: $18167.50	**Process Milestone 3 [P-4] Conduct PDSA by subspecialty clinic** Data Source**:** Advanced Quality Improvement (AQI) projects Process Milestone 3 Estimated Incentive Payment: *$21058* **Process Milestone 4 [P-5]:** Disseminate findings, including lessons learned and best practices, to stakeholders Data Source: Reports and participation in learning collaboratives Process Milestone 4 Estimated Incentive Payment*: $21058*	**Outcome Improvement Target 2** [**IT-5.2]** Per episode cost of care Improvement Target: TBD Data Source: EPIC Medical Record Outcome Improvement Target 2 Estimated Incentive Payment*:* $67,582	**Outcome Improvement Target 2** [**IT-5.2]** Per episode cost of care Improvement Target: TBD Data Source: EPIC Medical Record Outcome Improvement Target 2 Estimated Incentive Payment*:* $161,610
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $36335	Year 3 Estimated Outcome Amount: $42,116	Year 4 Estimated Outcome Amount: $67,582	Year 5 Estimated Outcome Amount: $161,610
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $$307,643			

<u>Title of Outcome Measure (Improvement Target):</u> OD-5: Cost of Care

<u>Unique RHP outcome identification number</u>: 139135109.3.29

<u>Outcome Measure Description:</u>
OD-5: Cost of Care
IT-5.3 Length of Stay

Process milestone:

DY 2 P-1; P-3
DY3 P-4; P-5

Outcome Improvement Targets for each year:

DY 4 IT-5.3;
DY 5 IT-5.3

<u>Rationale</u>: Process milestones P-1, P-3, and P-4 were chosen due to the lack of accurate reports and resources currently available to measure and monitor the cost of care for this population. P-1 and P-3 must be approached in DY 2 and DY3. In DY 3 we will establish a baseline percentage. P-5 will be approached in DY 3 after the initial gap assessment is completed. Lessons learned will be shared with the region and all stakeholders. Improvement targets were placed in DY4 and DY 5 based on the timeline allowed to put in place the proper resources and processes needed to collect data. Improvement target goals will be determined after baseline percentage is set in DY3. The baseline percentage, whether high or low, will dictate an appropriate improvement target goal. The overall success of this project is dependent upon the compliance rate of ours patients and primary care takers arriving for their appointments. If the compliance rate is poor, it will be a challenge to realize a reduction in the cost of care.

<u>Outcome Measure Valuation:</u> All projects are valued for cost avoidance of medical expenses and improved quality of life. For example, increased provider capacity leads to reduction in emergency room visits and reduction in inpatient hospital visits.[362] Our valuation includes an increase in the patient's quality of life. We used a conservative Quality Adjusted Life Year ("QALY") per year and a percentage of that QALY for the pediatric population.[363] The QALY is used as a one-time improvement in the quality of life, even though we know the patient's quality of life will be improved for many years. We recognize that this is a government funded waiver and thus we chose to have conservative valuations out of respect for the taxpayer funded program.

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139135109.3.29	*IT- 5.3*	Cost of Care	
Texas Children's Hospital			*139135109*
Related Category 1 or 2 Projects:	*139135109.1.11*		
Starting Point/Baseline:	*TBD in DY 3*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1[P-1] Project Planning – Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: EHR/Business Intelligence Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $18,167.50 **Process Milestone 2 [P-3]: Test Data System** Data Source: Enterprise Data Warehouse reports Process Milestone 2 Estimated Incentive Payment: $18,167.50	**Process Milestone 3 [P-4] Conduct PDSA by subspecialty clinic** Data Source**:** Advanced Quality Improvement (AQI) projects Process Milestone 3 Estimated Incentive Payment: *$21,058* **Process Milestone 4 [P-5]:** Disseminate findings, including lessons learned and best practices, to stakeholders Data Source: Reports and participation in learning collaboratives Process Milestone 4 Estimated Incentive Payment*: $21,058*	**Outcome Improvement Target 3 [IT-5.3]** Length of Stay Improvement Target: TBD Data Source: EPIC Medical Record Outcome Improvement Target 3 Estimated Incentive Payment*:* $67,582	**Outcome Improvement Target 3 [IT-5.3]** Length of Stay Improvement Target: TBD Data Source: EPIC Medical Record Outcome Improvement Target 3 Estimated Incentive Payment*:* $161,610
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $36,335	Year 3 Estimated Outcome Amount: $42,116	Year 4 Estimated Outcome Amount: $67,582	Year 5 Estimated Outcome Amount: $161,610

Title of Outcome Measure (Improvement Target): OD-5: Cost of Care

Unique RHP outcome identification number: 139135109.3.30

Outcome Measure Description:
OD-5: Cost of Care
IT-5.1 Improved cost savings:

Process milestone:
DY 2 P-1; P-3
DY3 P-4; P-5

Outcome Improvement Targets for each year:
DY 4 IT-5.1
DY 5 IT-5.1

Rationale: Process milestones P-1, P-3, and P-4 were chosen due to the lack of accurate reports and resources currently available to measure and monitor the cost of care for this population. P-1 and P-3 must be approached in DY 2 and DY3. In DY 3 we will establish a baseline percentage. P-5 will be approached in DY 3 after the initial gap assessment is completed. Lessons learned will be shared with the region and all stakeholders.
Improvement targets were placed in DY4 and DY 5 based on the timeline allowed to put in place the proper resources and processes needed to collect data. Improvement target goals will be determined after baseline percentage is set in DY3. The baseline percentage, whether high or low, will dictate an appropriate improvement target goal. We recognize that while increasing access to care we need to continue to focus on delivering quality, efficient and cost effective care. Medicaid is an entitlement program, but there is only a finite amount of money. The affordable Care Act focused on the triple aim- improving quality, reducing costs and improving access. This project strives to meet those same goals. We agree that increased access should be coupled with controlling unnecessary costs.

Outcome Measure Valuation: All projects are valued for cost avoidance of medical expenses and improved quality of life. For example, increased provider capacity leads to reduction in emergency room visits and reduction in inpatient hospital visits.[364] Our valuation includes an increase in the patient's quality of life. We used a conservative Quality Adjusted Life Year ("QALY") per year and a percentage of that QALY for the pediatric population.[365] The QALY is used as a one-time improvement in the quality of life, even though we know the patient's quality of life will be improved for many years. We recognize that this is a government funded waiver and thus we chose to have conservative valuations out of respect for the taxpayer funded program.

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139135109.3.30	*IT- 5.1*	Cost of Care	
	Texas Children's Hospital		*139135109*
Related Category 1 or 2 Projects:	*139135109.1.12*		
Starting Point/Baseline:	*TBD in DY 3*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1[P-1] Project Planning – Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: EHR/Business Intelligence Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $18,799 **Process Milestone 2 [P-3]: Test Data System** Data Source: Enterprise Data Warehouse reports Process Milestone 2 Estimated Incentive Payment: $18,799	**Process Milestone 3 [P-4] Conduct PDSA by subspecialty clinic** Data Source: Advanced Quality Improvement (AQI) projects Process Milestone 3 Estimated Incentive Payment: *$21,790.50* **Process Milestone 4 [P-5]:** Disseminate findings, including lessons learned and best practices, to stakeholders Data Source: Reports and participation in learning collaboratives Process Milestone 4 Estimated Incentive Payment*: $21,790.50*	**Outcome Improvement Target 1 [IT-5.1]** Improved cost savings: Demonstrate cost savings in care delivery Improvement Target: TBD Data Source: EPIC Medical Record Outcome Improvement Target 1 Estimated Incentive Payment*:* $69,932	**Outcome Improvement Target 1 [IT-5.1]** Improved cost savings: Demonstrate cost savings in care delivery Improvement Target: TBD Data Source: EPIC Medical Record Outcome Improvement Target 1 Estimated Incentive Payment*:* $167,230
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $37,598	Year 3 Estimated Outcome Amount: $43,581	Year 4 Estimated Outcome Amount: $69,932	Year 5 Estimated Outcome Amount: $167,230
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $318,341			

Title of Outcome Measure (Improvement Target): OD-5: Cost of Care

Unique RHP outcome identification number: 139135109.3.31

Outcome Measure Description:
OD-5: Cost of Care
IT-5.2 Per Episode of Care

Process milestone:
DY 2 P-1; P-3
DY3 P-4; P-5

Outcome Improvement Targets for each year:
DY 4 IT-5.2
DY 5 IT-5.2

Rationale: Process milestones P-1, P-3, and P-4 were chosen due to the lack of accurate reports and resources currently available to measure and monitor the cost of care for this population. P-1 and P-3 must be approached in DY 2 and DY3. In DY 3 we will establish a baseline percentage. P-5 will be approached in DY 3 after the initial gap assessment is completed. Lessons learned will be shared with the region and all stakeholders.
Improvement targets were placed in DY4 and DY 5 based on the timeline allowed to put in place the proper resources and processes needed to collect data. Improvement target goals will be determined after baseline percentage is set in DY3. The baseline percentage, whether high or low, will dictate an appropriate improvement target goal. We recognize that while increasing access to care we need to continue to focus on delivering quality, efficient and cost effective care. Medicaid is an entitlement program, but there is only a finite amount of money. The affordable Care Act focused on the triple aim- improving quality, reducing costs and improving access. This project strives to meet those same goals. We agree that increased access should be coupled with controlling unnecessary costs.

Outcome Measure Valuation: All projects are valued for cost avoidance of medical expenses and improved quality of life. For example, increased provider capacity leads to reduction in emergency room visits and reduction in inpatient hospital visits.[366] Our valuation includes an increase in the patient's quality of life. We used a conservative Quality Adjusted Life Year ("QALY") per year and a percentage of that QALY for the pediatric population.[367] The QALY is used as a one-time improvement in the quality of life, even though we know the patient's quality of life will be improved for many years. We recognize that this is a government funded waiver and thus we chose to have conservative valuations out of respect for the taxpayer funded program.

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139135109.3.31	*IT- 5.2*	Cost of Care	
Texas Children's Hospital			*139135109*
Related Category 1 or 2 Projects:	*139135109.1.12*		
Starting Point/Baseline:	*TBD in DY 3*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1[P-1] Project Planning – Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: EHR/Business Intelligence Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $18,799 **Process Milestone 2 [P-3]: Test Data System** Data Source: Enterprise Data Warehouse reports Process Milestone 2 Estimated Incentive Payment: $18,799	**Process Milestone 3 [P-4] Conduct PDSA by subspecialty clinic** Data Source: Advanced Quality Improvement (AQI) projects Process Milestone 3 Estimated Incentive Payment: *$21,790.50* **Process Milestone 4 [P-5]:** Disseminate findings, including lessons learned and best practices, to stakeholders Data Source: Reports and participation in learning collaboratives Process Milestone 4 Estimated Incentive Payment*:* *$21,790.50*	**Outcome Improvement Target 2** [**IT-5.2]** Per episode cost of care Improvement Target: TBD Data Source: EPIC Medical Record Outcome Improvement Target 2 Estimated Incentive Payment*:* $69,932	**Outcome Improvement Target 2** [**IT-5.2]** Per episode cost of care Improvement Target: TBD Data Source: EPIC Medical Record Outcome Improvement Target 2 Estimated Incentive Payment*:* $167,230
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $37,598	Year 3 Estimated Outcome Amount: $43,581	Year 4 Estimated Outcome Amount: $69,932	Year 5 Estimated Outcome Amount: $167,230
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $318,341			

<u>Title of Outcome Measure (Improvement Target):</u> OD-5: Cost of Care

<u>Unique RHP outcome identification number:</u> 139135109.3.32

<u>Outcome Measure Description</u>:
OD-5: Cost of Care
IT-5.3 Length of Stay

Process milestone:
DY 2 P-1; P-3
DY3 P-4; P-5

Outcome Improvement Targets for each year:
DY 4 IT-5.3
DY 5 IT-5.3

<u>Rationale</u>: Process milestones P-1, P-3, and P-4 were chosen due to the lack of accurate reports and resources currently available to measure and monitor the cost of care for this population. P-1 and P-3 must be approached in DY 2 and DY3. In DY 3 we will establish a baseline percentage. P-5 will be approached in DY 3 after the initial gap assessment is completed. Lessons learned will be shared with the region and all stakeholders.
Improvement targets were placed in DY4 and DY 5 based on the timeline allowed to put in place the proper resources and processes needed to collect data. Improvement target goals will be determined after baseline percentage is set in DY3. The baseline percentage, whether high or low, will dictate an appropriate improvement target goal. We recognize that while increasing access to care we need to continue to focus on delivering quality, efficient and cost effective care. Medicaid is an entitlement program, but there is only a finite amount of money. The affordable Care Act focused on the triple aim- improving quality, reducing costs and improving access. This project strives to meet those same goals. We agree that increased access should be coupled with controlling unnecessary costs.

<u>Outcome Measure Valuation</u>: All projects are valued for cost avoidance of medical expenses and improved quality of life. For example, increased provider capacity leads to reduction in emergency room visits and reduction in inpatient hospital visits.[368] Our valuation includes an increase in the patient's quality of life. We used a conservative Quality Adjusted Life Year ("QALY") per year and a percentage of that QALY for the pediatric population.[369] The QALY is used as a one-time improvement in the quality of life, even though we know the patient's quality of life will be improved for many years. We recognize that this is a government funded waiver and thus we chose to have conservative valuations out of respect for the taxpayer funded program.

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139135109.3.32	*IT- 5.3*	Cost of Care	
Texas Children's Hospital			*139135109*
Related Category 1 or 2 Projects:	*139135109.1.12*		
Starting Point/Baseline:	*TBD in DY 3*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1[P-1] Project Planning – Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: EHR/Business Intelligence Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $18,799 **Process Milestone 2 [P-3]: Test Data System** Data Source: Enterprise Data Warehouse reports Process Milestone 2 Estimated Incentive Payment: $18,799	**Process Milestone 3 [P-4] Conduct PDSA by subspecialty clinic** Data Source: Advanced Quality Improvement (AQI) projects Process Milestone 3 Estimated Incentive Payment: *$21,790.50* **Process Milestone 4 [P-5]:** Disseminate findings, including lessons learned and best practices, to stakeholders Data Source: Reports and participation in learning collaboratives Process Milestone 4 Estimated Incentive Payment*: $21,790.50*	**Outcome Improvement Target 3 [IT-5.3]** Length of Stay Improvement Target: TBD Data Source: EPIC Medical Record Outcome Improvement Target 3 Estimated Incentive Payment*:* $69,932	**Outcome Improvement Target 3 [IT-5.3]** Length of Stay Improvement Target: TBD Data Source: EPIC Medical Record Outcome Improvement Target 3 Estimated Incentive Payment*:* $167,230
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $37,598	Year 3 Estimated Outcome Amount: $43,581	Year 4 Estimated Outcome Amount: $69,932	Year 5 Estimated Outcome Amount: $167,230
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $318,341			

Title of Outcome Measure (Improvement Target): O-D5: Cost of Care

Unique RHP outcome identification number: 139135109.3.33

Outcome Measure Description: OD-5: Cost of Care
IT-5.1 Improved cost savings

Process milestone:
DY 2 P-1; P-3
DY3 P-4; P-5

Outcome Improvement Targets for each year:
DY 4 IT-5.1;
DY 5 IT-5.1

Rationale: Process milestones P-1, P-3, and P-4 were chosen due to the lack of accurate reports and resources currently available to measure and monitor the cost of care for this population. P-1 and P-3 must be approached in DY 2 and DY3. In DY 3 we will establish a baseline percentage. P-5 will be approached in DY 3 after the initial gap assessment is completed. Lessons learned will be shared with the region and all stakeholders.

Improvement targets were placed in DY4 and DY 5 based on the timeline allowed to put in place the proper resources and processes needed to collect data. Improvement target goals will be determined after baseline percentage is set in DY3. The baseline percentage, whether high or low, will dictate an appropriate improvement target goal. We recognize that while increasing access to care we need to continue to focus on delivering quality, efficient and cost effective care. Medicaid is an entitlement program, and there is only a finite amount of money to fund critical programs. The Affordable Care Act focused on the triple aim- improving quality, reducing costs and improving access. This project strives to meet these same goals. We agree that increased access should be coupled with controlling unnecessary costs.

Outcome Measure Valuation: All projects are valued for cost avoidance of medical expenses and improved quality of life. For example, increased provider capacity leads to reduction in emergency room visits and reduction in inpatient hospital visits.[370] Our valuation includes an increase in the patient's quality of life. We used a conservative Quality Adjusted Life Year ("QALY") per year and a percentage of that QALY for the pediatric population.[371] The QALY is used as a one-time improvement in the quality of life, even though we know the patient's quality of life will be improved for many years. We recognize that this is a government funded waiver and thus we chose to have conservative valuations out of respect for the taxpayer funded program.

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[370] Smith, John T, Price, Christopher, Stevens Peter M., Masters, Kevin S., and Young, Mark. "Selected Topics - Does Pediatric Orthopedic Subspecialization Affect Hospital Utilization and Charges?" *Journal of Pediatric Orthopedics*. 19.4 (1999): 553-555.

[371] Brannon, Ike. "Risk - What Is a Life Worth? Despite Its Prima Facie Callousness, Determining the Value of a Human Life Is Necessary for Good Public Policy." *Regulation*. 27.4 (2004): 60-63.

139135109.3.33	*IT- 5.1*	Cost of Care	
Texas Children's Hospital			*139135109*
Related Category 1 or 2 Projects:	*139135109.1.13*		
Starting Point/Baseline:	*TBD in DY 3*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1[P-1] Project Planning – Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: EHR/Business Intelligence Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $26,985.50 **Process Milestone 2 [P-3]: Test** Data System Data Source: Enterprise Data Warehouse reports Process Milestone 2 Estimated Incentive Payment: $26,985.50	**Process Milestone 3 [P-4]** Conduct PDSA by subspecialty clinic Data Source: Advanced Quality Improvement (AQI) projects Process Milestone 3 Estimated Incentive Payment: *$31,280* **Process Milestone 4 [P-5]:** Disseminate findings, including lessons learned and best practices, to stakeholders Data Source: Reports and participation in learning collaboratives Process Milestone 4 Estimated Incentive Payment*: $31,280*	**Outcome Improvement Target 1 [IT-5.1]** Improved cost savings: Demonstrate cost savings in care delivery Improvement Target: TBD Data Source: EPIC Medical Record Outcome Improvement Target 1 Estimated Incentive Payment*:* $100,387	**Outcome Improvement Target 1 [IT-5.1]** Improved cost savings: Demonstrate cost savings in care delivery Improvement Target: TBD Data Source: EPIC Medical Record Outcome Improvement Target 1 Estimated Incentive Payment*:* $240,056
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $53,971	Year 3 Estimated Outcome Amount: $62,560	Year 4 Estimated Outcome Amount: $100,387	Year 5 Estimated Outcome Amount: $240,056
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $456,974			

Title of Outcome Measure (Improvement Target): O-D5: Cost of Care

Unique RHP outcome identification number: 139135109.3.34

Outcome Measure Description: OD-5: Cost of Care
IT-5.2 Per Episode of Care

Process milestone:
DY 2 P-1; P-3
DY3 P-4; P-5

Outcome Improvement Targets for each year:
DY 4 IT-5.2
DY 5 IT-5.2

Rationale: Process milestones P-1, P-3, and P-4 were chosen due to the lack of accurate reports and resources currently available to measure and monitor the cost of care for this population. P-1 and P-3 must be approached in DY 2 and DY3. In DY 3 we will establish a baseline percentage. P-5 will be approached in DY 3 after the initial gap assessment is completed. Lessons learned will be shared with the region and all stakeholders.

Improvement targets were placed in DY4 and DY 5 based on the timeline allowed to put in place the proper resources and processes needed to collect data. Improvement target goals will be determined after baseline percentage is set in DY3. The baseline percentage, whether high or low, will dictate an appropriate improvement target goal. We recognize that while increasing access to care we need to continue to focus on delivering quality, efficient and cost effective care. Medicaid is an entitlement program, and there is only a finite amount of money to fund critical programs. The Affordable Care Act focused on the triple aim- improving quality, reducing costs and improving access. This project strives to meet these same goals. We agree that increased access should be coupled with controlling unnecessary costs.

Outcome Measure Valuation: All projects are valued for cost avoidance of medical expenses and improved quality of life. For example, increased provider capacity leads to reduction in emergency room visits and reduction in inpatient hospital visits.[372] Our valuation includes an increase in the patient's quality of life. We used a conservative Quality Adjusted Life Year ("QALY") per year and a percentage of that QALY for the pediatric population.[373] The QALY is used as a one-time improvement in the quality of life, even though we know the patient's quality of life will be improved for many years. We recognize that this is a government funded waiver and thus we chose to have conservative valuations out of respect for the taxpayer funded program.

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[373] Brannon, Ike. "Risk - What Is a Life Worth? Despite Its Prima Facie Callousness, Determining the Value of a Human Life Is Necessary for Good Public Policy." *Regulation*. 27.4 (2004): 60-63.

139135109.3.34	*IT- 5.2*	Cost of Care	
Texas Children's Hospital			*139135109*
Related Category 1 or 2 Projects:	*139135109.1.13*		
Starting Point/Baseline:	*TBD in DY 3*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1[P-1] Project Planning – Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: EHR/Business Intelligence Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $26,985.50 **Process Milestone 2 [P-3]: Test** Data System Data Source: Enterprise Data Warehouse reports Process Milestone 2 Estimated Incentive Payment: $26,985.50	**Process Milestone 3 [P-4]** Conduct PDSA by subspecialty clinic Data Source: Advanced Quality Improvement (AQI) projects Process Milestone 3 Estimated Incentive Payment: *$31,280* **Process Milestone 4 [P-5]:** Disseminate findings, including lessons learned and best practices, to stakeholders Data Source: Reports and participation in learning collaboratives Process Milestone 4 Estimated Incentive Payment*: $31,280*	**Outcome Improvement Target 2 [IT-5.2]** Per episode cost of care Improvement Target: TBD Data Source: EPIC Medical Record Outcome Improvement Target 2 Estimated Incentive Payment*:* $100,387	**Outcome Improvement Target 2 [IT-5.2]** Per episode cost of care Improvement Target: TBD Data Source: EPIC Medical Record Outcome Improvement Target 2 Estimated Incentive Payment*:* $240,055
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $53,971	Year 3 Estimated Outcome Amount: $62,560	Year 4 Estimated Outcome Amount: $100,387	Year 5 Estimated Outcome Amount: $240,056
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $456,974			

Title of Outcome Measure (Improvement Target): O-D5: Cost of Care

Unique RHP outcome identification number: 139135109.3.35

Outcome Measure Description: OD-5: Cost of Care
IT-5.3 Length of Stay

Process milestone:
DY 2 P-1; P-3
DY3 P-4; P-5

Outcome Improvement Targets for each year:
DY 4 IT-5.3
DY 5 IT-5.3

Rationale: Process milestones P-1, P-3, and P-4 were chosen due to the lack of accurate reports and resources currently available to measure and monitor the cost of care for this population. P-1 and P-3 must be approached in DY 2 and DY3. In DY 3 we will establish a baseline percentage. P-5 will be approached in DY 3 after the initial gap assessment is completed. Lessons learned will be shared with the region and all stakeholders.

Improvement targets were placed in DY4 and DY 5 based on the timeline allowed to put in place the proper resources and processes needed to collect data. Improvement target goals will be determined after baseline percentage is set in DY3. The baseline percentage, whether high or low, will dictate an appropriate improvement target goal. We recognize that while increasing access to care we need to continue to focus on delivering quality, efficient and cost effective care. Medicaid is an entitlement program, and there is only a finite amount of money to fund critical programs. The Affordable Care Act focused on the triple aim- improving quality, reducing costs and improving access. This project strives to meet these same goals. We agree that increased access should be coupled with controlling unnecessary costs.

Outcome Measure Valuation: All projects are valued for cost avoidance of medical expenses and improved quality of life. For example, increased provider capacity leads to reduction in emergency room visits and reduction in inpatient hospital visits.[374] Our valuation includes an increase in the patient's quality of life. We used a conservative Quality Adjusted Life Year ("QALY") per year and a percentage of that QALY for the pediatric population.[375] The QALY is used as a one-time improvement in the quality of life, even though we know the patient's quality of life will be improved for many years. We recognize that this is a government funded waiver and thus we chose to have conservative valuations out of respect for the taxpayer funded program.

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139135109.3.35	*IT- 5.3*	Cost of Care	
Texas Children's Hospital			*139135109*
Related Category 1 or 2 Projects:	*139135109.1.13*		
Starting Point/Baseline:	*TBD in DY 3*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1[P-1] Project Planning – Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: EHR/Business Intelligence Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $26,985.50 **Process Milestone 2 [P-3]: Test** Data System Data Source: Enterprise Data Warehouse reports Process Milestone 2 Estimated Incentive Payment: $26,985.50	**Process Milestone 3 [P-4]** Conduct PDSA by subspecialty clinic Data Source: Advanced Quality Improvement (AQI) projects Process Milestone 3 Estimated Incentive Payment: *$31,280* **Process Milestone 4 [P-5]:** Disseminate findings, including lessons learned and best practices, to stakeholders Data Source: Reports and participation in learning collaboratives Process Milestone 4 Estimated Incentive Payment*: $31,280*	**Outcome Improvement Target 3 [IT-5.3]** Length of Stay Improvement Target: TBD Data Source: EPIC Medical Record Outcome Improvement Target 3 Estimated Incentive Payment*:* $100,387	**Outcome Improvement Target 3 [IT-5.3]** Length of Stay Improvement Target: TBD Data Source: EPIC Medical Record Outcome Improvement Target 3 Estimated Incentive Payment*:* $240,055
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $53,971	Year 3 Estimated Outcome Amount: $62,560	Year 4 Estimated Outcome Amount: $100,387	Year 5 Estimated Outcome Amount: $240,056
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $456,974			

<u>Title of Outcome Measure (Improvement Target):</u> OD5-Cost of Care

<u>Unique RHP outcome identification number:</u> 139135109.3.36

<u>Outcome Measure Description:</u> Cost of Care

IT-5.1 Improved cost savings:

Process milestone:

DY 2 P-1; P-3

DY3 P-4; P-5

Outcome Improvement Targets for each year:

DY 4 IT-5.1;

DY 5 IT-5.1

<u>Rationale</u>: Process milestones P-1, P-3, and P-4 were chosen due to the lack of accurate reports and resources currently available to measure and monitor the cost of care for this population. P-1 and P-3 must be approached in DY 2 and DY3. In DY 3 we will establish a baseline percentage. P-5 will be approached in DY 3 after the initial gap assessment is completed. Lessons learned will be shared with the region and all stakeholders.

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<u>Outcome Measure Valuation</u>: All projects are valued for cost avoidance of medical expenses and improved quality of life. For example, increased provider capacity leads to reduction in emergency room visits and reduction in inpatient hospital visits.[376] Our valuation includes an increase in the patient's quality of life. We used a conservative Quality Adjusted Life Year ("QALY") per year and a percentage of that QALY for the pediatric population.[377] The QALY is used as a one-time improvement in the quality of life, even though we know the patient's quality of life will be improved for many years. We recognize that this is a government funded waiver and thus we chose to have conservative valuations out of respect for the taxpayer funded program.

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<table>
<tr><td>139135109.3.36</td><td>IT- 5.1</td><td colspan="2">Cost of Care</td></tr>
<tr><td colspan="3">Texas Children's Hospital</td><td>139135109</td></tr>
<tr><td>Related Category 1 or 2 Projects:</td><td colspan="3">139135109.1.14</td></tr>
<tr><td>Starting Point/Baseline:</td><td colspan="3">TBD in DY 3</td></tr>
<tr><th>Year 2
(10/1/2012 – 9/30/2013)</th><th>Year 3
(10/1/2013 – 9/30/2014)</th><th>Year 4
(10/1/2014 – 9/30/2015)</th><th>Year 5
(10/1/2015 – 9/30/2016)</th></tr>
<tr><td>Process Milestone 1[P-1] Project Planning – Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
Data Source: EHR/Business Intelligence

Process Milestone 1 Estimated Incentive Payment (maximum amount): $12,861.50

Process Milestone 2 [P-3]: Test Data System
Data Source: Enterprise Data Warehouse reports

Process Milestone 2 Estimated Incentive Payment: $12,861.50</td><td>Process Milestone 3 [P-4] Conduct PDSA by subspecialty clinic
Data Source: Advanced Quality Improvement (AQI) projects

Process Milestone 3 Estimated Incentive Payment:$14,908

Process Milestone 4 [P-5]: Disseminate findings, including lessons learned and best practices, to stakeholders
Data Source: Reports and participation in learning collaboratives

Process Milestone 4 Estimated Incentive Payment: $14,908</td><td>Outcome Improvement Target 1 [IT-5.1] Improved cost savings: Demonstrate cost savings in care delivery
Improvement Target: TBD
Data Source: EPIC Medical Record

Outcome Improvement Target 1 Estimated Incentive Payment: $47,844</td><td>Outcome Improvement Target 1 [IT-5.1] Improved cost savings: Demonstrate cost savings in care delivery
Improvement Target: TBD
Data Source: EPIC Medical Record

Outcome Improvement Target 1 Estimated Incentive Payment: $114,409</td></tr>
<tr><td>Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $25,723</td><td>Year 3 Estimated Outcome Amount: $29,816</td><td>Year 4 Estimated Outcome Amount: $47,844</td><td>Year 5 Estimated Outcome Amount: $114,409</td></tr>
<tr><td colspan="4">TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5): $217,792</td></tr>
</table>

Title of Outcome Measure (Improvement Target): OD5-Cost of Care

Unique RHP outcome identification number: 139135109.3.37

Outcome Measure Description: Cost of Care
IT-5.2 Per Episode of Care:
Process milestone:
DY 2 P-1; P-3
DY3 P-4; P-5

Outcome Improvement Targets for each year:
DY 4 IT-5.2;
DY 5 IT-5.2

Rationale: Process milestones P-1, P-3, and P-4 were chosen due to the lack of accurate reports and resources currently available to measure and monitor the cost of care for this population. P-1 and P-3 must be approached in DY 2 and DY3. In DY 3 we will establish a baseline percentage. P-5 will be approached in DY 3 after the initial gap assessment is completed. Lessons learned will be shared with the region and all stakeholders.
Improvement targets were placed in DY4 and DY 5 based on the timeline allowed to put in place the proper resources and processes needed to collect data. Improvement target goals will be determined after baseline percentage is set in DY3. The baseline percentage, whether high or low, will dictate an appropriate improvement target goal. We recognize that while increasing access to care we need to continue to focus on delivering quality, efficient and cost effective care. Medicaid is an entitlement program, but there is only a finite amount of money. The affordable Care Act focused on the triple aim- improving quality, reducing costs and improving access. This project strives to meet those same goals. We agree that increased access should be coupled with controlling unnecessary costs.

Outcome Measure Valuation: All projects are valued for cost avoidance of medical expenses and improved quality of life. For example, increased provider capacity leads to reduction in emergency room visits and reduction in inpatient hospital visits.[378] Our valuation includes an increase in the patient's quality of life. We used a conservative Quality Adjusted Life Year ("QALY") per year and a percentage of that QALY for the pediatric population.[379] The QALY is used as a one-time improvement in the quality of life, even though we know the patient's quality of life will be improved for many years. We recognize that this is a government funded waiver and thus we chose to have conservative valuations out of respect for the taxpayer funded program.

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139135109.3.37	*IT- 5.2*	*Cost of Care*	
Texas Children's Hospital			*139135109*
Related Category 1 or 2 Projects:	139135109.1.14		
Starting Point/Baseline:	*TBD in DY 3*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1[P-1] Project Planning – Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans **Data Source: EHR/Business Intelligence** Process Milestone 1 Estimated Incentive Payment *(maximum amount): $12,861.50* **Process Milestone 2 [P-3]: Test Data System** **Data Source:** Enterprise Data Warehouse reports Process Milestone 2 Estimated Incentive Payment: *$12,861.50*	**Process Milestone 3 [P-4] Conduct PDSA by subspecialty clinic** **Data Source:** Advanced Quality Improvement (AQI) projects Process Milestone 3 Estimated Incentive Payment: $14,908 **Process Milestone 4 [P-5]:** Disseminate findings, including lessons learned and best practices, to stakeholders **Data Source: Reports and participation in learning collaboratives** Process Milestone 4 Estimated Incentive Payment: $14,908	**Outcome Improvement Target 2 [IT-5.2] Per episode cost of care** Improvement Target: TBD Data Source: EPIC Medical Record Outcome Improvement Target 2 Estimated Incentive Payment: $47,844	**Outcome Improvement Target 2 [IT-5.2] Per episode cost of care** Improvement Target: TBD Data Source: EPIC Medical Record Outcome Improvement Target 2 Estimated Incentive Payment: $114,409
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $25,723	Year 3 Estimated Outcome Amount: $29,816	Year 4 Estimated Outcome Amount: $47,844	Year 5 Estimated Outcome Amount: $114,409
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** *$217,792*			

Title of Outcome Measure (Improvement Target): OD5-Cost of Care

Unique RHP outcome identification number: 139135109.3.38

Outcome Measure Description: Cost of Care
IT-5.3 Length of Stay:
Process milestone:
DY 2 P-1; P-3
DY3 P-4; P-5

Outcome Improvement Targets for each year:
DY 4 IT-5.3;
DY 5 IT-5.3

Rationale: Process milestones P-1, P-3, and P-4 were chosen due to the lack of accurate reports and resources currently available to measure and monitor the cost of care for this population. P-1 and P-3 must be approached in DY 2 and DY3. In DY 3 we will establish a baseline percentage. P-5 will be approached in DY 3 after the initial gap assessment is completed. Lessons learned will be shared with the region and all stakeholders.
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139135109.3.38	*IT- 5.3*	*Cost of Care*	
Texas Children's Hospital			*139135109*
Related Category 1 or 2 Projects:	139135109.1.14		
Starting Point/Baseline:	*TBD in DY 3*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1[P-1] Project Planning – Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans **Data Source: EHR/Business Intelligence** Process Milestone 1 Estimated Incentive Payment *(maximum amount): $12,861.50* **Process Milestone 2 [P-3]: Test Data System** **Data Source:** Enterprise Data Warehouse reports Process Milestone 2 Estimated Incentive Payment: *$12,861.50*	**Process Milestone 3 [P-4] Conduct PDSA by subspecialty clinic** **Data Source:** Advanced Quality Improvement (AQI) projects Process Milestone 3 Estimated Incentive Payment: $14,908 **Process Milestone 4 [P-5]:** Disseminate findings, including lessons learned and best practices, to stakeholders **Data Source: Reports and participation in learning collaboratives** Process Milestone 4 Estimated Incentive Payment: $14,908	**Outcome Improvement Target 3 [IT-5.3] Length of Stay** Improvement Target: TBD Data Source: EPIC Medical Record Outcome Improvement Target 3 Estimated Incentive Payment: $47,844	**Outcome Improvement Target 3 [IT-5.3] Length of Stay** Improvement Target: TBD Data Source: EPIC Medical Record Outcome Improvement Target 3 Estimated Incentive Payment: $114,409
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TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)*: *$217,792*			

Title of Outcome Measure (Improvement Target): OD-5: Cost of Care

Unique RHP outcome identification number: 139135109.3.39

Outcome Measure Description: OD-5: Cost of Care
IT-5.1 Improved cost savings

Process milestone:
DY 2 P-1; P-3
DY3 P-4; P-5

Outcome Improvement Targets for each year:
DY 4 IT-5.1;
DY 5 IT-5.1

Rationale: Process milestones P-1, P-3, and P-4 were chosen due to the lack of accurate reports and resources currently available to measure and monitor the cost of care for this population. P-1 and P-3 must be approached in DY 2 and DY3. In DY 3 we will establish a baseline percentage. P-5 will be approached in DY 3 after the initial gap assessment is completed. Lessons learned will be shared with the region and all stakeholders.

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139135109.3.39	*IT- 5.1*	Cost of Care	
Texas Children's Hospital			*139135109*
Related Category 1 or 2 Projects:	*139135109.1.15*		
Starting Point/Baseline:	*TBD in DY 3*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1[P-1] Project Planning – Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: EHR/Business Intelligence Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $34,876 **Process Milestone 2 [P-3]: Test Data System** Data Source: Enterprise Data Warehouse reports Process Milestone 2 Estimated Incentive Payment: $34,876	**Process Milestone 3 [P-4]** Conduct PDSA by subspecialty clinic Data Source: Advanced Quality Improvement (AQI) projects Process Milestone 3 Estimated Incentive Payment: *$40,425.50* **Process Milestone 4 [P-5]:** Disseminate findings, including lessons learned and best practices, to stakeholders Data Source: Reports and participation in learning collaboratives Process Milestone 4 Estimated Incentive Payment*: $40,425.50*	**Outcome Improvement Target 1 [IT-5.1]** Improved cost savings: Demonstrate cost savings in care delivery Improvement Target: TBD Data Source: EPIC Medical Record Outcome Improvement Target 1 Estimated Incentive Payment*:* $129,738	**Outcome Improvement Target 1 [IT-5.1]** Improved cost savings: Demonstrate cost savings in care delivery Improvement Target: TBD Data Source: EPIC Medical Record Outcome Improvement Target 1 Estimated Incentive Payment*:* $76,911
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $69,752	Year 3 Estimated Outcome Amount: $80,851	Year 4 Estimated Outcome Amount: $129,738	Year 5 Estimated Outcome Amount: $76,911
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $357,252			

Title of Outcome Measure (Improvement Target): OD-5: Cost of Care

Unique RHP outcome identification number: 139135109.3.40

Outcome Measure Description: OD-5: Cost of Care
IT-5.2 Per Episode of Care

Process milestone:
DY 2 P-1; P-3
DY3 P-4; P-5

Outcome Improvement Targets for each year:
DY 4 IT-5.2;
DY 5 IT-5.2

Rationale: Process milestones P-1, P-3, and P-4 were chosen due to the lack of accurate reports and resources currently available to measure and monitor the cost of care for this population. P-1 and P-3 must be approached in DY 2 and DY3. In DY 3 we will establish a baseline percentage. P-5 will be approached in DY 3 after the initial gap assessment is completed. Lessons learned will be shared with the region and all stakeholders.

Improvement targets were placed in DY4 and DY 5 based on the timeline allowed to put in place the proper resources and processes needed to collect data. Improvement target goals will be determined after baseline percentage is set in DY3. The baseline percentage, whether high or low, will dictate an appropriate improvement target goal. We recognize that while increasing access to care we need to continue to focus on delivering quality, efficient and cost effective care. Medicaid is an entitlement program, but there is a only a finite about of money. The affordable Care Act focused on the triple aim- improving quality, reducing costs and improving access. This project strives to meet those same goals. We agree that increased access should be coupled with controlling unnecessary costs.

Outcome Measure Valuation: All projects are valued for cost avoidance of medical expenses and improved quality of life. For example, increased provider capacity leads to reduction in emergency room visits and reduction in inpatient hospital visits.[384] Our valuation includes an increase in the patient's quality of life. We used a conservative Quality Adjusted Life Year ("QALY") per year and a percentage of that QALY for the pediatric population.[385] The QALY is used as a one-time improvement in the quality of life, even though we know the patient's quality of life will be improved for many years. We recognize that this is a government funded waiver and thus we chose to have conservative valuations out of respect for the taxpayer funded program.

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[384] Smith, John T, Price, Christopher, Stevens Peter M., Masters, Kevin S., and Young, Mark. "Selected Topics - Does Pediatric Orthopedic Subspecialization Affect Hospital Utilization and Charges?" *Journal of Pediatric Orthopedics*. 19.4 (1999): 553-555.

[385] Brannon, Ike. "Risk - What Is a Life Worth? Despite Its Prima Facie Callousness, Determining the Value of a Human Life Is Necessary for Good Public Policy." *Regulation*. 27.4 (2004): 60-63.

139135109.3.40	*IT- 5.2*	Cost of Care	
Texas Children's Hospital			*139135109*
Related Category 1 or 2 Projects:	*139135109.1.15*		
Starting Point/Baseline:	*TBD in DY 3*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1[P-1] Project Planning – Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: EHR/Business Intelligence Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $34,876 **Process Milestone 2 [P-3]: Test Data System** Data Source: Enterprise Data Warehouse reports Process Milestone 2 Estimated Incentive Payment: $34,876	**Process Milestone 3 [P-4]** Conduct PDSA by subspecialty clinic Data Source: Advanced Quality Improvement (AQI) projects Process Milestone 3 Estimated Incentive Payment: *$40,425.50* **Process Milestone 4 [P-5]:** Disseminate findings, including lessons learned and best practices, to stakeholders Data Source: Reports and participation in learning collaboratives Process Milestone 4 Estimated Incentive Payment*: $40,425.50*	**Outcome Improvement Target 2** [**IT-5.2]** Per episode cost of care Improvement Target: TBD Data Source: EPIC Medical Record Outcome Improvement Target 2 Estimated Incentive Payment*:* $129,738	**Outcome Improvement Target 2** [**IT-5.2]** Per episode cost of care Improvement Target: TBD Data Source: EPIC Medical Record Outcome Improvement Target 2 Estimated Incentive Payment*:* $76,911
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $69,752	Year 3 Estimated Outcome Amount: $80,851	Year 4 Estimated Outcome Amount: $129,738	Year 5 Estimated Outcome Amount: $76,911
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $357,252			

Title of Outcome Measure (Improvement Target): OD-5: Cost of Care

Unique RHP outcome identification number: 139135109.3.41

Outcome Measure Description: OD-5: Cost of Care
IT-5.3 Length of Stay

Process milestone:
DY 2 P-1; P-3
DY3 P-4; P-5

Outcome Improvement Targets for each year:
DY 4 IT-5.3;
DY 5 IT-5.3

Rationale: Process milestones P-1, P-3, and P-4 were chosen due to the lack of accurate reports and resources currently available to measure and monitor the cost of care for this population. P-1 and P-3 must be approached in DY 2 and DY3. In DY 3 we will establish a baseline percentage. P-5 will be approached in DY 3 after the initial gap assessment is completed. Lessons learned will be shared with the region and all stakeholders.

Improvement targets were placed in DY4 and DY 5 based on the timeline allowed to put in place the proper resources and processes needed to collect data. Improvement target goals will be determined after baseline percentage is set in DY3. The baseline percentage, whether high or low, will dictate an appropriate improvement target goal. We recognize that while increasing access to care we need to continue to focus on delivering quality, efficient and cost effective care. Medicaid is an entitlement program, but there is a only a finite about of money. The affordable Care Act focused on the triple aim- improving quality, reducing costs and improving access. This project strives to meet those same goals. We agree that increased access should be coupled with controlling unnecessary costs.

Outcome Measure Valuation: All projects are valued for cost avoidance of medical expenses and improved quality of life. For example, increased provider capacity leads to reduction in emergency room visits and reduction in inpatient hospital visits.[386] Our valuation includes an increase in the patient's quality of life. We used a conservative Quality Adjusted Life Year ("QALY") per year and a percentage of that QALY for the pediatric population.[387] The QALY is used as a one-time improvement in the quality of life, even though we know the patient's quality of life will be improved for many years. We recognize that this is a government funded waiver and thus we chose to have conservative valuations out of respect for the taxpayer funded program.

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[387] Brannon, Ike. "Risk - What Is a Life Worth? Despite Its Prima Facie Callousness, Determining the Value of a Human Life Is Necessary for Good Public Policy." *Regulation*. 27.4 (2004): 60-63.

<table>
<tr><td>139135109.3.41</td><td>IT- 5.3</td><td colspan="2">Cost of Care</td></tr>
<tr><td colspan="3">Texas Children's Hospital</td><td>139135109</td></tr>
<tr><td>Related Category 1 or 2 Projects:</td><td colspan="3">139135109.1.15</td></tr>
<tr><td>Starting Point/Baseline:</td><td colspan="3">TBD in DY 3</td></tr>
<tr><th>Year 2
(10/1/2012 – 9/30/2013)</th><th>Year 3
(10/1/2013 – 9/30/2014)</th><th>Year 4
(10/1/2014 – 9/30/2015)</th><th>Year 5
(10/1/2015 – 9/30/2016)</th></tr>
<tr><td>Process Milestone 1[P-1] Project Planning – Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
Data Source: EHR/Business Intelligence

Process Milestone 1 Estimated Incentive Payment (maximum amount): $34,876

Process Milestone 2 [P-3]: Test Data System
Data Source: Enterprise Data Warehouse reports

Process Milestone 2 Estimated Incentive Payment: $34,876</td><td>Process Milestone 3 [P-4] Conduct PDSA by subspecialty clinic
Data Source: Advanced Quality Improvement (AQI) projects

Process Milestone 3 Estimated Incentive Payment: $40,425.50

Process Milestone 4 [P-5]: Disseminate findings, including lessons learned and best practices, to stakeholders
Data Source: Reports and participation in learning collaboratives

Process Milestone 4 Estimated Incentive Payment: $40,425.50</td><td>Outcome Improvement Target 3 [IT-5.3] Length of Stay
Improvement Target: TBD
Data Source: EPIC Medical Record

Outcome Improvement Target 3 Estimated Incentive Payment: $129,738</td><td>Outcome Improvement Target 3 [IT-5.3] Length of Stay
Improvement Target: TBD
Data Source: EPIC Medical Record

Outcome Improvement Target 3 Estimated Incentive Payment: $76,911</td></tr>
<tr><td>Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $69,752</td><td>Year 3 Estimated Outcome Amount: $80,851</td><td>Year 4 Estimated Outcome Amount: $129,738</td><td>Year 5 Estimated Outcome Amount: $76,911</td></tr>
<tr><td colspan="4">TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5): $357,252</td></tr>
</table>

Title of Outcome Measure (Improvement Target): OD-2: Potentially Preventable Admission

Unique RHP outcome identification number: 139135109.3.42

Outcome Measure Description:
OD-2: Potentially Preventable Admission

IT-2.4 Reduce preventable admissions for patients with Behavioral Health/ Major Depressive Disorder
Process milestone:
DY 2 P-1; P-3
DY3 P-4; P-5
Outcome Improvement Targets for each year:
DY 4 IT-2.4
DY 5 IT-2.4
Rationale: Process milestones P-1, P-3, and P-4 were chosen due to the lack of accurate reports and resources currently available to measure and monitor the cost of care for this population. P-1 and P-3 must be approached in DY 2 and DY3. In DY 3 we will establish a baseline percentage. P-5 will be approached in DY 3 after the initial gap assessment is completed. Lessons learned will be shared with the region and all stakeholders.

Improvement targets were placed in DY4 and DY 5 based on the timeline allowed to put in place the proper resources and processes needed to collect data. Improvement target goals will be determined after baseline percentage is set in DY3. The baseline percentage, whether high or low, will dictate an appropriate improvement target 5%. We recognize that while increasing access to care we need to continue to focus on delivering quality, efficient and cost effective care. Medicaid is an entitlement program, but there is an only a finite about of money. The Affordable Care Act focused on the triple aim- improving quality, reducing costs and improving access. This project strives to meet those same goals. We agree that increased access should be coupled with controlling unnecessary costs.

Outcome Measure Valuation: All projects are valued for cost avoidance of medical expenses and improved quality of life. For example, increased provider capacity leads to reduction in emergency room visits and reduction in inpatient hospital visits.[388] Our valuation includes an increase in the patient's quality of life. We used a conservative Quality Adjusted Life Year ("QALY") per year and a percentage of that QALY for the pediatric population.[389] The QALY is used as a one-time improvement in the quality of life, even though we know the patient's quality of life will be improved for many years. We recognize that this is a government funded waiver and thus we chose to have conservative valuations out of respect for the taxpayer funded program.

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[388] Smith, John T, Price, Christopher, Stevens Peter M., Masters, Kevin S., and Young, Mark. "Selected Topics - Does Pediatric Orthopedic Subspecialization Affect Hospital Utilization and Charges?" *Journal of Pediatric Orthopedics*. 19.4 (1999): 553-555.
[389] Brannon, Ike. "Risk - What Is a Life Worth? Despite Its Prima Facie Callousness, Determining the Value of a Human Life Is Necessary for Good Public Policy." *Regulation*. 27.4 (2004): 60-63.

139135109.3.42	*IT- 2.4*	*Potentially Preventable Admissions*	
Texas Children's Hospital			*139135109*
Related Category 1 or 2 Projects:	139135109.1.16		
Starting Point/Baseline:	*TBD in DY 3*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1[P-1] Project Planning – Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: EHR/Business Intelligence Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $31,599 **Process Milestone 2 [P-3]: Test Data System** Data Source: Enterprise Data Warehouse reports Process Milestone 2 Estimated Incentive Payment: $31,599	**Process Milestone 3 [P-4] Conduct PDSA by subspecialty clinic** Data Source: Advanced Quality Improvement (AQI) projects Process Milestone 3 Estimated Incentive Payment: *$36,627.50* **Process Milestone 4 [P-5]:** Disseminate findings, including lessons learned and best practices, to stakeholders Data Source: Reports and participation in learning collaboratives Process Milestone 4 Estimated Incentive Payment*: $36,627.50*	**Outcome Improvement Target** [IT—2.4]: BH/MDD as the principal diagnosis a. Numerator: Outpatient visits with a primary mental health diagnosis. b. Denominator: Number of deliveries in Harris County Improvement Target: Decrease the percent of psychiatric patients admitted Data Source: EPIC medical record Estimated Incentive Payment*:* $117,549	**Outcome Improvement Target [** IT—2.4]: BH/MDD as the principal diagnosis a. Numerator: Outpatient visits with a primary mental health diagnosis. b. Denominator: Number of deliveries in Harris County Improvement Target: Decrease the percent of psychiatric patients admitted Data Source: EPIC medical record Estimated Incentive Payment*:* $281,095
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $63,198	Year 3 Estimated Outcome Amount: $73,255	Year 4 Estimated Outcome Amount: $117,549	Year 5 Estimated Outcome Amount: $281,095
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $535,097			

Title of Outcome Measure (Improvement Target): Patient Satisfaction
Unique RHP outcome identification number: 139135109.3.43

Outcome Measure Description: Patient Satisfaction

IT-6.1 Improved patient satisfaction

Process milestone:

DY 2 P-1; P-3
DY3 P-4; P-5

Outcome Improvement Targets for each year:

DY 4 IT-6.1
DY 5 IT-6.1

Rationale: Process milestones P-1, P-3, and P-4 were chosen due to the lack of accurate reports and resources currently available to measure and monitor the cost of care for this population. P-1 and P-3 must be approached in DY 2 and DY3. In DY 3 we will establish a baseline percentage. P-5 will be approached in DY 3 after the initial gap assessment is completed. Lessons learned will be shared with the region and all stakeholders.
Improvement targets were placed in DY4 and DY 5 based on the timeline allowed to put in place the proper resources and processes needed to collect data. Improvement target goals will be determined after baseline percentage is set in DY3. The baseline percentage, whether high or low, will dictate an appropriate improvement target goal.

Outcome Measure Valuation: All projects are valued for cost avoidance of medical expenses and improved quality of life. For example, increased provider capacity leads to reduction in emergency room visits and reduction in inpatient hospital visits.[390] Our valuation includes an increase in the patient's quality of life. We used a conservative Quality Adjusted Life Year ("QALY") per year and a percentage of that QALY for the pediatric population.[391] The QALY is used as a one-time improvement in the quality of life, even though we know the patient's quality of life will be improved for many years. We recognize that this is a government funded waiver and thus we chose to have conservative valuations out of respect for the taxpayer funded program.

[390] Smith, John T, Price, Christopher, Stevens Peter M., Masters, Kevin S., and Young, Mark. "Selected Topics - Does Pediatric Orthopedic Subspecialization Affect Hospital Utilization and Charges?" *Journal of Pediatric Orthopedics*. 19.4 (1999): 553-555.
[391] Brannon, Ike. "Risk - What Is a Life Worth? Despite Its Prima Facie Callousness, Determining the Value of a Human Life Is Necessary for Good Public Policy." *Regulation*. 27.4 (2004): 60-63.

139135109.3.43	*IT- 6.1*	Patient Satisfaction	
Texas Children's Hospital			*139135109*
Related Category 1 or 2 Projects:	*139135109.2.1*		
Starting Point/Baseline:	*TBD in DY3*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1[P-1] Project Planning – Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans **Data Source: EHR/Business Intelligence** Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $88,208.50 **Process Milestone 2 [P-3]: Test Data System** **Data Source:** Enterprise Data Warehouse reports Process Milestone 2 Estimated Incentive Payment: $88,208.50	**Process Milestone 1[P-1] Project Planning –** Engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans **Data Source: EHR/Business Intelligence** Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $102,245 **Process Milestone 2 [P-3]: Test Data System** **Data Source:** Enterprise Data Warehouse reports Process Milestone 2 Estimated Incentive Payment: $102,245	**Outcome Improvement Target 1 [IT-6.1] Improved patient satisfaction: Demonstrate cost savings in care delivery** Improvement Target: TBD Data Source: Press Ganey patient survey Outcome Improvement Target 1 Estimated Incentive Payment*:* $328,136	**Outcome Improvement Target 2** [IT-6.1] Patient Satisfaction Improvement Target: TBD Data Source: Press Ganey Patient survey Outcome Improvement Target 3 Estimated Incentive Payment*:* $784,673
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $176,417	Year 3 Estimated Outcome Amount: $204,490	Year 4 Estimated Outcome Amount: $328,136	Year 5 Estimated Outcome Amount: $784,673
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $1,493,716			

The Methodist Hospital

Pass 1

Title of Outcome Measure (Improvement Target): IT 1.18 - *Follow up after Hospitalization for Mental Illness*

Unique RHP outcome identification number(s): 137949705.3.1

Outcome Measure Description:

IT-1.18 Follow-Up After Hospitalization for Mental Illness- NQF 0576236 (Standalone measure)

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.

Our goal is that by year four we will have 60% with follow up within 30 days, and by year 5 we will have 80%.

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.

As it is difficult to arrange appointments so close to discharge because of patient and physician factors, our goal is that by the fourth year we will have 40% follow up within seven days and by the fifth year, 50%.

Process Milestones:

- DY2:
  - P-1: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans

- DY3:
  - P-2: Establish baseline rates

Outcome Improvement Targets for each year:

- DY4: IT-1.18 Follow-Up After Hospitalization for Mental Illness- NQF 0576236 (Standalone measure)
  - Improvement Target: 60% above baseline
- DY5: IT 1.18 Follow-Up After Hospitalization for Mental Illness- NQF 0576236 (Standalone measure)
  - Improvement Target: 80% above baseline

Rationale:

Process milestones in DY 2 are focused on training, education and partnership development. These efforts are largely external efforts focused on our medical staff, collaborating healthcare providers and community partners.

Process milestones in DY 3 are focused on establishing our baseline, factors that are driving utilization and establishing a process to follow up with patients post-discharge. These are largely internal efforts with our hospital based work teams.

Outcome Measure Valuation:

We have selected IT 1.18 as our quality outcome metric as we feel this is most important quality outcome to determine the success or impact of our project. Through a focused effort to follow up and coordinate the post discharge care needs of our targeted population we will demonstrate true value to the community. Meaning, our targeted population will receive higher quality care in the correct care setting, all at a lower cost.

137949705.3.1	*IT-1.18*	*Follow up after hospitalization for mental illness*	
The Methodist Hospital			*137949705*
Related Category 1 or 2 Projects:	137949705.3.1		
Starting Point/Baseline:	*To be established in DY3*		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: EHR; Business Intelligence Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $ 604,299	**Process Milestone 2** [P-2]: Establish baseline Data Source: EMR Process Milestone 2 Estimated Incentive Payment: $604,299	**Outcome Improvement Target 1** [IT-1.18]: Follow-Up After Hospitalization for Mental Illness-NQF 0576236 Improvement Target: 60% above baseline Data Source: EHR, Claims Outcome Improvement Target 1 Estimated Incentive Payment*:* $ 906,448	**Outcome Improvement Target 2** [IT-1.18]: Follow-Up After Hospitalization for Mental Illness-NQF 0576236 Improvement Target: 80% above baseline Data Source: EHR, Claims Outcome Improvement Target 2 Estimated Incentive Payment*:* $1,994,186
Year 2 Estimated Outcome Amount: $ 604,299	Year 3 Estimated Outcome Amount: $604,299	Year 4 Estimated Outcome Amount: $ 906,448	Year 5 Estimated Outcome Amount: $1,994,186
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)*: $4,109,232			

The University of Texas Health Science Center - Houston

Pass 1

Title of Outcome Measure (Improvement Target): OD-1 Primary Care and Chronic Disease Management

Unique RHP outcome identification number(s): 111810101.3.1
Performing Provider Name/TPI: UTHealth, UTPhysicians/111810101

Outcome Measure Description:
IT-1.1 Third next available appointment (Non- standalone measure)

Reduce the average length of time in days between the day a patient makes a request for an appointment with a physician and the third available appointment for a new patient physical, routine exam, or return visit exam. The goals will be to decrease number of days to third next available appointment to zero days (same day) for Primary Care.

Process Milestones:
DY2:
P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
DY3:
P-3 Develop and test data systems
P-2 Establish baseline rates

Outcome Improvement Targets for each year:

- DY4:
  - IT-1.1 Reduce by 1 day the average length of time in days between the day a patient makes a request for an appointment with a physician and the third available appointment for a new patient physical, routine exam, or return visit exam.
- DY5:
  - IT-1.1 Reduce the average length of time in days between the day a patient makes a request for an appointment with a physician and the third available appointment for a new patient physical, routine exam, or return visit exam to zero (0) days.

Rationale:

Access to primary care services can have an impact on healthcare outcomes, by providing early screening and treatment and patients are more likely to get these services when they are able to get appointments when first needed that accomodate their schedule. Since the goal of the project is to increase access to care and the third next available appointment is the healthcare industry's standard measure of access to care, we have chosen this outcome measure.

Outcome Measure Valuation:

Using the same project valuation scores assigned to the projects, the dollars allotted for each year were distributed across the projects' related Category 3 measures. For demonstration year 2 the amount was 5%, and for DYs 3, 4, and 5, the proportion of the funds allotted were 10%, 10%, and 20%, respectively.

111810101.3.1	*3.IT-1.1*	*Third next available appointment (Non- standalone measure)*	
UTHealth, UTPhysicians			*111810101*
Related Category 1 or 2 Projects:	*111810101.1.1*		
Starting Point/Baseline:	*To be determined during DY3.*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Project reports and documents Process Milestone 1 Estimated Incentive Payment*:* $ 78,980	Process Milestone 2 [P-2]: Establish baseline rates Data Source: Provider reports Process Milestone 2 Estimated Incentive Payment: $ 94,024 Process Milestone 3 [P-3]: Develop and test data systems Data Source: Project reports, EMR, claims Process Milestone 3 Estimated Incentive Payment: $ 94,024	Outcome Improvement Target 1 [IT-1.1]: Reduce by 1 day the average length of time in days between the day a patient makes a request for an appointment with a physician and the third available appointment for a new patient physical, routine exam, or return visit exam. Data Source: Appointment management system Outcome Improvement Target 1 Estimated Incentive Payment*:* $ 195,570	Outcome Improvement Target 2 [IT-1.1]: Reduce the average length of time in days between the day a patient makes a request for an appointment with a physician and the third available appointment for a new patient physical, routine exam, or return visit exam to zero (0) days. Data Source: Appointment management system Outcome Improvement Target 2 Estimated Incentive Payment*:* $ 442,945
Year 2 Estimated Outcome Amount: $ 78,980	Year 3 Estimated Outcome Amount: $ 188,048	Year 4 Estimated Outcome Amount: $ 195,570	Year 5 Estimated Outcome Amount: $ 442,945
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*:* $ 905,543			

Title of Outcome Measure (Improvement Target): OD-12 Primary Care and Primary Prevention

Unique RHP outcome identification number(s): 111810101.3.2

Performing Provider Name/TPI: UTHealth, UTPhysicians/111810101

Outcome Measure Description:

IT-12.1 Breast Cancer Screening (HEDIS 2012) (Non-standalone measure)

Numerator: Number of women aged 40 to 69 that have received an annual mammogram during the reporting period. Denominator: Number of women aged 40 to 69 in the patient or target population. Women who have had a bilateral mastectomy are excluded.

Process Milestones:

- DY2:
  - P-1 Project planning - engage stakeholders, identify current capacity and needed resources,
  - determine timelines and document implementation plans
- DY3:
  - P-3 Develop and test data systems
  - P-2 Establish baseline rates

Outcome Improvement Targets for each year:

DY4:

IT-12.1 Increase by 3% the percentage of women patients of UT Physicians aged 40 to 69 that have received an annual mammogram during the reporting period. Women who have had a bilateral mastectomy are excluded.

DY5:

IT-12.1 Increase by 5% the percentage of women patients of UT Physicians aged 40 to 69 that have received an annual mammogram during the reporting period. Women who have had a bilateral mastectomy are excluded.

Rationale:

By increasing primary care capacity, preventative care and recommended screenings to detect cancer early would be available to more people in the community. By screening for early stages of disease before symptoms occur, patients testing positive can receive appropriate follow-up diagnostic tests, treatment, and follow-up. Early detection may reduce the impact of cancer when treatment may be easier and more effective than for an advanced cancer diagnosis in terms of the disease burden, harm and cost. Along with additional physicians to see patients for primary care, the extended hours would make it more convenient for patients to get these early screening tests.

Outcome Measure Valuation:

Using the same project valuation scores assigned to the projects, the dollars allotted for each year were distributed across the projects' related Category 3 measures. For demonstration year 2 the amount was 5%, and for DYs 3, 4, and 5, the proportion of the funds allotted were 10%, 10%, and 20%, respectively.

111810101.3.2	*3.IT-12.1*	*Breast Cancer Screening (HEDIS 2012) (Non-standalone measure)*	
UTHealth, UTPhysicians			*111810101*
Related Category 1 or 2 Projects:	*111810101.1.1*		
Starting Point/Baseline:	*To be determined during DY3.*		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Project reports and documents Process Milestone 1 Estimated Incentive Payment*:* $ 78,980	Process Milestone 2 [P-2]: Establish baseline rates Data Source: Provider reports Process Milestone 2 Estimated Incentive Payment: $ 94,024 Process Milestone 3 [P-3]: Develop and test data systems Data Source: Project reports, EMR, claims Process Milestone 3 Estimated Incentive Payment: $ 94,024	Outcome Improvement Target 1 [IT-12.1]: Increase by 3% the percentage of women patients of UT Physicians aged 40 to 69 that have received an annual mammogram during the reporting period. Women who have had a bilateral mastectomy are excluded. Data Source: EHR, Claims Outcome Improvement Target 1 Estimated Incentive Payment*:* $ 195,570	Outcome Improvement Target 2 [IT-12.1]: Increase by 5% the percentage of women patients of UT Physicians aged 40 to 69 that have received an annual mammogram during the reporting period. Women who have had a bilateral mastectomy are excluded. Data Source: EHR, Claims Outcome Improvement Target 2 Estimated Incentive Payment*:* $ 442,945
Year 2 Estimated Outcome Amount: $ 78,980	Year 3 Estimated Outcome Amount: $ 188,048	Year 4 Estimated Outcome Amount: $ 195,570	Year 5 Estimated Outcome Amount: $ 442,945
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*:* $ 905,543			

Title of Outcome Measure (Improvement Target): OD-12 Primary Care and Primary Prevention

Unique RHP outcome identification number(s): 111810101.3.3

Performing Provider Name/TPI: UTHealth, UTPhysicians/111810101

Outcome Measure Description:

IT-12.3 Colorectal Cancer Screening (HEDIS 2012) (Non-standalone measure)

Numerator: Number of adults aged 50 to 75 that have received one of the following screenings. Fecal occult blood test yearly, Flexible sigmoidoscopy every five years, Colonoscopy every 10 years

Denominator: Number of adults aged 50 to 75 in the patient or target population. Adults with colorectal cancer or total colectomy are excluded.

Process Milestones:

- DY2:
  - P-1 Project planning - engage stakeholders, identify current capacity and needed resources,
  - determine timelines and document implementation plans
- DY3:
  - P-3 Develop and test data systems
  - P-2 Establish baseline rates

Outcome Improvement Targets for each year:

DY4:

IT-12.3 Increase by 3% the percentage of adult patients of UT Physicians (established and new patients) aged 50 to 75 that have received one of the following screenings: Fecal occult blood test yearly, Flexible sigmoidoscopy every five years, Colonoscopy every 10 years. Adults with colorectal cancer or total colectomy are excluded.

DY5:

IT-12.3 Increase by 5% the percentage of adult patients of UT Physicians (established and new patients) aged 50 to 75 that have received one of the following screenings: Fecal occult blood test yearly, Flexible sigmoidoscopy every five years, Colonoscopy every 10 years. Adults with colorectal cancer or total colectomy are excluded.

Rationale:

By increasing primary care capacity, preventative care and recommended screenings to detect cancer early would be available to more people in the community. By screening for early stages of disease before symptoms occur, patients testing positive can receive appropriate follow-up diagnostic tests, treatment, and follow-up. Early detection may reduce the impact of cancer when treatment may be easier and more effective than for an advanced cancer diagnosis in terms of the disease burden, harm and cost. Along with additional physicians to see patients for primary care, the extended hours would make it more convenient for patients to get these early screening tests.

Outcome Measure Valuation:

Using the same project valuation scores assigned to the projects, the dollars allotted for each year were distributed across the projects' related Category 3 measures. For demonstration year 2 the amount was 5%, and for DYs 3, 4, and 5, the proportion of the funds allotted were 10%, 10%, and 20%, respectively.

111810101.3.3	*3.IT-12.3*	*Colorectal Cancer Screening (HEDIS 2012) (Non-standalone measure)*	
UTHealth, UTPhysicians			*111810101*
Related Category 1 or 2 Projects:	*111810101.1.1*		
Starting Point/Baseline:	*To be determined during DY3.*		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Project reports and documents Process Milestone 1 Estimated Incentive Payment*:* $ 78,980	Process Milestone 2 [P-2]: Establish baseline rates Data Source: Provider reports Process Milestone 2 Estimated Incentive Payment: $ 94,024 Process Milestone 3 [P-3]: Develop and test data systems Data Source: Project reports, EMR, claims Process Milestone 3 Estimated Incentive Payment: $ 94,024	Outcome Improvement Target 1 [IT-12.3]: Increase by 3% the percentage of adult patients of UT Physicians (established and new patients) aged 50 to 75 that have received one of the following screenings: Fecal occult blood test yearly, Flexible sigmoidoscopy every five years, Colonoscopy every 10 years. Adults with colorectal cancer or total colectomy are excluded. Data Source: EHR, Claims Outcome Improvement Target 1 Estimated Incentive Payment*:* $ 195,570	Outcome Improvement Target 2 [IT-12.3]: Increase by 5% the percentage of adult patients of UT Physicians (established and new patients) aged 50 to 75 that have received one of the following screenings: Fecal occult blood test yearly, Flexible sigmoidoscopy every five years, Colonoscopy every 10 years. Adults with colorectal cancer or total colectomy are excluded. Data Source: EHR, Claims Outcome Improvement Target 2 Estimated Incentive Payment*:* $ 421,228
Year 2 Estimated Outcome Amount: $ 78,980	Year 3 Estimated Outcome Amount: $ 188,048	Year 4 Estimated Outcome Amount: $ 195,570	Year 5 Estimated Outcome Amount: $ 442,945
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*:* $ 905,543			

<u>Title of Outcome Measure (Improvement Target)</u>: OD-14 Workforce Development

<u>Unique RHP outcome identification number(s)</u>: 111810101.3.4
<u>Performing Provider Name/TPI:</u> UTHealth, UTPhysicians/111810101

<u>Outcome Measure Description:</u>
IT – 14.6 Percent of trainees who have spent at least 5 years living in a health professional shortage area (HPSA) or medically underserved area (MUA)

Process Milestones:
DY2:
P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
DY3:
P-3 Develop and test data systems
P-2 Establish baseline rates

Outcome Improvement Targets for each year:
DY4: Increase by 3% over baseline the percent of trainees who have spent at least 5 years living in a health professional shortage area (HPSA) or medically underserved area (MUA)
DY5: Increase by 5% over baseline the percent of trainees who have spent at least 5 years living in a health professional shortage area (HPSA) or medically underserved area (MUA)

Rationale:
In order to move closer to a well-functioning health care delivery system, providers must have training that prepares them for the coordinated, outcomes- and evidence-based health care systems they will be entering. A recent nation-wide study conducted with medical students found that students felt their training was appropriate in terms of clinical decision making and clinical care, but felt that their training had not prepared them appropriately for practicing medicine (Patel MS, Davis MM, Lypson ML. Medical Student Perceptions of Education in Health Care Systems. September, 2009. Academic Medicine, 84(9):1301-6).
By training residents in the new primary care in continuity care clinics located in HPSAs or MUAs, it is expected that more of them will continue to practice in these areas.

Outcome Measure Valuation:
Using the same project valuation scores assigned to the projects, the dollars allotted for each year were distributed across the projects' related Category 3 measures. For demonstration year 2 the amount was 5%, and for DYs 3, 4, and 5, the proportion of the funds allotted were 10%, 10%, and 20%, respectively.

111810101.3.4	*3.IT-14.6*	*Percent of trainees who have spent at least 5 years living in a health professional shortage area (HPSA) or medically underserved area (MUA)*	
UTHealth, UTPhysicians			*111810101*
Related Category 1 or 2 Projects:	*111810101.1.2*		
Starting Point/Baseline:	*To be determined during DY3.*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Project reports and documents Process Milestone 1 Estimated Incentive Payment: $ 29,408	Process Milestone 2 [P-2]: Establish baseline rates Data Source: Provider reports Process Milestone 2 Estimated Incentive Payment: $ 35,009 Process Milestone 3 [P-3]: Develop and test data systems Data Source: Project reports, EMR, claims Process Milestone 3 Estimated Incentive Payment: $ 35,009	Outcome Improvement Target 1[IT–14. 6]: Increase by 3% over baseline the percent of trainees who have spent at least 5 years living in a health professional shortage area (HPSA) or medically underserved area (MUA) Outcome Improvement Target 1 Estimated Incentive Payment: $ 72,819	Outcome Improvement Target 2 [IT–14. 6]: Increase by 5% over baseline the percent of trainees who have spent at least 5 years living in a health professional shortage area (HPSA) or medically underserved area (MUA) Outcome Improvement Target 2 Estimated Incentive Payment: $ 164,079
Year 2 Estimated Outcome Amount: $ 29,408	Year 3 Estimated Outcome Amount: $ 70,018	Year 4 Estimated Outcome Amount: $ 72,819	Year 5 Estimated Outcome Amount: $ 164,079
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $ 336,324			

<u>Title of Outcome Measure (Improvement Target)</u>: OD-14 Workforce Development

<u>Unique RHP outcome identification number(s)</u>: 111810101.3.5
<u>Performing Provider Name/TPI:</u> UTHealth, UTPhysicians/111810101

<u>Outcome Measure Description:</u>
IT – 14. 7 Percent of trainees who report that they plan to practice in HPSAs or MUAs based on a systematic survey

Process Milestones:
DY2:
P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
DY3:
P-3 Develop and test data systems
P-2 Establish baseline rates

Outcome Improvement Targets for each year:
DY4: Increase by 3% over baseline the percent of trainees who report that they plan to practice in HPSAs or MUAs based on a systematic survey
DY5: Increase by 5% over baseline the percent of trainees who report that they plan to practice in HPSAs or MUAs based on a systematic survey

Rationale:

In order to move closer to a well-functioning health care delivery system, providers must have training that prepares them for the coordinated, outcomes- and evidence-based health care systems they will be entering. A recent nation-wide study conducted with medical students found that students felt their training was appropriate in terms of clinical decision making and clinical care, but felt that their training had not prepared them appropriately for practicing medicine (Patel MS, Davis MM, Lypson ML. Medical Student Perceptions of Education in Health Care Systems. September, 2009. Academic Medicine, 84(9):1301-6).

By training residents in the new primary care in continuity care clinics located in HPSAs or MUAs, it is expected that more of them will continue to practice in these areas.

Outcome Measure Valuation:

Using the same project valuation scores assigned to the projects, the dollars allotted for each year were distributed across the projects' related Category 3 measures. For demonstration year 2 the amount was 5%, and for DYs 3, 4, and 5, the proportion of the funds allotted were 10%, 10%, and 20%, respectively.

111810101.3.5	*3.IT-14.7*	*Percent of trainees who report that they plan to practice in HPSAs or MUAs based on a systematic survey*	
UTHealth, UTPhysicians			*111810101*
Related Category 1 or 2 Projects:	*111810101.1.2*		
Starting Point/Baseline:	*To be determined during DY3.*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Project reports and documents Process Milestone 1 Estimated Incentive Payment: $ 29,408	Process Milestone 2 [P-2]: Establish baseline rates Data Source: Provider reports Process Milestone 2 Estimated Incentive Payment: $ 35,009 Process Milestone 3 [P-3]: Develop and test data systems Data Source: Project reports, EMR, claims Process Milestone 3 Estimated Incentive Payment: $ 35,009	Outcome Improvement Target 1 [IT–14. 7]: Increase by 3% over baseline the percent of trainees who report that they plan to practice in HPSAs or MUAs based on a systematic survey Outcome Improvement Target 1 Estimated Incentive Payment: $ 72,819	Outcome Improvement Target 2 [IT–14. 7]: Increase by 5% over baseline the percent of trainees who report that they plan to practice in HPSAs or MUAs based on a systematic survey Outcome Improvement Target 2 Estimated Incentive Payment: $ 164,079
Year 2 Estimated Outcome Amount: $ 29,408	Year 3 Estimated Outcome Amount: $ 70,018	Year 4 Estimated Outcome Amount: $ 72,819	Year 5 Estimated Outcome Amount: $ 164,079
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $ 336,324			

Title of Outcome Measure (Improvement Target): OD-14 Workforce Development

Unique RHP outcome identification number(s): 111810101.3.5
Performing Provider Name/TPI: UTHealth, UTPhysicians/111810101

Outcome Measure Description:
IT – 14. 8 Percent of trainees who report that they plan to serve Medicaid populations based on a systematic survey

Process Milestones:
DY2:
P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
DY3:
P-3 Develop and test data systems
P-2 Establish baseline rates

Outcome Improvement Targets for each year:
DY4: Increase by 3% over baseline the percent of trainees who report that they plan to serve Medicaid populations based on a systematic survey
DY5: Increase by 5% over baseline the percent of trainees who report that they plan to serve Medicaid populations based on a systematic survey

Rationale:
In order to move closer to a well-functioning health care delivery system, providers must have training that prepares them for the coordinated, outcomes- and evidence-based health care systems they will be entering. A recent nation-wide study conducted with medical students found that students felt their training was appropriate in terms of clinical decision making and clinical care, but felt that their training had not prepared them appropriately for practicing medicine (Patel MS, Davis MM, Lypson ML. Medical Student Perceptions of Education in Health Care Systems. September, 2009. Academic Medicine, 84(9):1301-6).
By training residents in the new primary care in continuity care clinics located in HPSAs or MUAs, it is expected that more of them will continue to practice in these areas.

Outcome Measure Valuation:
Using the same project valuation scores assigned to the projects, the dollars allotted for each year were distributed across the projects' related Category 3 measures. For demonstration year 2 the amount was 5%, and for DYs 3, 4, and 5, the proportion of the funds allotted were 10%, 10%, and 20%, respectively.

111810101.3.5	*3.IT-14.8*	*Percent of trainees who report that they plan to serve Medicaid populations based on a systematic survey*	
UTHealth, UTPhysicians			*111810101*
Related Category 1 or 2 Projects:	*111810101.1.2*		
Starting Point/Baseline:	*To be determined during DY3.*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Project reports and documents Process Milestone 1 Estimated Incentive Payment: $ 29,407	Process Milestone 2 [P-2]: Establish baseline rates Data Source: Provider reports Process Milestone 2 Estimated Incentive Payment: $ 35,009 Process Milestone 3 [P-3]: Develop and test data systems Data Source: Project reports, EMR, claims Process Milestone 3 Estimated Incentive Payment: $ 35,009	Outcome Improvement Target 1 [IT–14. 8]: Increase by 3% over baseline the percent of trainees who report that they plan to serve Medicaid populations based on a systematic survey Outcome Improvement Target 1 Estimated Incentive Payment: $ 72,818	Outcome Improvement Target 2 [IT–14. 8]: Increase by 3% over baseline the percent of trainees who report that they plan to serve Medicaid populations based on a systematic survey Outcome Improvement Target 2 Estimated Incentive Payment: $ 164,079
Year 2 Estimated Outcome Amount: $ 29,407	Year 3 Estimated Outcome Amount: $ 70,018	Year 4 Estimated Outcome Amount: $ 72,818	Year 5 Estimated Outcome Amount: $ 164,079
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $ 336,322			

Title of Outcome Measure (Improvement Target): OD-11 Addressing Health Disparities in Minority Populations

Unique RHP outcome identification number(s): 111810101.3.7
Performing Provider Name/TPI: UTHealth, UTPhysicians/111810101

Outcome Measure Description:
IT-11.5 (IT-2.10) Select any other Category 3 outcome (PPAs, PPRs, or ED utilization) or a combination of non-standalone measures and target a specific minority population with a demonstrated disparity in the particular measure (Standalone measure) (IT-2.10 Flu and pneumonia Admission Rate)
For the Hispanic population:
Numerator: All discharges of age 18 years and older with a principal diagnosis code of flu or pneumonia.
Denominator: Population in Metro Area or county, age 18 years and older.

Process Milestones:
DY2:
P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
DY3:
P-3 Develop and test data systems
P-2 Establish baseline rates

Outcome Improvement Targets for each year:
DY4:
IT-11.5 (IT-2.10) Reduce by 3% the percentage of all discharges of Hispanics age 18 years and older with a principal diagnosis code of flu or pneumonia, who are patients of UT Physicians.
DY5:
IT-11.5 (IT-2.10) Reduce by 5% the percentage of all discharges of Hispanics age 18 years and older with a principal diagnosis code of flu or pneumonia, who are patients of UT Physicians.

Rationale:
Hispanics have a high rate of death from influenza and pneumonia (2009 CDC, Minority Health. http://www.cdc.gov/minorityhealth/populations/REMP/hispanic.html#10). Harris County and the UT Physician service areas have considerably more Hispanics (Harris County-40.8%; Bayshore-49.2%; Bellair-46%; Cinco Ranch-26.2%; Sienna Village-23.5%) than the national average (16.3%). (Population race/ethnicity statistics are from the U.S. Census Bureau, 2010 Census Summary File 1, Tables P8, PCT4, PCT5, and PCT8. Note: Derived from 2010 Census Summary File 1 data by the Texas State Data Center.) The delivery of culturally sensitive care is more likely to increase the adoption of preventive services such as influenza vaccinations among Hispanics. CHWs have been proven to be effective in serving as linkages between patients and the health system, helping patients to navigate the daunting challenges posed by the fragmented nature of health care delivery on the US. Most CHWs come from the local population, are in touch with the community, hence they are able to aid the health system to deliver culturally sensitive care, and by so doing will help address health disparities in minority populations.

Therefore, a reduction in admissions for flu and pneumonia for the Hispanic population served UT Physicians would be an appropriate measure for the success of this program.

Outcome Measure Valuation:

Using the same project valuation scores assigned to the projects, the dollars allotted for each year were distributed across the projects' related Category 3 measures. For demonstration year 2 the amount was 5%, and for DYs 3, 4, and 5, the proportion of the funds allotted were 10%, 10%, and 20%, respectively.

111810101.3.7	*3.IT-11.5 (IT-2.10)*	*Select any other Category 3 outcome (PPAs, PPRs, or ED utilization) or a combination of non-standalone measures and target a specific minority population with a demonstrated disparity in the particular measure (Standalone measure) (IT-2.10 Flu and pneumonia Admission Rate)*	
UTHealth, UTPhysicians			*111810101*
Related Category 1 or 2 Projects:	*111810101.1.3*		
Starting Point/Baseline:	*To be determined during DY3.*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Project reports and documents Process Milestone 1 Estimated Incentive Payment*:* $ 136,115	Process Milestone 2 [P-2]: Establish baseline rates Data Source: Provider reports Process Milestone 2 Estimated Incentive Payment: $ 162,041 Process Milestone 3 [P-3]: Develop and test data systems Data Source: Project reports, EMR, claims Process Milestone 3 Estimated Incentive Payment: $ 162,042	Outcome Improvement Target 1 [IT-11.5 (IT-2.10)]: Reduce by 3% the percentage of all discharges of Hispanics age 18 years and older with a principal diagnosis code of flu or pneumonia, who are patients of UT Physicians. Data Source: EMR, Claims Outcome Improvement Target 1 Estimated Incentive Payment*:* $ 337,046	Outcome Improvement Target 2 [IT-11.5 (IT-2.10)]: Reduce by 5% the percentage of all discharges of Hispanics age 18 years and older with a principal diagnosis code of flu or pneumonia, who are patients of UT Physicians. Data Source: EMR, Claims Outcome Improvement Target 2 Estimated Incentive Payment*:* $ 747,663
Year 2 Estimated Outcome Amount: $ 136,115	Year 3 Estimated Outcome Amount: $ 324,083	Year 4 Estimated Outcome Amount: $ 337,046	Year 5 Estimated Outcome Amount: $ 747,663
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*:* $ 1,544,907			

<u>Title of Outcome Measure (Improvement Target)</u>: OD-1 Primary Care and Chronic Disease Management
<u>Unique RHP outcome identification number(s)</u>: 111810101.3.6
<u>Performing Provider Name/TPI:</u> UTHealth, UTPhysicians/111810101

<u>Outcome Measure Description:</u>
IT-1.7 Controlling high blood pressure (NCQA-HEDIS 2012, NQF 0018)12 (Stand-alone measure)

Improve the number of patients 18 to 85 years of age with a diagnosis of hypertension,whose most recent blood pressure (BP) is adequately controlled (BP less than 140/90 mm Hg) during the measurement year.

Process Milestones:
DY2:
P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
DY3:
P-3 Develop and test data systems
P-2 Establish baseline rates

Outcome Improvement Targets for each year:
DY4:
IT-1.7 Improve by 3% the percentage of UT Physician's patients (ages 18 to 85 years) with a diagnosis of hypertension, whose most recent blood pressure (BP) is adequately controlled (BP less than 140/90 mm Hg) during the measurement year.
DY5:
IT-1.7 Improve by 5% the percentage of UT Physician's patients (ages 18 to 85 years) with a diagnosis of hypertension, whose most recent blood pressure (BP) is adequately controlled (BP less than 140/90 mm Hg) during the measurement year.

<u>Rationale:</u>
Effective control of blood pressure significantly decreases the risk of coronary artery disease, congestive heart failure, and stroke in hypertensive pateints. For instance a 12-point to 13-point reduction in blood pressure can lower the risk of heart attack by 21%, stroke by 37%, and total cardiovascular deaths by 25% (Rein DB, Constantine RT, Orenstein D, Chen H, Jones P, Brownstein JN, et al. A cost evaluation of the Georgia Stroke and Heart Attack Prevention Program. Prev Chronic Dis [serial online] 2006). Use of the chronic disease registry will enable care teams to more closely monitor patients with hypertension and enable them to provide better care, which is expected to leading to better blood pressure control among our hypertensive patients.

<u>Outcome Measure Valuation:</u>

Using the same project valuation scores assigned to the projects, the dollars allotted for each year were distributed across the projects' related Category 3 measures. For demonstration year 2 the amount was 5%, and for DYs 3, 4, and 5, the proportion of the funds allotted were 10%, 10%, and 20%, respectively.

111810101.3.6	*3.IT-1.7*	*Controlling high blood pressure (NCQA-HEDIS 2012, NQF 0018)12 (Stand-alone measure)*	
UTHealth, UTPhysicians			*111810101*
Related Category 1 or 2 Projects:	*111810101.1.4*		
Starting Point/Baseline:	*To be determined during DY3.*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Project reports and documents Process Milestone 1 Estimated Incentive Payment: $ 95,785	Process Milestone 2 [P-2]: Establish baseline rates Data Source: Provider reports Process Milestone 2 Estimated Incentive Payment: $ 114,029 Process Milestone 3 [P-3]: Develop and test data systems Data Source: Project reports, EMR, claims Process Milestone 3 Estimated Incentive Payment: $ 114,029	Outcome Improvement Target 1 [IT-1.7]: Improve by 3% the percentage of UT Physician's patients (ages 18 to 85 years) with a diagnosis of hypertension, whose most recent blood pressure (BP) is adequately controlled (BP less than 140/90 mm Hg) during the measurement year. Data Source: EMR, Registry Outcome Improvement Target 1 Estimated Incentive Payment: $ 237,180	Outcome Improvement Target 2 [IT-1.7]: Improve by 5% the percentage of UT Physician's patients (ages 18 to 85 years) with a diagnosis of hypertension, whose most recent blood pressure (BP) is adequately controlled (BP less than 140/90 mm Hg) during the measurement year. Data Source: EMR, Registry Outcome Improvement Target 2 Estimated Incentive Payment: $ 532,568
Year 2 Estimated Outcome Amount: $ 95,785	Year 3 Estimated Outcome Amount: $ 228,058	Year 4 Estimated Outcome Amount: $ 237,180	Year 5 Estimated Outcome Amount: $ 532,568
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $ 1,093,591			

Title of Outcome Measure (Improvement Target): OD-2 Potentially Preventable Admissions

Unique RHP outcome identification number(s): 111810101.3.9
Performing Provider Name/TPI: UTHealth, UTPhysicians/111810101

Outcome Measure Description:
IT-2.11 Ambulatory Care Sensitive Conditions Admissions Rate: (Standalone measure)
Numerator: Total number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years (including any one most responsible diagnosis code of: Grand mal status and other epileptic convulsions, Chronic obstructive pulmonary diseases, Asthma, Heart failure and pulmonary edema, Hypertension, Angina, and Diabetes). Exclusions: Individuals 75 years of age and older, or death before discharge.
Denominator: Total mid-year population under age 75

Process Milestones:
DY2:
P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
DY3:
P-3 Develop and test data systems
P-2 Establish baseline rates

Outcome Improvement Targets for each year:
DY4:
IT-2.11 Reduce by 3% the percentage of acute care hospitalizations for ambulatory care sensitive conditions (including any one most responsible diagnosis code of: Grand mal status and other epileptic convulsions, Chronic obstructive pulmonary diseases, Asthma, Heart failure and pulmonary edema, Hypertension, Angina, and Diabetes) for persons under the age 75 years. Exclusions: Individuals 75 years of age and older, or death before discharge.
DY5:
IT-2.11 Reduce by 5% the percentage of acute care hospitalizations for ambulatory care sensitive conditions (including any one most responsible diagnosis code of: Grand mal status and other epileptic convulsions, Chronic obstructive pulmonary diseases, Asthma, Heart failure and pulmonary edema, Hypertension, Angina, and Diabetes) for persons under the age 75 years. Exclusions: Individuals 75 years of age and older, or death before discharge.

Rationale:
We expect the use of the Nurse-line medical triage call center to reduce hospitalizations for ambulatory care sensitive conditions (ACSC), which is an indicator of access to appropriate primary health care. The Nurse-line will facilitate access to appropriate primary care, thereby reducing hospitalizations for ambulatory care sensitive conditions. Appropriate primary care has the potential to prevent the onset of these types of illnesses, control acute episodes, or manage a chronic disease.

Outcome Measure Valuation:

Using the same project valuation scores assigned to the projects, the dollars allotted for each year were distributed across the projects' related Category 3 measures. For demonstration year 2 the amount was 5%, and for DYs 3, 4, and 5, the proportion of the funds allotted were 10%, 10%, and 20%, respectively.

111810101.3.9	*3.IT-2.11*	*Ambulatory Care Sensitive Conditions Admissions Rate: (Standalone measure)*	
UTHealth, UTPhysicians			*111810101*
Related Category 1 or 2 Projects:	*111810101.1.5*		
Starting Point/Baseline:	*To be determined during DY3.*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Project reports and documents Process Milestone 1 Estimated Incentive Payment: $ 214,255	Process Milestone 2 [P-2]: Establish baseline rates Data Source: Provider reports Process Milestone 2 Estimated Incentive Payment: $ 255,065 Process Milestone 3 [P-3]: Develop and test data systems Data Source: Project reports, EMR, claims Process Milestone 3 Estimated Incentive Payment: $ 255,066	Outcome Improvement Target 1 [IT-2.11]: Reduce by 3% the percentage of acute care hospitalizations for ambulatory care sensitive conditions (including any one most responsible diagnosis code of: Grand mal status and other epileptic convulsions, Chronic obstructive pulmonary diseases, Asthma, Heart failure and pulmonary edema, Hypertension, Angina, and Diabetes) for persons under the age 75 years. Data Source: EHR, Claims Outcome Improvement Target 1 Estimated Incentive Payment: $ 530,536	Outcome Improvement Target 2 [IT-2.11]: Reduce by 5% the percentage of acute care hospitalizations for ambulatory care sensitive conditions (including any one most responsible diagnosis code of: Grand mal status and other epileptic convulsions, Chronic obstructive pulmonary diseases, Asthma, Heart failure and pulmonary edema, Hypertension, Angina, and Diabetes) for persons under the age 75 years. Data Source: EHR, Claims Outcome Improvement Target 2 Estimated Incentive Payment: $ 1,164,410
Year 2 Estimated Outcome Amount: $ 214,255	Year 3 Estimated Outcome Amount: $ 510,131	Year 4 Estimated Outcome Amount: $ 530,536	Year 5 Estimated Outcome Amount: $ 1,164,410
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $ 2,419,332			

Title of Outcome Measure (Improvement Target): OD-6 Patient Satisfaction

Unique RHP outcome identification number(s): 111810101.3.10
Performing Provider Name/TPI: UTHealth, UTPhysicians/111810101

Outcome Measure Description:
IT-6.1 (3) Percent improvement over baseline of patient satisfaction scores: (3) patient's rating of doctor access to specialist; (Stand-alone measure)
Percent improvement over baseline of patient satisfaction scores for one or more of the patient satisfaction domains that the provider targets for improvement in a specific tool. Certain supplemental modules for the adult CG-CAHPS survey may be used to establish if patients: (3) patient's rating of doctor access to specialist; (patients of other primary care practices that accessed the specialty care services via Telemedicine program)

Process Milestones:
DY2:
P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
DY3:
P-3 Develop and test data systems
P-2 Establish baseline rates

Outcome Improvement Targets for each year:
DY4:
IT-6.1 (3) Increase by 3% the improvement over baseline (for patients of non-UT Physician primary care practices that accessed the specialty care services via Telemedicine program) of patient satisfaction scores for patient's rating of doctor access to specialist using the adult CG-CAHPS survey module.
DY5:
IT-6.1 (3) Increase by 5% the improvement over baseline (for patients of non-UT Physician primary care practices that accessed the specialty care services via Telemedicine program) of patient satisfaction scores for patient's rating of doctor access to specialist using the adult CG-CAHPS survey module.

Rationale:
Telemedicine offers an innovative solution to the problem of poor access to specialist care. The telemedicine project will thus make it easier for patients and their primary care providers to get specialist consults in a timely manner and more convenient manner. Therefore, it is expected that patients' assessments of doctor access to specialists on the CG-CAHPS survey will be a good measure of this new telemedicine program.

Outcome Measure Valuation:
Using the same project valuation scores assigned to the projects, the dollars allotted for each year were distributed across the projects' related Category 3 measures. For demonstration year 2 the amount was 5%, and for DYs 3, 4, and 5, the proportion of the funds allotted were 10%, 10%, and 20%, respectively.

<table>
<tr><td>111810101.3.10</td><td>3.IT-6.1 (3)</td><td colspan="2">Percent improvement over baseline of patient satisfaction scores: (3) patient's rating of doctor access to specialist; (Stand-alone measure)</td></tr>
<tr><td colspan="3">UTHealth, UTPhysicians</td><td>111810101</td></tr>
<tr><td>Related Category 1 or 2 Projects:</td><td colspan="3">111810101.1.6</td></tr>
<tr><td>Starting Point/Baseline:</td><td colspan="3">To be determined during DY3.</td></tr>
<tr><th>Year 2
(10/1/2012 – 9/30/2013)</th><th>Year 3
(10/1/2013 – 9/30/2014)</th><th>Year 4
(10/1/2014 – 9/30/2015)</th><th>Year 5
(10/1/2015 – 9/30/2016)</th></tr>
<tr><td>Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources,
determine timelines and document implementation plans
Data Source: Project reports and documents

Process Milestone 1 Estimated Incentive Payment: $ 216,776</td><td>Process Milestone 2 [P-2]: Establish baseline rates
Data Source: Provider reports

Process Milestone 2 Estimated Incentive Payment: $ 258,066

Process Milestone 3 [P-3]: Develop and test data systems
Data Source: Project reports, EMR, claims

Process Milestone 3 Estimated Incentive Payment: $ 258,066</td><td>Outcome Improvement Target 1 [IT-6.1 (3)]: Increase by 3% the improvement over baseline (for patients of non-UT Physician primary care practices that accessed the specialty care services via Telemedicine program) of patient satisfaction scores for patient's rating of doctor access to specialist using the adult CG-CAHPS survey module.
Data Source: Surveys

Outcome Improvement Target 1 Estimated Incentive Payment:
$ 536,778</td><td>Outcome Improvement Target 2 [IT-6.1 (3)]: Increase by 5% the improvement over baseline (for patients of non-UT Physician primary care practices that accessed the specialty care services via Telemedicine program) of patient satisfaction scores for patient's rating of doctor access to specialist using the adult CG-CAHPS survey module.
Data Source: Surveys

Outcome Improvement Target 2 Estimated Incentive Payment:
$ 1,177,853</td></tr>
<tr><td>Year 2 Estimated Outcome Amount:
$ 216,776</td><td>Year 3 Estimated Outcome Amount:
$ 516,132</td><td>Year 4 Estimated Outcome Amount:
$ 536,778</td><td>Year 5 Estimated Outcome Amount:
$ 1,177,853</td></tr>
<tr><td colspan="4">TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $ 2,447,539</td></tr>
</table>

Title of Outcome Measure (Improvement Target): OD-1 Primary Care and Chronic Disease Management

Unique RHP outcome identification number(s): 111810101.3.11
Performing Provider Name/TPI: UTHealth, UTPhysicians/111810101

Outcome Measure Description:
IT-1.1 Third next available appointment (Non- standalone measure)
Reduce the average length of time in days between the day a patient makes a request for an appointment with a physician and the third available appointment for a new patient, or return visit/exam. The goals will be to decrease number of days to third next available appointment to two days for Specialty Care.

Process Milestones:
DY2:
P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
DY3:
P-3 Develop and test data systems
P-2 Establish baseline rates

Outcome Improvement Targets for each year:
DY4:
IT-1.1 Reduce by 1 day over baseline the average length of time in days between the day a patient makes a request for an appointment with a physician and the third next available appointment for a new patient, or return visit/exam. The goal will be to decrease number of days to third next available appointment to two days for Specialty Care.
DY5:
IT-1.1 Reduce by 2 day over baseline the average length of time in days between the day a patient makes a request for an appointment with a physician and the third next available appointment for a new patient, or return visit/exam. The goal will be to decrease number of days to third next available appointment to two days for Specialty Care.

Rationale:
Access to care services can have an impact on healthcare outcomes, by providing early screening and treatment and patients are more likely to get these services when they are able to get appointments when first needed that accomodate their schedule. Since the goal of the project is to increase access to care and the third next available appointment is the healthcare industry's standard measure of access to care, we have chosen this outcome measure.

Outcome Measure Valuation:
Using the same project valuation scores assigned to the projects, the dollars allotted for each year were distributed across the projects' related Category 3 measures. For demonstration year 2 the amount was 5%, and for DYs 3, 4, and 5, the proportion of the funds allotted were 10%, 10%, and 20%, respectively.

111810101.3.11	*3.IT-1.1*	*Third next available appointment (Non- standalone measure)*	
UTHealth, UTPhysicians			*111810101*
Related Category 1 or 2 Projects:	*111810101.1.7*		
Starting Point/Baseline:	*To be determined during DY3.*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Project reports and documents Process Milestone 1 Estimated Incentive Payment: $ 114,689	Process Milestone 2 [P-2]: Establish baseline rates Data Source: Provider reports Process Milestone 2 Estimated Incentive Payment: $ 136,535 Process Milestone 3 [P-3]: Develop and test data systems Data Source: Project reports, EMR, claims Process Milestone 3 Estimated Incentive Payment: $ 136,535	Outcome Improvement Target 1 [IT-1.1]: Reduce by 1 day over baseline the average length of time in days between the day a patient makes a request for an appointment with a physician and the third next available appointment for a new patient, or return visit/exam. The goal will be to decrease number of days to third next available appointment to two days for Specialty Care. Data Source: Appointment management system Outcome Improvement Target 1 Estimated Incentive Payment: $ 283,993	Outcome Improvement Target 2 [IT-1.1]: Reduce by 2 day over baseline the average length of time in days between the day a patient makes a request for an appointment with a physician and the third next available appointment for a new patient, or return visit/exam. The goal will be to decrease number of days to third next available appointment to two days for Specialty Care. Data Source: Appointment management system Outcome Improvement Target 2 Estimated Incentive Payment: $ 611,677
Year 2 Estimated Outcome Amount: $ 114,689	Year 3 Estimated Outcome Amount: $ 273,070	Year 4 Estimated Outcome Amount: $ 283,993	Year 5 Estimated Outcome Amount: $ 611,677
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $ 1,283,429			

Title of Outcome Measure (Improvement Target): OD-1 Primary Care and Chronic Disease Management

Unique RHP outcome identification number(s): 111810101.3.12

Performing Provider Name/TPI: UTHealth, UTPhysicians/111810101

Outcome Measure Description:

IT-1.6 Cholesterol management for patients with cardiovascular conditions (NCQA-HEDIS 2012) (Standalone measure)

Increase the number of patients who had each of the following during the reporting period:

Low-density Lipoprotein Cholesterol (LDL-C) Screening: An LDL-C test performed during the measurement year.

LDL-C Level Less Than 100 mg/dL: The most recent LDL-C level during the measurement year is less than 100 mg/dL.

Process Milestones:

- DY2:
  - P-1 Project planning - engage stakeholders, identify current capacity and needed resources,
  - determine timelines and document implementation plans
- DY3:
  - P-3 Develop and test data systems
  - P-2 Establish baseline rates

Outcome Improvement Targets for each year:

DY4:

Increase by 3% the percentage of patients who had each of the following during the reporting period:

Low-density Lipoprotein Cholesterol (LDL-C) Screening (performed during the measurement year) and LDL-C Level <100 mg/dL (the most recent during the measurement year)

DY5:

Increase by 5% the percentage of patients who had each of the following during the reporting period:

Low-density Lipoprotein Cholesterol (LDL-C) Screening (performed during the measurement year) and LDL-C Level <100 mg/dL (the most recent during the measurement year)

Rationale:

By increasing access to specialty care, such as the expansion of cardiology care to UT Physicians primary care clinics, we expect that patients at risk for coronary artery disease (CAD) and coronary heart disease (CHD), heart attack, and stroke, are more likely to get the cholesterol screening that would facilitate appropriate care. Working together with patients with known heart disease to reduce cholesterol has the potential to reduce morbidity (heart attack and stroke) and mortality. Using established guidelines (National Cholesterol Education Program) for managing cholesterol levels in patients with heart disease, we would aim to see a reduction in LDL-C of less than or equal to 100 mg/dL.

Outcome Measure Valuation:

Using the same project valuation scores assigned to the projects, the dollars allotted for each year were distributed across the projects' related Category 3 measures. For demonstration year 2 the amount was 5%, and for DYs 3, 4, and 5, the proportion of the funds allotted were 10%, 10%, and 20%, respectively.

111810101.3.12	*3.IT-1.6*	*Cholesterol management for patients with cardiovascular conditions (NCQA-HEDIS 2012) (Standalone measure)*	
UTHealth, UTPhysicians			*111810101*
Related Category 1 or 2 Projects:	*111810101.1.7*		
Starting Point/Baseline:	*To be determined during DY3.*		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Project reports and documents Process Milestone 1 Estimated Incentive Payment*:* $ 114,689	Process Milestone 2 [P-2]: Establish baseline rates Data Source: Provider reports Process Milestone 2 Estimated Incentive Payment: $ 136,535 Process Milestone 3 [P-3]: Develop and test data systems Data Source: Project reports, EMR, claims Process Milestone 3 Estimated Incentive Payment: $ 136,535	Outcome Improvement Target 1 [IT-1.6]: Increase by 3% the percentage of patients who had each of the following during the reporting period: Low-density Lipoprotein Cholesterol (LDL-C) Screening (performed during the measurement year) and LDL-C Level <100 mg/dL (the most recent during the measurement year) Data Source: EMR, Claim Outcome Improvement Target 1 Estimated Incentive Payment*:* $ 283,993	Outcome Improvement Target 2 [IT-1.6]: Increase by 5% the percentage of patients who had each of the following during the reporting period: Low-density Lipoprotein Cholesterol (LDL-C) Screening (performed during the measurement year) and LDL-C Level <100 mg/dL (the most recent during the measurement year) Data Source: EMR, Claim Outcome Improvement Target 2 Estimated Incentive Payment*:* $ 611,677
Year 2 Estimated Outcome Amount: $ 114,689	Year 3 Estimated Outcome Amount: $ 273,070	Year 4 Estimated Outcome Amount: $ 283,993	Year 5 Estimated Outcome Amount: $ 611,677
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*:* $ 1,283,429			

Title of Outcome Measure (Improvement Target): OD-4 Potentially Preventable Complications and Healthcare Acquired Conditions

Unique RHP outcome identification number(s): 111810101.3.13
Performing Provider Name/TPI: UTHealth, UTPhysicians/111810101

Outcome Measure Description:
IT-4.8 Sepsis mortality (Standalone measure)
Reduce the percentage of patients expiring during current month hospitalization with sepsis, severe sepsis or septic shock and/or an infection and organ dysfunction.

Process Milestones:
DY2:
P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
DY3:
P-3 Develop and test data systems
P-2 Establish baseline rates

Outcome Improvement Targets for each year:
DY4:
IT-4.8 Reduce by 3% the percentage of patients expiring during current month hospitalization with sepsis, severe sepsis, or septic shock and/or an infection and organ dysfunction.
DY5:
IT-4.8 Reduce by 5% the percentage of patients expiring during current month hospitalization with sepsis, severe sepsis, or septic shock and/or an infection and organ dysfunction.

Rationale:
Sepsis is one of the leading causes of death in the intensive care unit (ICU) (Bone RC, Balk RA, Cerra FB, Dellinger RP, Fein AM, Knaus WA, et al. Definitions for sepsis and organ failure and guidelines for the use of innovative therapies in sepsis. Chest 1992; 101:1644-55). The number of severe sepsis cases is set to grow at a rate of 1.5% per annum, adding an additional 1 million cases per year in the USA by 2020 (Angus DC, Linde-Zwirble WT, Lidicker J, Clermont G, Carcillo J, Pinsky MR. Epidemiology of severe sepsis in the United States: analysis of incidence, outcome, and associated costs of care. Crit Care Med. 2001 Jul;29(7):1303-10), mainly due to the growing use of invasive procedures and increasing numbers of elderly and high-risk individuals, such as cancer and HIV patients. Sepsis from invaisve procedures can be highly reduced by greater adherence to guidelines and by addressing systemic factors that lead to breach of aseptic standards. By improving health care quality, this project will lead to reduction in hospital acquired conditions such as sepsis.

Outcome Measure Valuation:
Using the same project valuation scores assigned to the projects, the dollars allotted for each year were distributed across the projects' related Category 3 measures. For demonstration year 2 the amount was 5%, and for DYs 3, 4, and 5, the proportion of the funds allotted were 10%, 10%, and 20%, respectively.

111810101.3.13	*3.IT-4.8*	*Sepsis mortality (Standalone measure)*	
UTHealth, UTPhysicians			*111810101*
Related Category 1 or 2 Projects:	*111810101.1.8*		
Starting Point/Baseline:	*To be determined during DY3.*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Project reports and documents Process Milestone 1 Estimated Incentive Payment: $ 95,785	Process Milestone 2 [P-2]: Establish baseline rates Data Source: Provider reports Process Milestone 2 Estimated Incentive Payment: $ 114,029 Process Milestone 3 [P-3]: Develop and test data systems Data Source: Project reports, EMR, claims Process Milestone 3 Estimated Incentive Payment: $ 114,029	Outcome Improvement Target 1 [IT-4.8]: Reduce by 3% the percentage of patients expiring during current month hospitalization with sepsis, severe sepsis, or septic shock and/or an infection and organ dysfunction. Data Source: Memorial Hermann Hospital-TMC data Outcome Improvement Target 1 Estimated Incentive Payment: $ 237,181	Outcome Improvement Target 2 [IT-4.8]: Reduce by 5% the percentage of patients expiring during current month hospitalization with sepsis, severe sepsis, or septic shock and/or an infection and organ dysfunction. Data Source: Memorial Hermann Hospital-TMC data Outcome Improvement Target 2 Estimated Incentive Payment: $ 510,851
Year 2 Estimated Outcome Amount: $ 95,785	Year 3 Estimated Outcome Amount: $ 228,058	Year 4 Estimated Outcome Amount: $ 237,181	Year 5 Estimated Outcome Amount: $ 510,851
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $ 1,071,875			

Title of Outcome Measure (Improvement Target): OD-6 Patient Satisfaction

Unique RHP outcome identification number(s): 111810101.3.14
Performing Provider Name/TPI: UTHealth, UTPhysicians/111810101

Outcome Measure Description:
IT-6.1 (1) Percent improvement over baseline of patient satisfaction scores (1) are getting timely care, appointments, and information (stand alone measure)
Percent improvement over baseline of patient satisfaction scores (all questions within a survey need to be answered to be a stand-alone measure). Percent improvement over baseline of patient satisfaction scores for one or more of the patient satisfaction domains that the provider targets for improvement in a specific tool. Certain supplemental modules for the adult CG-CAHPS survey may be used to establish if patients: (1) are getting timely care, appointments, and information (already established patients at UTP Clinics, who are not cancer surgery patients and who were assigned to a medical home)

Process Milestones:
DY2:
P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
DY3:
P-3 Develop and test data systems
P-2 Establish baseline rates

Outcome Improvement Targets for each year:
DY4:
IT-6.1 (1) Improve by 3% the percent improvement over baseline of patient satisfaction scores for getting timely care, appointments, and information (using the supplemental module for the adult CG-CAHPS survey) for patients of UT Physician Clinics, who are not cancer surgery patients and who were assigned to a medical home.
DY5:
IT-6.1 (1) Improve by 5% the percent improvement over baseline of patient satisfaction scores for getting timely care, appointments, and information (using the supplemental module for the adult CG-CAHPS survey) for patients of UT Physician Clinics, who are not cancer surgery patients and who were assigned to a medical home.

Rationale:
The medical home project will provide a primary care "home base" for patients, and they will be assigned a health care team that will effectively coordinate their care across inpatient and outpatient settings, and proactively provide preventive, primary, routine and chronic care to them. This would translate to increased likelihood of getting timely care, ease of setting up appointments and receiving helpful care information. Thus assessing patient satisfaction (for patients of UT Physician clinics, who are not cancer surgery patients and have been assigned to a medical home) in these domains of their care experience, as measured using the adult CG-CAHPS survey for the domain of getting timely care, appointments, and information, will be a good measure of the outcome of this project.

Outcome Measure Valuation:

Using the same project valuation scores assigned to the projects, the dollars allotted for each year were distributed across the projects' related Category 3 measures. For demonstration year 2 the amount was 5%, and for DYs 3, 4, and 5, the proportion of the funds allotted were 10%, 10%, and 20%, respectively.

111810101.3.14	*3.IT-6.1 (1)*	*Percent improvement over baseline of patient satisfaction scores (1) are getting timely care, appointments, and information (stand alone measure)*	
UTHealth, UTPhysicians			*111810101*
Related Category 1 or 2 Projects:	*111810101.2.1*		
Starting Point/Baseline:	*To be determined during DY3.*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Project reports and documents Process Milestone 1 Estimated Incentive Payment: $ 166,363	Process Milestone 2 [P-2]: Establish baseline rates Data Source: Provider reports Process Milestone 2 Estimated Incentive Payment: $ 198,051 Process Milestone 3 [P-3]: Develop and test data systems Data Source: Project reports, EMR, claims Process Milestone 3 Estimated Incentive Payment: $ 198,051	Outcome Improvement Target 1 [IT-6.1 (1)]: Improve by 3% the percent improvement over baseline of patient satisfaction scores for getting timely care, appointments, and information (using the supplemental module for the adult CG-CAHPS survey) for patients of UT Physician Clinics, who are not cancer surgery patients and who were assigned to a medical home. Data Source: Surveys Outcome Improvement Target 1 Estimated Incentive Payment: $ 411,946	Outcome Improvement Target 2 [IT-6.1 (1)]: Improve by 5% the percent improvement over baseline of patient satisfaction scores for getting timely care, appointments, and information (using the supplemental module for the adult CG-CAHPS survey) for patients of UT Physician Clinics, who are not cancer surgery patients and who were assigned to a medical home. Data Source: Surveys Outcome Improvement Target 2 Estimated Incentive Payment: $ 887,267
Year 2 Estimated Outcome Amount: $ 166,363	Year 3 Estimated Outcome Amount: $ 396,102	Year 4 Estimated Outcome Amount: $ 411,946	Year 5 Estimated Outcome Amount: $ 887,267
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $ 1,861,678			

Title of Outcome Measure (Improvement Target): OD-9 Right Care, Right Setting

Unique RHP outcome identification number(s): 111810101.3.15
Performing Provider Name/TPI: UTHealth, UTPhysicians/111810101

Outcome Measure Description:
IT-9.2 ED appropriate utilization (Stand-alone measure)
Reduce Emergency Department visits for
o Asthma
o COPD
o CHF
o Diabetes
o Hypertension

Process Milestones:
DY2:
P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
DY3:
P-3 Develop and test data systems
P-2 Establish baseline rates

Outcome Improvement Targets for each year:
DY4:
IT-9.2 Reduce by 3% the percentage of Emergency Department visits for asthma, COPD, CHF, Diabetes, and Hypertension.
DY5:
IT-9.2 Reduce by 5% the percentage of Emergency Department visits for asthma, COPD, CHF, Diabetes, and Hypertension.

Rationale:
This project aims to develop and implement evidence based chronic disease management interventions (Coleman et al. Evidence on the Chronic Care Model in the New Millennium. Health Affairs 28, no. 1 (2009): 75–85) that will ultimately improve patient clinical indicators, health outcomes, and reduce unnecessary acute and emergency care utilization for patients with chronic diseases. Thus measuring ED visits for the targeted chronic diseases will be a good way of assessing its impact.

Outcome Measure Valuation:
Using the same project valuation scores assigned to the projects, the dollars allotted for each year were distributed across the projects' related Category 3 measures. For demonstration year 2 the amount was 5%, and for DYs 3, 4, and 5, the proportion of the funds allotted were 10%, 10%, and 20%, respectively.

111810101.3.15	*3.IT-9.2*	*ED appropriate utilization (Stand-alone measure)*	
UTHealth, UTPhysicians			*111810101*
Related Category 1 or 2 Projects:	*111810101.2.2*		
Starting Point/Baseline:	*To be determined during DY3.*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Project reports and documents Process Milestone 1 Estimated Incentive Payment*:* $ 136,115	Process Milestone 2 [P-2]: Establish baseline rates Data Source: Provider reports Process Milestone 2 Estimated Incentive Payment: $ 162,041 Process Milestone 3 [P-3]: Develop and test data systems Data Source: Project reports, EMR, claims Process Milestone 3 Estimated Incentive Payment: $ 162,042	Outcome Improvement Target 1 [IT-9.2]: Reduce by 3% the percentage of Emergency Department visits for asthma, COPD, CHF, Diabetes, and Hypertension. Data Source: EMR, Claims Outcome Improvement Target 1 Estimated Incentive Payment*:* $ 337,046	Outcome Improvement Target 2 [IT-9.2]: Reduce by 5% the percentage of Emergency Department visits for asthma, COPD, CHF, Diabetes, and Hypertension. Data Source: EMR, Claims Outcome Improvement Target 2 Estimated Incentive Payment*:* $ 725,946
Year 2 Estimated Outcome Amount: $ 136,115	Year 3 Estimated Outcome Amount: $ 324,083	Year 4 Estimated Outcome Amount: $ 337,046	Year 5 Estimated Outcome Amount: $ 725,946
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*:* $ 1,523,190			

Title of Outcome Measure (Improvement Target): OD-3 Potentially Preventable Re-Admissions- 30 day Readmission Rates (PPRs)

Unique RHP outcome identification number(s): 111810101.3.16
Performing Provider Name/TPI: UTHealth, UTPhysicians/111810101

Outcome Measure Description:
IT-3.9 Chronic Obstructive Pulmonary Disease 30 day readmission rate (Standalone measure)
Numerator: The number of readmissions (for patients 18 years and older), for any cause, within 30 days of discharge from the index COPD admission. If an index admission has more than 1 readmission, only first is counted as a readmission.
Denominator: The number of admissions (for patients 18 years and older), for patients discharged from the hospital with a principal diagnosis of COPD and with a complete claims history for the 12 months prior to admission.

Process Milestones:
DY2:
P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
DY3:
P-3 Develop and test data systems
P-2 Establish baseline rates

Outcome Improvement Targets for each year:
DY4:
IT-3.9 Reduce by 3% the percentage of readmissions (for patients 18 years and older), for any cause, within 30 days of discharge from the index COPD admission. If an index admission has more than 1 readmission, only first is counted as a readmission.
DY5:
IT-3.9 Reduce by 5% the percentage of readmissions (for patients 18 years and older), for any cause, within 30 days of discharge from the index COPD admission. If an index admission has more than 1 readmission, only first is counted as a readmission.

Rationale:
When a patient is discharged without optimal follow-up, it could have terrible consequences such as hospital readmission and possibly death Without sufficient information and an understanding of their diagnoses, medication, and self-care needs, patients cannot fully participate in their care during and after hospital stays.

Outcome Measure Valuation:
Using the same project valuation scores assigned to the projects, the dollars allotted for each year were distributed across the projects' related Category 3 measures. For demonstration year 2 the amount was 5%, and for DYs 3, 4, and 5, the proportion of the funds allotted were 10%, 10%, and 20%, respectively.

111810101.3.16	*3.IT-3.9*	*Chronic Obstructive Pulmonary Disease 30 day readmission rate (Standalone measure)*	
UTHealth, UTPhysicians			*111810101*
Related Category 1 or 2 Projects:	*111810101.2.3*		
Starting Point/Baseline:	*To be determined during DY3.*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Project reports and documents Process Milestone 1 Estimated Incentive Payment*:* $ 151,239	Process Milestone 2 [P-2]: Establish baseline rates Data Source: Provider reports Process Milestone 2 Estimated Incentive Payment: $ 180,046 Process Milestone 3 [P-3]: Develop and test data systems Data Source: Project reports, EMR, claims Process Milestone 3 Estimated Incentive Payment: $ 180,046	Outcome Improvement Target 1 [IT-3.9]: Reduce by 3% the percentage of readmissions (for patients 18 years and older), for any cause, within 30 days of discharge from the index COPD admission. If an index admission has more than 1 readmission, only first is counted as a readmission. Data Source: Surveys Outcome Improvement Target 1 Estimated Incentive Payment*:* $ 374,496	Outcome Improvement Target 2 [IT-3.9]: Reduce by 5% the percentage of readmissions (for patients 18 years and older), for any cause, within 30 days of discharge from the index COPD admission. If an index admission has more than 1 readmission, only first is counted as a readmission. Data Source: Surveys Outcome Improvement Target 2 Estimated Incentive Payment*:* $ 806,607
Year 2 Estimated Outcome Amount: $ 151,239	Year 3 Estimated Outcome Amount: $ 360,092	Year 4 Estimated Outcome Amount: $ 374,496	Year 5 Estimated Outcome Amount: $ 806,607
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*:* $ 1,692,434			

Title of Outcome Measure (Improvement Target): OD-13 Palliative Care

Unique RHP outcome identification number(s): 111810101.3.17
Performing Provider Name/TPI: UTHealth, UTPhysicians/111810101

Outcome Measure Description:
IT-13.1 Pain assessment (NQF-1637) (Non-standalone measure)
Increase the number of patients enrolled in hospice OR receiving palliative care who received a comprehensive clinical assessment to determine the severity, etiology and impact of their pain within 24 hours of screening positive for pain on the admission evaluation / initial encounter.
Exclusion: patients with length of stay < 1 day in palliative care or <7 days in hospice, patients who were not screened for pain. Patients who screen negative for pain are excluded from the denominator.

Process Milestones:
DY2:
P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
DY3:
P-3 Develop and test data systems
P-2 Establish baseline rates

Outcome Improvement Targets for each year:
DY4:
IT-13.1 Increase by 3% the percentage of patients enrolled in hospice OR receiving palliative care who received a comprehensive clinical assessment to determine the severity, etiology and impact of their pain within 24 hours of screening positive for pain on the admission evaluation / initial encounter.
Exclusion: patients with length of stay < 1 day in palliative care or <7 days in hospice, patients who were not screened for pain. Patients who screen negative for pain are excluded from the denominator.
DY5:
IT-13.1 Increase by 5% the percentage of patients enrolled in hospice OR receiving palliative care who received a comprehensive clinical assessment to determine the severity, etiology and impact of their pain within 24 hours of screening positive for pain on the admission evaluation / initial encounter.
Exclusion: patients with length of stay < 1 day in palliative care or <7 days in hospice, patients who were not screened for pain. Patients who screen negative for pain are excluded from the denominator.

Rationale:

Reasearch shows that the prevalence of pain among patients with incurable illness and at the end of life is as high as 40 – 70% (Gade G, Venohr I, Conner D, et al. Impact of an inpatient palliative care team: a randomized control trial. J Palliat Med. 2008;11(2):180–190), and pain is under-recognized by clinicians and undertreated, resulting in excess suffering among these

patients. Pain screening and assessments will thus be a good measure of the quality of palliative care services provided to patients.

Outcome Measure Valuation:

Using the same project valuation scores assigned to the projects, the dollars allotted for each year were distributed across the projects' related Category 3 measures. For demonstration year 2 the amount was 5%, and for DYs 3, 4, and 5, the proportion of the funds allotted were 10%, 10%, and 20%, respectively.

111810101.3.17	*3.IT-13.1*	*Pain assessment (NQF-1637) (Non-standalone measure)*	
UTHealth, UTPhysicians			*111810101*
Related Category 1 or 2 Projects:	*111810101.2.4*		
Starting Point/Baseline:	*To be determined during DY3.*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Project reports and documents Process Milestone 1 Estimated Incentive Payment*:* $ 26,047	**Process Milestone 2** [P-2]: Establish baseline rates Data Source: Provider reports Process Milestone 2 Estimated Incentive Payment: $ 31,008 **Process Milestone 3** [P-3]: Develop and test data systems Data Source: Project reports, EMR, claims Process Milestone 3 Estimated Incentive Payment: $ 31,008	**Outcome Improvement Target 1** [IT-13.1]: Increase by 3% the percentage of patients enrolled in hospice OR receiving palliative care who received a comprehensive clinical assessment to determine the severity, etiology and impact of their pain within 24 hours of screening positive for pain on the admission evaluation / initial encounter. Data Source: EMR, Claims Outcome Improvement Target 1 Estimated Incentive Payment*:* $ 64,497	**Outcome Improvement Target 2** [IT-13.1]: Increase by 5% the percentage of patients enrolled in hospice OR receiving palliative care who received a comprehensive clinical assessment to determine the severity, etiology and impact of their pain within 24 hours of screening positive for pain on the admission evaluation / initial encounter. Data Source: EMR, Claims Outcome Improvement Target 2 Estimated Incentive Payment*:* $ 138,916
Year 2 Estimated Outcome Amount: $ 26,047	Year 3 Estimated Outcome Amount: $ 62,016	Year 4 Estimated Outcome Amount: $ 64,497	Year 5 Estimated Outcome Amount: $ 138,916
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*:* $ 291,476			

Title of Outcome Measure (Improvement Target): OD-13 Palliative Care

Unique RHP outcome identification number(s): 111810101.3.18

Performing Provider Name/TPI: UTHealth, UTPhysicians/111810101

Outcome Measure Description:

IT-13.2 Treatment Preferences (NQF 1641) (Non-standalone measure)

Percentage of seriously ill patients enrolled in hospice OR receiving specialty palliative care in an acute hospital setting with chart documentation of preferences for life sustaining treatments.

Exclusions: patients with length of stay < 1 day in palliative care or <7 days in hospice.

Process Milestones:

- DY2:
  - P-1 Project planning - engage stakeholders, identify current capacity and needed resources,
  - determine timelines and document implementation plans
- DY3:
  - P-3 Develop and test data systems
  - P-2 Establish baseline rates

Outcome Improvement Targets for each year:

DY4:

Increase by 3% the percentage of seriously ill patients enrolled in hospice OR receiving specialty palliative care in an acute hospital setting with chart documentation of preferences for life sustaining treatments.

Exclusions: patients with length of stay < 1 day in palliative care or <7 days in hospice.

DY5:

Increase by 5% the percentage of seriously ill patients enrolled in hospice OR receiving specialty palliative care in an acute hospital setting with chart documentation of preferences for life sustaining treatments.

Exclusions: patients with length of stay < 1 day in palliative care or <7 days in hospice.

Rationale:

In the absence of a clear guideline for end-of-life care, care decisions are often taken by the physician/care team and this tends to be in favor of life sustaining treatments. As a result of

these aggressive treatments, lots of expensive interventions are given to patients in the last few months of life with poor and questionable outcomes. Site of death accounts for significant variation in end-of-life costs; for example costs for Medicare beneficiaries who died in a hospital inpatient setting have been found to be twice those for beneficiaries who died in other settings such as their homes (Carol Raphael, Joann Ahrens, & Nicole Fowler. Financing end-of-life care in the USA. J R Soc Med. 2001 September; 94(9): 458–461). Palliative care aims to address these imbalances and it is necessary to measure the success of the project by assessing how much patient preferences are being respected.

Outcome Measure Valuation:

Using the same project valuation scores assigned to the projects, the dollars allotted for each year were distributed across the projects' related Category 3 measures. For demonstration year 2 the amount was 5%, and for DYs 3, 4, and 5, the proportion of the funds allotted were 10%, 10%, and 20%, respectively.

111810101.3.18	*3.IT-13.2*	*Treatment Preferences (NQF 1641) (Non-standalone measure)*	
UTHealth, UTPhysicians			*111810101*
Related Category 1 or 2 Projects:	*111810101.2.4*		
Starting Point/Baseline:	*To be determined during DY3.*		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Project reports and documents Process Milestone 1 Estimated Incentive Payment*:* $ 26,047	Process Milestone 2 [P-2]: Establish baseline rates Data Source: Provider reports Process Milestone 2 Estimated Incentive Payment: $ 31,008 Process Milestone 3 [P-3]: Develop and test data systems Data Source: Project reports, EMR, claims Process Milestone 3 Estimated Incentive Payment: $ 31,008	Outcome Improvement Target 1 [IT-13.2]: Increase by 3% the percentage of seriously ill patients enrolled in hospice OR receiving specialty palliative care in an acute hospital setting with chart documentation of preferences for life sustaining treatments. Exclusions: patients with length of stay < 1 day in palliative care or <7 days in hospice. Data Source: EMR, Claims Outcome Improvement Target 1 Estimated Incentive Payment*:* $ 64,497	Outcome Improvement Target 2 [IT-13.2]: Increase by 5% the percentage of seriously ill patients enrolled in hospice OR receiving specialty palliative care in an acute hospital setting with chart documentation of preferences for life sustaining treatments. Exclusions: patients with length of stay < 1 day in palliative care or <7 days in hospice. Data Source: EMR, Claims Outcome Improvement Target 2 Estimated Incentive Payment*:* $ 138,916
Year 2 Estimated Outcome Amount: $ 26,047	Year 3 Estimated Outcome Amount: $ 62,016	Year 4 Estimated Outcome Amount: $ 64,497	Year 5 Estimated Outcome Amount: $ 138,916
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*:* $ 291,476			

Title of Outcome Measure (Improvement Target): OD-13 Palliative Care

Unique RHP outcome identification number(s): 111810101.3.19

Performing Provider Name/TPI: UTHealth, UTPhysicians/111810101

Outcome Measure Description:

IT-13.5 Percentage of patients receiving hospice or palliative care services with documentation in the clinical record of a discussion of spiritual/religions concerns or documentation that the patient/caregiver did not want to discuss. (NQF 1647 modified) (Non-st

Increase the number of patients discharged from hospice or palliative care with clinical record documentation of spiritual/religious concerns

or documentation that the patient/family did not want to discuss during the reporting period.

Process Milestones:

- DY2:
  - P-1 Project planning - engage stakeholders, identify current capacity and needed resources,
  - determine timelines and document implementation plans
- DY3:
  - P-3 Develop and test data systems
  - P-2 Establish baseline rates

Outcome Improvement Targets for each year:

DY4:

Increase by 3% the percentage of patients discharged from hospice or palliative care with clinical record documentation of discussion of spiritual/religious concerns

or documentation that the patient/family did not want to discuss during the reporting period.

DY5:

Increase by 5% the percentage of patients discharged from hospice or palliative care with clinical record documentation of discussion of spiritual/religious concerns

or documentation that the patient/family did not want to discuss during the reporting period.

Rationale:

A comprehensive interdisciplinary approach is one of the hallmarks of pallaitive care, and this entails caring for the physical, psychosocial, and spiritual needs of patients and their families. An essential step to providing for the needs of patients is initiating discussions about

their spiritual concerns. This measure will thus be an important indicator of the quality of palliative care provided throught this project.

Outcome Measure Valuation:

Using the same project valuation scores assigned to the projects, the dollars allotted for each year were distributed across the projects' related Category 3 measures. For demonstration year 2 the amount was 5%, and for DYs 3, 4, and 5, the proportion of the funds allotted were 10%, 10%, and 20%, respectively.

111810101.3.19	*3.IT-13.5*	*Percentage of patients receiving hospice or palliative care services with documentation in the clinical record of a discussion of spiritual/religions concerns or documentation that the patient/caregiver did not want to discuss. (NQF 1647 modified) (Non-st*	
UTHealth, UTPhysicians			*111810101*
Related Category 1 or 2 Projects:	*111810101.2.4*		
Starting Point/Baseline:	*To be determined during DY3.*		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Project reports and documents Process Milestone 1 Estimated Incentive Payment*:* $ 26,047	Process Milestone 2 [P-2]: Establish baseline rates Data Source: Provider reports Process Milestone 2 Estimated Incentive Payment: $ 31,008 Process Milestone 3 [P-3]: Develop and test data systems Data Source: Project reports, EMR, claims Process Milestone 3 Estimated Incentive Payment: $ 31,008	Outcome Improvement Target 1 [IT-13.5]: Increase by 3% the percentage of patients discharged from hospice or palliative care with clinical record documentation of discussion of spiritual/religious concerns or documentation that the patient/family did not want to discuss during the reporting period. Data Source: EMR, Claims Outcome Improvement Target 1 Estimated Incentive Payment*:* $ 64,497	Outcome Improvement Target 2 [IT-13.5]: Increase by 5% the percentage of patients discharged from hospice or palliative care with clinical record documentation of discussion of spiritual/religious concerns or documentation that the patient/family did not want to discuss during the reporting period. Data Source: EMR, Claims Outcome Improvement Target 2 Estimated Incentive Payment*:* $ 138,916
Year 2 Estimated Outcome Amount: $ 26,047	Year 3 Estimated Outcome Amount: $ 62,016	Year 4 Estimated Outcome Amount: $ 64,497	Year 5 Estimated Outcome Amount: $ 138,916
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*:* $ 291,476			

Title of Outcome Measure (Improvement Target): OD-1 Primary Care and Chronic Disease Management

Unique RHP outcome identification number(s): 111810101.3.25

Performing Provider Name/TPI: UTHealth, UTPhysicians/111810101

Outcome Measure Description:

IT-1.9 Depression management: Depression Remission at Twelve Months (NQF# 0710)

(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.

Exclusions: 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.

Process Milestones:

- DY2:
  - P-1 Project planning - engage stakeholders, identify current capacity and needed resources,
  - determine timelines and document implementation plans
- DY3:
  - P-3 Develop and test data systems
  - P-2 Establish baseline rates

Outcome Improvement Targets for each year:

DY4:

Increase by 3% the percentage of 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.

DY5:

Increase by 5% the percentage of 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.

Rationale:

The Patient Health Questionnaire (PHQ-9) tool is a widely accepted and standardized tool that is utilized by providers to monitor treatment progress. There is evidence that integrated behavioral health services enhance access to mental health care services, improve quality of life, reduce the incidence of depression and utilization of emergency department services, and overall health care costs (AHRQ. Service Delivery Innovation Profile: Integrated Behavioral Health Reduces Depression and Anxiety in Primary Care Patients, Improving Quality of Life and Reducing Costs. http://www.innovations.ahrq.gov/content.aspx?id=2951). Assessment of depression remission will thus be suitable to assess the success of this integrated care project.

Outcome Measure Valuation:

Using the same project valuation scores assigned to the projects, the dollars allotted for each year were distributed across the projects' related Category 3 measures. For demonstration year 2 the amount was 5%, and for DYs 3, 4, and 5, the proportion of the funds allotted were 10%, 10%, and 20%, respectively.

111810101.3.25	*3.IT-1.9*	*Depression management: Depression Remission at Twelve Months (NQF# 0710) (Standalone measure)*	
UTHealth, UTPhysicians			*111810101*
Related Category 1 or 2 Projects:	*111810101.2.7*		
Starting Point/Baseline:	*To be determined during DY3.*		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Project reports and documents Process Milestone 1 Estimated Incentive Payment*:* $ 78,140	Process Milestone 2 [P-2]: Establish baseline rates Data Source: Provider reports Process Milestone 2 Estimated Incentive Payment: $ 93,024 Process Milestone 3 [P-3]: Develop and test data systems Data Source: Project reports, EMR, claims Process Milestone 3 Estimated Incentive Payment: $ 93,024	Outcome Improvement Target 1 [IT-1.9]: Increase by 3% the percentage of 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. Data Source: Electronic Clinical Data, Electronic Health Record, Paper Records Outcome Improvement Target 1 Estimated Incentive Payment*:* $ 193,490	Outcome Improvement Target 2 [IT-1.9]: Increase by 5% the percentage of 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. Data Source: Electronic Clinical Data, Electronic Health Record, Paper Records Outcome Improvement Target 2 Estimated Incentive Payment*:* $ 416,747
Year 2 Estimated Outcome Amount: $ 78,140	Year 3 Estimated Outcome Amount: $ 186,048	Year 4 Estimated Outcome Amount: $ 193,490	Year 5 Estimated Outcome Amount: $ 416,747
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*:* $ 874,425			

The University of Texas Health Science Center - Houston

Pass 2

Title of Outcome Measure (Improvement Target): IT- 1.1 Third next available appointment

Unique RHP outcome identification number(s): 111810101.3.24 / Pass 2
Performing Provider Name/TPI: UTHealth, UTPhysicians/111810101

Outcome Measure Description:
IT-1.1 Third next available appointment (Non- standalone measure)

Reduce the average length of time in days between the day a patient makes a request for an appointment with a physician and the third available appointment for a new patient physical, routine exam, or return visit exam. The goals will be to decrease number of days to third next available appointment to zero days (same day) for Primary Care.

Process Milestones:
DY2:
P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
DY3:
P-3 Develop and test data systems
P-2 Establish baseline rates

Outcome Improvement Targets for each year:

- DY4:
  - IT-1.1 Reduce by 1 day the average length of time in days between the day a patient makes a request for an appointment with a physician and the third available appointment for a new patient physical, routine exam, or return visit exam.
- DY5:
  - IT-1.1 Reduce the average length of time in days between the day a patient makes a request for an appointment with a physician and the third available appointment for a new patient physical, routine exam, or return visit exam to zero (0) days.

Rationale:

Access to primary care services can have an impact on healthcare outcomes, by providing early screening and treatment and patients are more likely to get these services when they are able to get appointments when first needed that accomodate their schedule. Since the goal of the project is to increase access to care and the third next available appointment is the healthcare industry's standard measure of access to care, we have chosen this outcome measure.

Outcome Measure Valuation:

Using the same project valuation scores assigned to the projects, the dollars allotted for each year were distributed across the projects' related Category 3 measures. For demonstration year 2 the amount was 5%, and for DYs 3, 4, and 5, the proportion of the funds allotted were 10%, 10%, and 20%, respectively.

111810101.3.24	*3.IT-1.1*	*Third next available appointment (Non- standalone measure)*	
UTHealth, UTPhysicians			*111810101*
Related Category 1 or 2 Projects:	*111810101.1.9*		
Starting Point/Baseline:	*To be determined during DY3.*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Project reports and documents Process Milestone 1 Estimated Incentive Payment: $ 71,123	**Process Milestone 2** [P-2]: Establish baseline rates Data Source: Provider reports Process Milestone 2 Estimated Incentive Payment: $ 84,256 **Process Milestone 3** [P-3]: Develop and test data systems Data Source: Project reports, EMR, claims Process Milestone 3 Estimated Incentive Payment: $ 84,256	**Outcome Improvement Target 1** [IT-1.1]: Average length of time in days between the day a patient makes a request for an appointment with a physician and the third available appointment for a new patient physical, routine exam, or return visit exam. Improvement Target: Reduce by 1 day the average length of time in days between the day a patient makes a request for an appointment with a physician and the third available appointment for a new patient physical, routine exam, or return visit exam. Data Source: Appointment management system Outcome Improvement Target 1 Estimated Incentive Payment: $ 182,353	**Outcome Improvement Target 2** [IT-1.1]: Average length of time in days between the day a patient makes a request for an appointment with a physician and the third available appointment for a new patient physical, routine exam, or return visit exam. Improvement Target: Reduce the average length of time in days between the day a patient makes a request for an appointment with a physician and the third available appointment for a new patient physical, routine exam, or return visit exam to zero (0) days. Data Source: Appointment management system Outcome Improvement Target 2 Estimated Incentive Payment: $ 395,017
Year 2 Estimated Outcome Amount: $ 71,123	Year 3 Estimated Outcome Amount: $ 168,512	Year 4 Estimated Outcome Amount: $ 182,353	Year 5 Estimated Outcome Amount: $ 395,017
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $ 817,005			

Title of Outcome Measure (Improvement Target): IT-12.1 Breast Cancer Screening (HEDIS 2012) (Non-standalone measure)

Unique RHP outcome identification number(s): 111810101.3.25 / Pass 2

Performing Provider Name/TPI: UTHealth, UTPhysicians/111810101

Outcome Measure Description:

IT-12.1 Breast Cancer Screening (HEDIS 2012) (Non-standalone measure)

Numerator: Number of women aged 40 to 69 that have received an annual mammogram during the reporting period. Denominator: Number of women aged 40 to 69 in the patient or target population. Women who have had a bilateral mastectomy are excluded.

Process Milestones:

DY2:

P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans

DY3:

P-3 Develop and test data systems

P-2 Establish baseline rates

Outcome Improvement Targets for each year:

DY4:

IT-12.1 Increase by 3% the percentage of women patients of UT Physicians aged 40 to 69 that have received an annual mammogram during the reporting period. Women who have had a bilateral mastectomy are excluded.

DY5:

IT-12.1 Increase by 5% the percentage of women patients of UT Physicians aged 40 to 69 that have received an annual mammogram during the reporting period. Women who have had a bilateral mastectomy are excluded.

Rationale:

By increasing primary care capacity, preventative care and recommended screenings to detect cancer early would be available to more people in the community. By screening for early stages of disease before symptoms occur, patients testing positive can receive appropriate

follow-up diagnostic tests, treatment, and follow-up. Early detection may reduce the impact of cancer when treatment may be easier and more effective than for an advanced cancer diagnosis in terms of the disease burden, harm and cost. Along with additional physicians to see patients for primary care, the extended hours would make it more convenient for patients to get these early screening tests.

Outcome Measure Valuation:

Using the same project valuation scores assigned to the projects, the dollars allotted for each year were distributed across the projects' related Category 3 measures. For demonstration year 2 the amount was 5%, and for DYs 3, 4, and 5, the proportion of the funds allotted were 10%, 10%, and 20%, respectively.

111810101.3.25	*3.IT-12.1*	*Breast Cancer Screening (HEDIS 2012) (Non-standalone measure)*	
UTHealth, UTPhysicians			*111810101*
Related Category 1 or 2 Projects:	*111810101.1.9*		
Starting Point/Baseline:	*To be determined during DY3.*		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Project reports and documents Process Milestone 1 Estimated Incentive Payment*:* $ 71,122	**Process Milestone 2** [P-2]: Establish baseline rates Data Source: Provider reports Process Milestone 2 Estimated Incentive Payment: $ 84,255 **Process Milestone 3** [P-3]: Develop and test data systems Data Source: Project reports, EMR, claims Process Milestone 3 Estimated Incentive Payment: $ 84,255	**Outcome Improvement Target 1** [IT-12.1]: Breast Cancer Screening Improvement Target: Increase by 3% the percentage of women patients of UT Physicians aged 40 to 69 that have received an annual mammogram during the reporting period. Women who have had a bilateral mastectomy are excluded. Data Source: EHR, Claims Outcome Improvement Target 1 Estimated Incentive Payment*:* $ 182,352	**Outcome Improvement Target 2** [IT-12.1]: Breast Cancer Screening Improvement Target: Increase by 5% the percentage of women patients of UT Physicians aged 40 to 69 that have received an annual mammogram during the reporting period. Women who have had a bilateral mastectomy are excluded. Data Source: EHR, Claims Outcome Improvement Target 2 Estimated Incentive Payment*:* $ 395,016
Year 2 Estimated Outcome Amount: $ 71,122	Year 3 Estimated Outcome Amount: $ 168,510	Year 4 Estimated Outcome Amount: $ 182,352	Year 5 Estimated Outcome Amount: $ 395,016
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*:* $ 817,000			

Title of Outcome Measure (Improvement Target): IT-12.3 Colorectal Cancer Screening

Unique RHP outcome identification number(s): 111810101.3.26 / Pass 2

Performing Provider Name/TPI: UTHealth, UTPhysicians/111810101

Outcome Measure Description:

IT-12.3 Colorectal Cancer Screening (HEDIS 2012) (Non-standalone measure)

Numerator: Number of adults aged 50 to 75 that have received one of the following screenings. Fecal occult blood test yearly, Flexible sigmoidoscopy every five years, Colonoscopy every 10 years

Denominator: Number of adults aged 50 to 75 in the patient or target population. Adults with colorectal cancer or total colectomy are excluded.

Process Milestones:

DY2:

P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans

DY3:

P-3 Develop and test data systems

P-2 Establish baseline rates

Outcome Improvement Targets for each year:

DY4:

IT-12.3 Increase by 3% the percentage of adult patients of UT Physicians (established and new patients) aged 50 to 75 that have received one of the following screenings: Fecal occult blood test yearly, Flexible sigmoidoscopy every five years, Colonoscopy every 10 years. Adults with colorectal cancer or total colectomy are excluded.

DY5:

IT-12.3 Increase by 5% the percentage of adult patients of UT Physicians (established and new patients) aged 50 to 75 that have received one of the following screenings: Fecal occult blood test yearly, Flexible sigmoidoscopy every five years, Colonoscopy every 10 years. Adults with colorectal cancer or total colectomy are excluded.

Rationale:

By increasing primary care capacity, preventative care and recommended screenings to detect cancer early would be available to more people in the community. By screening for early stages of disease before symptoms occur, patients testing positive can receive appropriate follow-up diagnostic tests, treatment, and follow-up. Early detection may reduce the impact of cancer when treatment may be easier and more effective than for an advanced cancer diagnosis in terms of the disease burden, harm and cost. Along with additional physicians to see patients for primary care, the extended hours would make it more convenient for patients to get these early screening tests.

Outcome Measure Valuation:

Using the same project valuation scores assigned to the projects, the dollars allotted for each year were distributed across the projects' related Category 3 measures. For demonstration year 2 the amount was 5%, and for DYs 3, 4, and 5, the proportion of the funds allotted were 10%, 10%, and 20%, respectively.

111810101.3.26	*3.IT-12.3*	*Colorectal Cancer Screening (HEDIS 2012) (Non-standalone measure)*	
UTHealth, UTPhysicians			*111810101*
Related Category 1 or 2 Projects:	*111810101.1.9*		
Starting Point/Baseline:	*To be determined during DY3.*		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Project reports and documents Process Milestone 1 Estimated Incentive Payment*:* $ 71,123	**Process Milestone 2** [P-2]: Establish baseline rates Data Source: Provider reports Process Milestone 2 Estimated Incentive Payment: $ 84,256 **Process Milestone 3** [P-3]: Develop and test data systems Data Source: Project reports, EMR, claims Process Milestone 3 Estimated Incentive Payment: $ 84,255	**Outcome Improvement Target 1** [IT-12.3]: Colorectal Cancer Screening Improvement Target: Increase by 3% the percentage of adult patients of UT Physicians (established and new patients) aged 50 to 75 that have received one of the following screenings: Fecal occult blood test yearly, Flexible sigmoidoscopy every five years, Colonoscopy every 10 years. Adults with colorectal cancer or total colectomy are excluded. Data Source: EHR, Claims Outcome Improvement Target 1 Estimated Incentive Payment*:* $ 182,353	**Outcome Improvement Target 2** [IT-12.3]: Colorectal Cancer Screening Improvement Target: Increase by 5% the percentage of adult patients of UT Physicians (established and new patients) aged 50 to 75 that have received one of the following screenings: Fecal occult blood test yearly, Flexible sigmoidoscopy every five years, Colonoscopy every 10 years. Adults with colorectal cancer or total colectomy are excluded. Data Source: EHR, Claims Outcome Improvement Target 2 Estimated Incentive Payment*:* $ 395,017
Year 2 Estimated Outcome Amount: $ 71,123	Year 3 Estimated Outcome Amount: $ 168,511	Year 4 Estimated Outcome Amount: $ 182,353	Year 5 Estimated Outcome Amount: $ 395,017
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*:* $ 817,004			

Title of Outcome Measure (Improvement Target): IT-1.1 Third next available appointment

Unique RHP outcome identification number(s): 111810101.3.27 / Pass 2
Performing Provider Name/TPI: UTHealth, UTPhysicians/111810101

Outcome Measure Description:
IT-1.1 Third next available appointment (Non- standalone measure)
Reduce the average length of time in days between the day a patient makes a request for an appointment with a physician and the third available appointment for a new patient, or return visit/exam. The goals will be to decrease number of days to third next available appointment to two days for Specialty Care.

Process Milestones:
DY2:
P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
DY3:
P-3 Develop and test data systems
P-2 Establish baseline rates

Outcome Improvement Targets for each year:
DY4:
IT-1.1 Reduce by 1 day over baseline the average length of time in days between the day a patient makes a request for an appointment with a physician and the third next available appointment for a new patient, or return visit/exam. The goal will be to decrease number of days to third next available appointment to two days for Specialty Care.
DY5:
IT-1.1 Reduce by 2 day over baseline the average length of time in days between the day a patient makes a request for an appointment with a physician and the third next available appointment for a new patient, or return visit/exam. The goal will be to decrease number of days to third next available appointment to two days for Specialty Care.

Rationale:

Access to care services can have an impact on healthcare outcomes, by providing early screening and treatment and patients are more likely to get these services when they are able to get appointments when first needed that accomodate their schedule. Since the goal of the project is to increase access to care and the third next available appointment is the healthcare industry's standard measure of access to care, we have chosen this outcome measure.

Outcome Measure Valuation:

Using the same project valuation scores assigned to the projects, the dollars allotted for each year were distributed across the projects' related Category 3 measures. For demonstration year 2 the amount was 5%, and for DYs 3, 4, and 5, the proportion of the funds allotted were 10%, 10%, and 20%, respectively.

111810101.3.27	*3.IT-1.1*	*Third next available appointment (Non- standalone measure)*	
UTHealth, UTPhysicians			*111810101*
Related Category 1 or 2 Projects:	*111810101.1.10*		
Starting Point/Baseline:	*To be determined during DY3.*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Project reports and documents Process Milestone 1 Estimated Incentive Payment: $ 66,458	**Process Milestone 2** [P-2]: Establish baseline rates Data Source: Provider reports Process Milestone 2 Estimated Incentive Payment: $ 78,731 **Process Milestone 3** [P-3]: Develop and test data systems Data Source: Project reports, EMR, claims Process Milestone 3 Estimated Incentive Payment: $ 78,731	**Outcome Improvement Target 1** [IT-1.1]: Third next available appointment Improvement Target: Reduce by 1 day over baseline the average length of time in days between the day a patient makes a request for an appointment with a physician and the third next available appointment for a new patient, or return visit/exam. The goal will be to decrease number of days to third next available appointment to two days for Specialty Care. Data Source: Appointment management system Outcome Improvement Target 1 Estimated Incentive Payment: $ 170,396	**Outcome Improvement Target 2** [IT-1.1]: Third next available appointment Improvement Target: Reduce by 2 day over baseline the average length of time in days between the day a patient makes a request for an appointment with a physician and the third next available appointment for a new patient, or return visit/exam. The goal will be to decrease number of days to third next available appointment to two days for Specialty Care. Data Source: Appointment management system Outcome Improvement Target 2 Estimated Incentive Payment: $ 369,114
Year 2 Estimated Outcome Amount: $ 66,458	Year 3 Estimated Outcome Amount: $ 157,462	Year 4 Estimated Outcome Amount: $ 170,396	Year 5 Estimated Outcome Amount: $ 369,114
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $ 763,430			

Title of Outcome Measure (Improvement Target): IT-1.6 Cholesterol management for patients with cardiovascular conditions

Unique RHP outcome identification number(s): 111810101.3.28 / Pass 2

Performing Provider Name/TPI: UTHealth, UTPhysicians/111810101

Outcome Measure Description:

IT-1.6 Cholesterol management for patients with cardiovascular conditions (NCQA-HEDIS 2012) (Standalone measure)

Increase the number of patients who had each of the following during the reporting period:

Low-density Lipoprotein Cholesterol (LDL-C) Screening: An LDL-C test performed during the measurement year.

LDL-C Level Less Than 100 mg/dL: The most recent LDL-C level during the measurement year is less than 100 mg/dL.

Process Milestones:

DY2:

P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans

DY3:

P-3 Develop and test data systems

P-2 Establish baseline rates

Outcome Improvement Targets for each year:

DY4:

Increase by 3% the percentage of patients who had each of the following during the reporting period:

Low-density Lipoprotein Cholesterol (LDL-C) Screening (performed during the measurement year) and LDL-C Level <100 mg/dL (the most recent during the measurement year)

DY5:

Increase by 5% the percentage of patients who had each of the following during the reporting period:

Low-density Lipoprotein Cholesterol (LDL-C) Screening (performed during the measurement year) and LDL-C Level <100 mg/dL (the most recent during the measurement year)

Rationale:

By increasing access to specialty care, such as the expansion of cardiology care to UT Physicians primary care clinics, we expect that patients at risk for coronary artery disease (CAD) and coronary heart disease (CHD), heart attack, and stroke, are more likely to get the cholesterol screening that would facilitate appropriate care. Working together with patients with known heart disease to reduce cholesterol has the potential to reduce morbidity (heart attack and stroke) and mortality. Using established guidelines (National Cholesterol Education Program) for managing cholesterol levels in patients with heart disease, we would aim to see a reduction in LDL-C of less than or equal to 100 mg/dL.

Outcome Measure Valuation:

Using the same project valuation scores assigned to the projects, the dollars allotted for each year were distributed across the projects' related Category 3 measures. For demonstration year 2 the amount was 5%, and for DYs 3, 4, and 5, the proportion of the funds allotted were 10%, 10%, and 20%, respectively.

111810101.3.28	*3.IT-1.6*	*Cholesterol management for patients with cardiovascular conditions (NCQA - HEDIS 2012) (Standalone measure)*	
UTHealth, UTPhysicians			*111810101*
Related Category 1 or 2 Projects:	*111810101.1.10*		
Starting Point/Baseline:	*To be determined during DY3.*		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Project reports and documents Process Milestone 1 Estimated Incentive Payment*:* $ 66,458	**Process Milestone 2** [P-2]: Establish baseline rates Data Source: Provider reports Process Milestone 2 Estimated Incentive Payment: $ 78,730 **Process Milestone 3** [P-3]: Develop and test data systems Data Source: Project reports, EMR, claims Process Milestone 3 Estimated Incentive Payment: $ 78,730	**Outcome Improvement Target 1** [IT-1.6]: Cholesterol management for patients with cardiovascular conditions Improvement Target: Increase by 3% the percentage of patients who had each of the following during the reporting period: Low-density Lipoprotein Cholesterol (LDL-C) Screening (performed during the measurement year) and LDL-C Level <100 mg/dL (the most recent during the measurement year) Data Source: EMR, Claim Outcome Improvement Target 1 Estimated Incentive Payment*:* $ 170,397	**Outcome Improvement Target 2** [IT-1.6]: Cholesterol management for patients with cardiovascular conditions Improvement Target: Increase by 5% the percentage of patients who had each of the following during the reporting period: Low-density Lipoprotein Cholesterol (LDL-C) Screening (performed during the measurement year) and LDL-C Level <100 mg/dL (the most recent during the measurement year) Data Source: EMR, Claim Outcome Improvement Target 2 Estimated Incentive Payment*:* $ 369,114
Year 2 Estimated Outcome Amount: $ 66,458	Year 3 Estimated Outcome Amount: $ 157,460	Year 4 Estimated Outcome Amount: $ 170,397	Year 5 Estimated Outcome Amount: $ 369,114
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*:* $ 763,429			

The University of Texas Health Science Center - Houston

Pass 3

<u>Title of Outcome Measure (Improvement Target)</u>: IT-1.1 Third next available appointment (Non- standalone measure)

<u>Unique RHP outcome identification number(s)</u>: 111810101.3.31
<u>Performing Provider Name/TPI:</u> UTHealth, UTPhysicians/111810101

<u>Outcome Measure Description:</u>
IT-1.1 Third next available appointment (Non- standalone measure)
Reduce the average length of time in days between the day a patient makes a request for an appointment with a physician and the third available appointment for a new patient, or return visit/exam. The goals will be to decrease number of days to third next available appointment to two days for Specialty Care.

Process Milestones:
DY2:
P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
DY3:
P-3 Develop and test data systems
P-2 Establish baseline rates

Outcome Improvement Targets for each year:
DY4:
IT-1.1 Reduce by 1 day over baseline the average length of time in days between the day a patient makes a request for an appointment with a physician and the third next available appointment for a new patient, or return visit/exam. The goal will be to decrease number of days to third next available appointment to two days for Specialty Care.
DY5:
IT-1.1 Reduce by 2 day over baseline the average length of time in days between the day a patient makes a request for an appointment with a physician and the third next available appointment for a new patient, or return visit/exam. The goal will be to decrease number of days to third next available appointment to two days for Specialty Care.

<u>Rationale:</u>
Access to care services can have an impact on healthcare outcomes, by providing early screening and treatment, patients are more likely to get these services when they are able to get appointments when first needed that accomodate their schedule. Since the goal of the project is to increase access to care and the third next available appointment is the healthcare industry's standard measure of access to care, we have chosen this outcome measure.

<u>Outcome Measure Valuation:</u>
Using the same project valuation scores assigned to the projects, the dollars allotted for each year were distributed across the projects' related Category 3 measures. For demonstration year 2 the amount was 5%, and for DYs 3, 4, and 5, the proportion of the funds allotted were 10%, 10%, and 20%, respectively.

111810101.3.31	*3.IT-1.1*	*Third next available appointment (Non- standalone measure)*	
UTHealth, UTPhysicians			*111810101*
Related Category 1 or 2 Projects:	*111810101.2.8*		
Starting Point/Baseline:	*To be determined during DY3.*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Project reports and documents Process Milestone 1 Estimated Incentive Payment*:* $ 97,675	Process Milestone 2 [P-2]: Establish baseline rates Data Source: Provider reports Process Milestone 2 Estimated Incentive Payment: $ 116,280 Process Milestone 3 [P-3]: Develop and test data systems Data Source: Project reports, EMR, claims Process Milestone 3 Estimated Incentive Payment: $ 116,280	Outcome Improvement Target 1 [IT-1.1]: Reduce by 1 day over baseline the average length of time in days between the day a patient makes a request for an appointment with a physician and the third next available appointment for a new patient, or return visit/exam. The goal will be to decrease number of days to third next available appointment to two days for Specialty Care. Data Source: Appointment management system Outcome Improvement Target 1 Estimated Incentive Payment*:* $ 241,862	Outcome Improvement Target 2 [IT-1.1]: Reduce by 2 day over baseline the average length of time in days between the day a patient makes a request for an appointment with a physician and the third next available appointment for a new patient, or return visit/exam. The goal will be to decrease number of days to third next available appointment to two days for Specialty Care. Data Source: Appointment management system Outcome Improvement Target 2 Estimated Incentive Payment*:* $ 520,934
Year 2 Estimated Outcome Amount: $ 97,675	Year 3 Estimated Outcome Amount: $ 232,560	Year 4 Estimated Outcome Amount: $ 241,862	Year 5 Estimated Outcome Amount: $ 520,934
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD*:* $ 1,093,031			

Title of Outcome Measure (Improvement Target): IT-1.19 Antidepressant Medication Management
Unique RHP outcome identification number(s): 111810101.3.32
Performing Provider Name/TPI: UTHealth, UTPhysicians/111810101
Outcome Measure Description:
IT-1.19 Antidepressant Medication Management - NQF 0105 (Standalone measure)
The management of antidepressant medication in children ages 6-18 (who were discharged alive) from an acute inpatient setting (including acute care psychiatric facilities) with a principal mental health diagnosis: A) the acute phase treatment period consisting at least 84 days (12 weeks) of continuous treatment with antidepressant medication during the 114-day period following the IPSD (inclusive), and B) the continuation phase treatment period consisting of at least 180 days (6 months) of continuous treatment with antidepressant medication (Table AMM-D) during the 231-day period following the IPSD (inclusive).

Process Milestones:
DY2:
P-1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
DY3:
P-3 Develop and test data systems
P-2 Establish baseline rates

Outcome Improvement Targets for each year:
DY4:
IT-1.19 Increase by 3% the number of patients ages 6-18 who complete at least 84 days of continuous treatment with an antidpressant medication during the 114-day acute phase treatment period folloing the IPSD and who complete at least 180 days of continuoust treatment with antidepressant medication during the 231-day continuation phase following the IPSD.
DY5:
IT-1.19 Increase by 5% the number of patients ages 6-18 who complete at least 84 days of continuous treatment with an antidpressant medication during the 114-day acute phase treatment period folloing the IPSD and who complete at least 180 days of continuoust treatment with antidepressant medication during the 231-day continuation phase following the IPSD.

Rationale:

According to the American Psychiatric Association, "as many as one in ten children between ages six and twelve experience persistent feelings of sadness . . . . Treatment is essential for children struggling with depression so that they can be free to develop necessary academic and social skills. Treatment involves psychotherapy either alone or in combination with medication." (http://www.psychiatry.org/mental-health/people/children)

Outcome Measure Valuation:

Using the same project valuation scores assigned to the projects, the dollars allotted for each year were distributed across the projects' related Category 3 measures. For demonstration year 2 the amount was 5%, and for DYs 3, 4, and 5, the proportion of the funds allotted were 10%, 10%, and 20%, respectively.

111810101.3.32	*3.IT-1.19*	*Antidepressant Medication Management*	
UTHealth, UTPhysicians			*111810101*
Related Category 1 or 2 Projects:	*111810101.2.8*		
Starting Point/Baseline:	*To be determined during DY3.*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Project reports and documents Process Milestone 1 Estimated Incentive Payment: $ 97,675	Process Milestone 2 [P-2]: Establish baseline rates Data Source: Provider reports Process Milestone 2 Estimated Incentive Payment: $ 116,280 Process Milestone 3 [P-3]: Develop and test data systems Data Source: Project reports, EMR, claims Process Milestone 3 Estimated Incentive Payment: $ 116,279	Outcome Improvement Target 1 [IT-1.19]: Increase by 3% the number of patients ages 6-18 who complete at least 84 days of continuous treatment with an antidpressant medication during the 114-day acute phase treatment period folloing the IPSD and who complete at least 180 days of continuoust treatment with antidepressant medication during the 231-day continuation phase following the IPSD. Data Source: EHR, Claims Outcome Improvement Target 1 Estimated Incentive Payment: $ 241,862	Outcome Improvement Target 2 [IT-1.19]: Increase by 5% the number of patients ages 6-18 who complete at least 84 days of continuous treatment with an antidpressant medication during the 114-day acute phase treatment period folloing the IPSD and who complete at least 180 days of continuoust treatment with antidepressant medication during the 231-day continuation phase following the IPSD. Data Source: EHR, Claims Outcome Improvement Target 2 Estimated Incentive Payment: $ 520,933
Year 2 Estimated Outcome Amount: $ 97,675	Year 3 Estimated Outcome Amount: $ 232,559	Year 4 Estimated Outcome Amount: $ 241,862	Year 5 Estimated Outcome Amount: $ 520,933
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD: $ 1,093,029			

Tomball Regional Hospital

Pass 1

Title of Outcome Measure (Improvement Target): OD-2- Potentially Preventable Admissions

Title of Outcome Measure (Improvement Target): IT-2.5 Chronic Obstructive Pulmonary Disease (COPD) Admission Rate- 241PQI 5 *(Stand alone measure)*

a. Numerator: All non-maternal discharges of age 18 years and older with a principal diagnosis code for COPD.

b. Denominator: Population in Metro Area or county, age 18 years and older.

c. Data Source: EHR, Claims

d. Rationale/Evidence: COPD with MCC is the fourth largest admission category for the target population in Tomball. Combined with all COPD cases in this population group the diagnosis creates four admissions per month. Please see footnote for specific diagnosis codes to be included as well as criteria for case exclusion.

Title of Outcome Measure (Improvement Target): IT-2.10 Flu and pneumonia Admission Rate *(Stand alone measure)*

a. Numerator: All discharges of age 18 years and older with a principal diagnosis code of flu or pneumonia.

b. Denominator: Population in Metro Area or county, age 18 years and older.

c. Data Source: EHR, Claims

d. Rationale/Evidence: Hospitalizations for the Bacterial Pneumonia are considered "potentially preventable," because if the individual had access to and cooperated with appropriate outpatient healthcare, the hospitalization would likely not have occurred. The methodology used to identify "potentially preventable hospitalizations" was developed by the Agency for Healthcare Research and Quality (AHRQ). AHRQ is the lead federal agency responsible for research on healthcare quality costs, outcomes and patient safety.

The above targets were chose due to the fact that these diagnoses represent the two largest groups of preventable admissions in Tomball. By providing access to care, patients can receive treatment in a timely fashion and therefore prevent the escalation of illness to the point of requiring hospital services. The targeted reduction of five percent of these admissions would reduce state payments for hospital services and uncompensated care by $265,000 annually for each Improvement Target.

To achieve these targets, a planning group will be formed to include Pulmonologists, ED providers, Family Practice Physician, the clinic Mid-Level provider and representatives of the Clinic and Hospital Administrative teams. This group will be tasked to identify proper clinical

protocols, patient education material, other needed resources and to document implementation plans.

Valuation is based on the potential savings of admissions and the providers' time to develop the program.

241http://www.qualityindicators.ahrq.gov/Downloads/Modules/PQI/V41/TechSpecs/PQI%2005%20Chronic%20Obstructive%20Pulmonary%20Disease%20(COPD)%20Admission%20Rate.pdf

131044305.3.1	IT – 2.5	Chronic Obstructive Pulmonary disease (COPD) Admission Rate	
Tomball Regional Medical Center			288523801
Related Category 1 or 2 Projects:	288523801.1.1		
Starting Point/Baseline:			
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Process Milestone 1 [*RHP PP Process Milestone* – P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Implementation Plan Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $ 31,726	**Process Milestone 2 [P-4]** Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Data Source: Plan Documentation Process Milestone 2 Estimated Incentive Payment: $31,726 **Process Milestone 3 [P-5]** Disseminate findings, including lessons learned and best practices, to stakeholders Process Milestone 3 Estimated Incentive Payment: $31,726 **Outcome Improvement Target 1 IT-2.5 Chronic Obstructive Pulmonary Disease (COPD) Admission Rate- 241PQI 5** ***(Standalone measure)*** a Numerator: All non-maternal discharges of age 18 years and older with a principal diagnosis code for COPD. b Denominator: Population in Metro Area or county, age 18 years and older. c Data Source: EHR, ClaimsIT-1.1]: Outcome Improvement Target 1 2%	**Outcome Improvement Target 2 [IT-2.5 Chronic Obstructive Pulmonary Disease (COPD) Admission Rate- 241PQI 5** ***(Standalone measure)*** a Numerator: All non-maternal discharges of age 18 years and older with a principal diagnosis code for COPD. b Denominator: Population in Metro Area or county, age 18 years and older. c Data Source: EHR, Outcome Improvement Target 4% Estimated Incentive Payment*:* $212,000	**Outcome Improvement Target 3 [IT-2.5 Chronic Obstructive Pulmonary Disease (COPD) Admission Rate- 241PQI 5** ***(Standalone measure)*** a Numerator: All non-maternal discharges of age 18 years and older with a principal diagnosis code for COPD. b Denominator: Population in Metro Area or county, age 18 years and older. c Data Source: EHR, Claims Outcome Improvement Target 5% Estimated Incentive Payment*:* $265,000

131044305.3.1	*IT – 2.5*	*Chronic Obstructive Pulmonary disease (COPD) Admission Rate*	
Tomball Regional Medical Center			*288523801*
Related Category 1 or 2 Projects:	288523801.1.1		
Starting Point/Baseline:			
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
	Estimated Incentive Payment*:* $ $106,000		
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $ 31,726	Year 3 Estimated Outcome Amount: $ 137,726	Year 4 Estimated Outcome Amount: $ 212,000	Year 5 Estimated Outcome Amount: $ 265,000
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $ 646,452			

131044305.3.2	IT – 2.10	*Flu and pneumonia Admission Rate*	
Tomball Regional Medical Center			*288523801]*
Related Category 1 or 2 Projects:	288523801.1.1		
Starting Point/Baseline:			
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Process Milestone 1 [*RHP PP Process Milestone* – P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Implementation Plan Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $ 31,726	**Process Milestone 2 [P-4]** Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Data Source: Plan Documentation Process Milestone 2 Estimated Incentive Payment: $45,909 **Process Milestone 3 [P-5]** Disseminate findings, including lessons learned and best practices, to stakeholders Process Milestone 3 Estimated Incentive Payment: $45,909 **Outcome Improvement Target 1 IT-2.10 Flu and pneumonia Admission Rate *(Standalone measure)*** Data Source: EHR, Claims Outcome Improvement Target 1: 5 fewer uninsured or Medicaid inpatient admissions from Tomball zip codes, Estimated Incentive Payment: $ 45,909	**Outcome Improvement Target 2 IT-2.10 Flu and pneumonia Admission Rate *(Standalone measure)*** Data Source: EHR, Claims Outcome Improvement Target 2: 25 fewer uninsured or Medicaid inpatient admissions from Tomball zip codes, Estimated Incentive Payment: $212,000	**Outcome Improvement Target 3 IT-2.10 Flu and pneumonia Admission Rate *(Standalone measure)*** Data Source: EHR, Claims Outcome Improvement Target 3: 35 fewer uninsured or Medicaid inpatient admissions from Tomball zip codes, Estimated Incentive Payment: $265,000

131044305.3.2	*IT – 2.10*	*Flu and pneumonia Admission Rate*	
Tomball Regional Medical Center			*288523801]*
Related Category 1 or 2 Projects:	288523801.1.1		
Starting Point/Baseline:			
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $ 31,726	Year 3 Estimated Outcome Amount: $ 137,726	Year 4 Estimated Outcome Amount: $ 212,000	Year 5 Estimated Outcome Amount: $ 265,000
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $ 646,452			

Title of Outcome Measure (Improvement Target): OD-3 Potentially Preventable Re-Admissions - 30-day Readmission Rates (PPRs)

Outcome Measure Description:

The relationship between hospital readmission rates and quality of care is well-documented, and is driven by a general consensus that readmissions may result from circumstances surrounding the initial hospital stay. Given data limitations, only readmissions to the same facility will be included as part of each hospital's rates.

Readmission rates are calculated for the following individual medical conditions: Congestive heart failure, diabetes, chronic obstructive pulmonary disease, stroke, and asthma. Readmissions create excessive healthcare cost to providers and payers. In addition, the extended recovery period places that patient at undue risk and reduces the quality of life.

With the increased access to primary care, patients will receive post hospital follow-up and educations. Recovery and progress will be monitored and treatment plans can be amended to fit the patient's condition.

Title of Outcome Measure (Improvement Target): IT-3.1 All cause 30-day readmission rate-NQF 1789250 *(Stand alone measure)*

a. Numerator: The outcome for this measure is unplanned all-cause 30-day readmission. Readmission is defined as an inpatient admission to any acute care facility which occurs within 30 days of the discharge date of an eligible index admission. All readmissions are counted as outcomes except those that are considered planned.

b. Denominator: Admissions to acute care facilities for patients aged 18 years or older.

c. Data Source: EHR, Claims

A planning group will also be convened to develop the plans and monitor the progress of this initiative. For this project data will have to be defined, baselines determined and goals established. Target improvement by year 5 is a 5% reduction in the defined diagnostic groups. Estimated savings to patients and payers is projected to reach $265,000 by DY 5.

131044305.3.3	*IT – 3.1*	*All cause 30 day readmission rate*	
Tomball Regional Medical Center			*288523801*
Related Category 1 or 2 Projects:	288523801.1.1		
Starting Point/Baseline:			
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Process Milestone 1 [*RHP PP Process Milestone* – P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Implementation Plan Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $ 31,726 Process Milestone P- 2 Establish baseline rates Data Source: To be Determined Process Milestone 2 Estimated Incentive Payment: $31,726	**Process Milestone 3 [P-4]** Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Data Source: Plan Documentation Process Milestone 3 Estimated Incentive Payment: $31,726 **Process Milestone 3 [P-5]** Disseminate findings, including lessons learned and best practices, to stakeholders Process Milestone 3 Estimated Incentive Payment: $31,726 **IT-3.1 All cause 30 day readmission rate- NQF 1789250 *(Standalone measure)*** a Numerator: The outcome for this measure is unplanned all-cause 30-day readmission. Readmission is defined as an inpatient admission to any acute care facility which occurs within 30 days of the discharge date of an eligible index admission. All readmissions are counted as outcomes except those that are considered planned. b Denominator: Admissions to acute	**IT-3.1 All cause 30 day readmission rate- NQF 1789250 *(Standalone measure)*** a Numerator: The outcome for this measure is unplanned all-cause 30-day readmission. Readmission is defined as an inpatient admission to any acute care facility which occurs within 30 days of the discharge date of an eligible index admission. All readmissions are counted as outcomes except those that are considered planned. b Denominator: Admissions to acute care facilities for patients aged 18 years or older. We have tested the measure in both age groups. c Data Source: EHR, Claims Outcome Improvement Target 4% Estimated Incentive Payment*:* $212,000	**IT-3.1 All cause 30 day readmission rate- NQF 1789250 *(Standalone measure)*** a Numerator: The outcome for this measure is unplanned all-cause 30-day readmission. Readmission is defined as an inpatient admission to any acute care facility which occurs within 30 days of the discharge date of an eligible index admission. All readmissions are counted as outcomes except those that are considered planned. b Denominator: Admissions to acute care facilities for patients aged 18 years or older. We have tested the measure in both age groups. c Data Source: EHR, Claims Outcome Improvement Target 4% Estimated Incentive Payment*:* $265,000

131044305.3.3	*IT – 3.1*	*All cause 30 day readmission rate*	
Tomball Regional Medical Center			*288523801*
Related Category 1 or 2 Projects:	288523801.1.1		
Starting Point/Baseline:			
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
	care facilities for patients aged 18 years or older. We have tested the measure in both age groups. c Data Source: EHR, Claims Outcome Improvement Target:2% Estimated Incentive Payment*:* $132,500		
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $ 63,452	Year 3 Estimated Outcome Amount: $ 195,952	Year 4 Estimated Outcome Amount: $ 212,000	Year 5 Estimated Outcome Amount: $ 265,000
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)**:*** $ 736,404			

Title of Outcome Measure (Improvement Target): OD-9 Right Care, Right Setting

Title of Outcome Measure (Improvement Target): IT-9.2 ED appropriate utilization *(Standalone measure)*

- Reduce pediatric Emergency Department visits (CHIPRA Core Measure)272
- Reduce Emergency Department visits for target conditions
  - o Congestive Heart Failure
  - o Diabetes
  - o End Stage Renal Disease
  - o Cardiovascular Disease /Hypertension
  - o Behavioral Health/Substance Abuse
  - o Chronic Obstructive Pulmonary Disease
  - o Asthma

This outcome measure is chosen because it reflects all of the above indicators. By increasing access to primary care, after-hours services, access to vaccinations and post hospital follow-up care patients will receive the right care in the right setting. This will result in conditions not escalating to the point that they require emergency and hospital services and thereby, improve the overall health of the patient population.

During 2012, Tomball Regional Medical Center has experienced a 10.4% growth in ED visits. Visits by uninsured patients have increased by 19.2%. A five percent reduction in visits from indigent and uninsured will reduce payments by payers and uncompensated care by $527,431.

131044305.3.4	*IT- 9.2*	*ED appropriate utilization*	
Tomball Regional Medical Center			288523801
Related Category 1 or 2 Projects:	288523801.1.1		
Starting Point/Baseline:			
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Process Milestone 1 [*RHP PP Process Milestone* – P-1]: Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: Implementation Plan Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $ 31,726 Process Milestone P- 2 Establish baseline rates Data Source: To be Determined Process Milestone 2 Estimated Incentive Payment: $31,726 **Outcome Milestone 1 IT-9.2 ED appropriate** Reduce pediatric Emergency Department visits Reduce Emergency Department visits for target conditions o Congestive Heart Failure o Diabetes o End Stage Renal Disease o Cardiovascular Disease /Hypertension	**Process Milestone 3 [P-4]** Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities Data Source: Plan Documentation Process Milestone 3 Estimated Incentive Payment: $31,726 **Process Milestone 3 [P-5]** Disseminate findings, including lessons learned and best practices, to stakeholders Process Milestone 3 Estimated Incentive Payment: $31,726 **Outcome Milestone 1 IT-9.2 ED appropriate** Reduce pediatric Emergency Department visits Reduce Emergency Department visits for target conditions o Congestive Heart Failure o Diabetes o End Stage Renal Disease o Cardiovascular Disease /Hypertension o Behavioral Health/Substance Abuse o Chronic Obstructive Pulmonary Disease	**Outcome Milestone 1 IT-9.2 ED appropriate** Reduce pediatric Emergency Department visits Reduce Emergency Department visits for target conditions o Congestive Heart Failure o Diabetes o End Stage Renal Disease o Cardiovascular Disease /Hypertension o Behavioral Health/Substance Abuse o Chronic Obstructive Pulmonary Disease o Asthma Goal: 4% reductions from 2012 Data Source: ED registration data, claims data, HER Outcome Milestone 1 Estimated Incentive Payment *(maximum amount):* $421,944.	**Process Milestone 1 IT-9.2 ED appropriate** Reduce pediatric Emergency Department visits Reduce Emergency Department visits for target conditions o Congestive Heart Failure o Diabetes o End Stage Renal Disease o Cardiovascular Disease /Hypertension o Behavioral Health/Substance Abuse o Chronic Obstructive Pulmonary Disease o Asthma Goal: 5% reductions from 2012 Data Source: ED registration data, claims data, HER Process Milestone 1 Estimated Incentive Payment *(maximum amount):* $527,432.

131044305.3.4	IT- 9.2	*ED appropriate utilization*	
Tomball Regional Medical Center			288523801
Related Category 1 or 2 Projects:	288523801.1.1		
Starting Point/Baseline:			
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
o Behavioral Health/Substance Abuse o Chronic Obstructive Pulmonary Disease o Asthma Goal: 2% reductions from 2012 Data Source: ED registration data, claims data, HER Outcome Milestone 1 Estimated Incentive Payment *(maximum amount):* $ 210,973.	o Asthma Goal: 3% reductions from 2012 Data Source: ED registration data, claims data, HER Outcome Milestone 1 Estimated Incentive Payment *(maximum amount):* $ 316,459.		
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): $ 274,425	Year 3 Estimated Outcome Amount: $ 379,911	Year 4 Estimated Outcome Amount: $ 421,944	Year 5 Estimated Outcome Amount: $ 527,432
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $ 1,603,712			

University of Texas M.D. Anderson Cancer Center

Pass 1

Title of Outcome Measure (Improvement Target): IT-11.1 – Improvement in Clinical Indicator in identified disparity group

Unique RHP outcome identification number(s): 112672402.3.1

Outcome Measure Description:

IT-11.1 Improvement in Clinical Indicator in identified disparity group (Improvement in rates of CRC screening among African American and Hispanic clinic population)

- Numerator: TBD by performing provider

Process Milestones:

- DY2:
  - P-1 – Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-3 – Develop and test data systems
- DY3:
  - P-3 – Develop and test data systems

Outcome Improvement Targets for each year:

- DY4: IT – 11.1 Numerator: Number of African American and Hispanic patients given FIT CRC screening – Improvement percent TBD
- DY5: IT – 11.1 Number of African American and Hispanic patients given FIT CRC screening – Improvement percent TBD

Rationale:

Process milestones P-1 and P-3 were chosen due to the lack of accurate reports and resources currently available to measure and monitor the provision of CRC screening services. In order to report accurate data and establish baselines, P-1 and P-3 must be approached in DY2-DY3.

Improvement target percentages will be based on the timeframe in which the intervention will occur and expectations based on research of similar interventions for what is achievable during the start-up period of a CRC screening program.

Outcome Measure Valuation:

We valued our Outcome Measures equally within each DY based on our percent allocation for Category 3 per DY (10%, 10%, 15%, and 33%). Within each Outcome Measure, milestones and improvement targets received equal estimated incentive payments based on the total number of milestones and improvement targets within that DY.

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Unique CAT 3 ID: *112672402.3.1*		*Reference Number for RHP PP:* *3.IT-11.1*	*Improvement in Clinical Indicator in identified disparity group*	
Performing Provider Name: The University of Texas MD Anderson Cancer Center				*TPI - 112672402*
Related Category 1 or 2 Projects:	*Unique Category 2 project identifier – 112672402.2.7*			
Starting Point/Baseline:	*To be determined*			
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**		**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: EHR reports; Stakeholder meeting summaries; Staff meeting summaries Process Milestone 1 Estimated Incentive Payment*:* $74,384.31 **Process Milestone 2** [P-3]: Develop and test data systems Data Source: EHR reports; Stakeholder meeting summaries; Staff meeting summaries Process Milestone 2 Estimated Incentive Payment: $74,384.31	**Process Milestone 3 [P-3]:** Develop and test data systems Data Source: EHR reports; Stakeholder meeting summaries; Staff meeting summaries Process Milestone 3 Estimated Incentive Payment: $150,223.01		**Outcome Improvement Target 1** [IT-11.1]: Improvement in Clinical Indicator in identified disparity group (Improvement in rates of CRC screening among African American and Hispanic clinic population. Baseline/Goal: TBD Improvement Target: Number of African American and Hispanic patients given FIT CRC screening Data Source: EHR reports Outcome Improvement Target 1 Estimated Incentive Payment*:* $226,804.10	**Outcome Improvement Target 2** [IT-11.1]: Improvement in Clinical Indicator in identified disparity group (Improvement in rates of CRC screening among African American and Hispanic clinic population. Baseline/Goal" DY 4 baseline/ Improvement Target: Number of African American and Hispanic patients given FIT CRC screening by 10% Data Source: EHR reports Outcome Improvement Target 2 Estimated Incentive Payment*:* $705,461.01
Year 2 Estimated Outcome Amount: $148,768.62	Year 3 Estimated Outcome Amount: $150,223.01		Year 4 Estimated Outcome Amount: $226,804.10	Year 5 Estimated Outcome Amount: $705,461.01
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $1,231,257				

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Title of Outcome Measure (Improvement Target): IT-12.3 – Colorectal Cancer Screening (HEDIS 2012)
Unique RHP outcome identification number(s): 112672402.3.2
Outcome Measure Description:

IT-12.3 Colorectal Cancer Screening (HEDIS 2012)

- Numerator: Number of adults in clinic client population aged 50 to 75 that have received one of the following screenings: Fecal occult blood test yearly, Flexible sigmoidoscopy every five years, Colonoscopy every 10 years)

Process Milestones:

- DY2:
  - P-1 – Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-3 – Develop and test data systems
- DY3:
  - P-3 – Develop and test data systems

Outcome Improvement Targets for each year:

- DY4: IT – 12.3 Numerator: Number of adults aged 50 to 75 that have received one of the following screenings: Fecal occult blood test yearly, Flexible sigmoidoscopy every five years, Colonoscopy every 10 years) – Improvement percent TBD
- DY5: IT – 12.3 Fecal occult blood test yearly, Flexible sigmoidoscopy every five years, Colonoscopy every 10 years) – Improvement percent TBD

Rationale:

Process milestones P-1 and P-3 were chosen due to the lack of accurate reports and resources currently available to measure and monitor the provision of CRC screening services. In order to report accurate data and establish baselines, P-1 and P-3 must be approached in DY2-DY3.

Improvement target percentages will be based on the timeframe in which the intervention will occur and expectations based on research of similar interventions for what is achievable during the start-up period of a CRC screening program.

Outcome Measure Valuation:

We valued our Outcome Measures equally within each DY based on our percent allocation for Category 3 per DY (10%, 10%, 15%, and 33%). Within each Outcome Measure, milestones and improvement targets received equal estimated incentive payments based on the total number of milestones and improvement targets within that DY.

Unique CAT 3 ID: *112672402.3.2*	*Reference Number for RHP PP:* *3.IT-12.3*	*Colorectal Cancer Screening (HEDIS 2012)*	
Performing Provider Name: The University of Texas MD Anderson Cancer Center			*TPI - 112672402*
Related Category 1 or 2 Projects:	*Unique Category 2 project identifier – 112672402.2.7*		
Starting Point/Baseline:	*To be determined*		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: EHR reports; Stakeholder meeting summaries; Staff meeting summaries Process Milestone 1 Estimated Incentive Payment: $74,384.31 **Process Milestone 2** [P-3]: Develop and test data systems Data Source: EHR reports; Stakeholder meeting summaries; Staff meeting summaries Process Milestone 2 Estimated Incentive Payment: $74,384.31	**Process Milestone 3 [P-3]:** Develop and test data systems Data Source: EHR reports; Stakeholder meeting summaries; Staff meeting summaries Process Milestone 3 Estimated Incentive Payment: $150,223.01	**Outcome Improvement Target 1** [IT-12.3]: Colorectal Cancer Screening (HEDIS 2012) Baseline/Goal: TBD/ Improvement Target: Number of adults in clinic client population aged 50 to 75 who receive one of the following screenings: Fecal occult blood test yearly, Flexible sigmoidoscopy every five years, Colonoscopy every 10 years Data Source: EHR reports Outcome Improvement Target 1 Estimated Incentive Payment: $226,804.10	**Outcome Improvement Target 2** [IT-12.3]: Colorectal Cancer Screening (HEDIS 2012) Baseline/Goal: DY 4 baseline/ Improvement Target: Number of adults in clinic client population aged 50 to 75 who receive one of the following screenings: Fecal occult blood test yearly, Flexible sigmoidoscopy every five years, Colonoscopy every 10 years increased by 5% over baseline. Data Source: EHR reports Outcome Improvement Target 2 Estimated Incentive Payment: $705,461.01
Year 2 Estimated Outcome Amount: $148,768.62	Year 3 Estimated Outcome Amount: $150,223.01	Year 4 Estimated Outcome Amount: $226,804.10	Year 5 Estimated Outcome Amount: $705,461.01
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $1,231,257			

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Title of Outcome Measure (Improvement Target): IT-11.6 – Other Outcome Improvement Target (Quit Attempts)

Unique RHP outcome identification number(s): 112672402.3.3

Outcome Measure Description:

IT-11.6 – Other Outcome Improvement Target (Quit Attempts)

- Numerator: Number of HIV+ smokers that make a quit attempt

Process Milestones:

- DY2:
  - P-1 – Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-3 – Develop and test data systems
- DY3:
  - P-3 – Develop and test data systems

Outcome Improvement Targets for each year:

- DY4: IT – 11.6 Numerator: Number of HIV+ smokers that make a quit attempt – 45% of enrollees will make a successful quit attempt
- DY5: IT – 11.6 Numerator: Number of HIV+ smokers that make a quit attempt – 45% of the remaining enrollees will make a successful quit attempt

Rationale:

Process milestones P-1 and P-3 were chosen due to the lack of accurate reports and resources currently available to measure and monitor the provision of smoking cessation services provided to HIV+ smokers. In order to report accurate data and establish baselines, P-1 and P-3 must be approached in DY2-DY3.

Improvement target percentages will be based on the timeframe in which the intervention will occur and expectations based on research of similar interventions for what is achievable during the start-up period of a smoking cessation program for HIV+ smokers.

Outcome Measure Valuation:

We valued our Outcome Measures equally within each DY based on our percent allocation for Category 3 per DY (10%, 10%, 15%, and 33%). Within each Outcome Measure, milestones and improvement targets received equal estimated incentive payments based on the total number of milestones and improvement targets within that DY.

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Unique CAT 3 ID: *112672402.3.3*	*Reference Number for RHP PP:* *3.IT-11.6*	*Other Outcome Improvement Target (Quit Attempts)*	
Performing Provider Name: The University of Texas MD Anderson Cancer Center			*TPI - 112672402*
Related Category 1 or 2 Projects:	*Unique Category 2 project identifier – 112672402.2.7*		
Starting Point/Baseline:	*To be determined*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: EHR reports; Stakeholder meeting summaries; Staff meeting summaries Process Milestone 1 Estimated Incentive Payment*:* $74,384.31 **Process Milestone 2** [P-3]: Develop and test data systems Data Source: EHR reports; Stakeholder meeting summaries; Staff meeting summaries Process Milestone 2 Estimated Incentive Payment: $74,384.31	**Process Milestone 3 [P-3]:** Develop and test data systems Data Source: EHR reports; Stakeholder meeting summaries; Staff meeting summaries Process Milestone 3 Estimated Incentive Payment: $150,223.01	**Outcome Improvement Target 1** [IT-11.6]: Other Outcome Improvement Target (Quit Attempts) Baseline/Goal: TBD/ Improvement Target: Number of HIV+ smokers that make a quit attempt – 45% of enrollees will make a successful quit attempt Data Source: Primary data collection to be recorded in medical records and program databases Outcome Improvement Target 1 Estimated Incentive Payment*:* $226,804.10	**Outcome Improvement Target 2** [IT-11.6]: Other Outcome Improvement Target (Quit Attempts) Baseline/Goal: DY 4 baseline/ Improvement Target: Number of HIV+ smokers that make a quit attempt – 45% of remaining enrollees will make a successful quit attempt Data Source: Primary data collection to be recorded in medical records and program databases Outcome Improvement Target 2 Estimated Incentive Payment*:* $705,461.01
Year 2 Estimated Outcome Amount: $148,768.62	Year 3 Estimated Outcome Amount: $150,223.01	Year 4 Estimated Outcome Amount: $226,804.10	Year 5 Estimated Outcome Amount: $750,461.01
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***:** $1,231,257			

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Title of Outcome Measure (Improvement Target): IT-11.6 – Other Outcome Improvement Target (Smoking Cessation - Staying Quit)

Unique RHP outcome identification number(s): 112672402.3.4

Outcome Measure Description:

IT-11.6 – Other Outcome Improvement Target (Smoking Cessation – Staying Quit)

- Numerator: Number of HIV+ smokers that will be abstinent at the time of follow-up

Process Milestones:

- DY2:
  - P-1 – Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-3 – Develop and test data systems
- DY3:
  - P-3 – Develop and test data systems

Outcome Improvement Targets for each year:

- DY4: IT – 11.6 Numerator: 25% of HIV+ smokers will be abstinent at the time of follow-up
- DY5: IT – 11.6 Numerator: 25% of HIV+ smokers will be abstinent at the time of follow-up

Rationale:

Process milestones P-1 and P-3 were chosen due to the lack of accurate reports and resources currently available to measure and monitor the provision of smoking cessation services provided to HIV+ smokers. In order to report accurate data and establish baselines, P-1 and P-3 must be approached in DY2-DY3.

Improvement target percentages will be based on the timeframe in which the intervention will occur and expectations based on research of similar interventions for what is achievable during the start-up period of a smoking cessation program for HIV+ smokers.

Outcome Measure Valuation:

We valued our Outcome Measures equally within each DY based on our percent allocation for Category 3 per DY (10%, 10%, 15%, and 33%). Within each Outcome Measure, milestones and improvement targets received equal estimated incentive payments based on the total number of milestones and improvement targets within that DY.

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Unique CAT 3 ID: *112672402.3.4*	*Reference Number for RHP PP:* *3.IT-11.6*	*Other Outcome Improvement Target (Smoking Cessation – Staying Quit)*	
Performing Provider Name: The University of Texas MD Anderson Cancer Center			*TPI - 112672402*
Related Category 1 or 2 Projects:	*Unique Category 2 project identifier – 112672402.2.7*		
Starting Point/Baseline:	*To be determined*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3** (10/1/2013 – 9/30/2014)	**Year 4** (10/1/2014 – 9/30/2015)	**Year 5** (10/1/2015 – 9/30/2016)
Process Milestone 1 [P-1]: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: EHR reports; Stakeholder meeting summaries; Staff meeting summaries Process Milestone 1 Estimated Incentive Payment: $74,384.31 **Process Milestone 2** [P-3]: Develop and test data systems Data Source: EHR reports; Stakeholder meeting summaries; Staff meeting summaries Process Milestone 2 Estimated Incentive Payment: $74,384.31	**Process Milestone 3 [P-3]:** Develop and test data systems Data Source: EHR reports; Stakeholder meeting summaries; Staff meeting summaries Process Milestone 3 Estimated Incentive Payment: $150,223.01	**Outcome Improvement Target 1** [IT-11.6]: Other Outcome Improvement Target (Smoking Cessation - Staying Quit) Baseline/Goal: TBD/Improvement Target: Number of HIV+ smokers that make a quit attempt – 45% of enrollees will make a successful quit attempt Data Source: Primary data collection, including expired CO and self-report data collected from enrollees and stored in program databases. Outcome Improvement Target 1 Estimated Incentive Payment: $226,804.10	**Outcome Improvement Target 2** [IT-11.6]: Other Outcome Improvement Target (Smoking Cessation – Staying Quit) Baseline/Goal: DY 4 baseline/ Improvement Target: Number of HIV+ smokers that make a quit attempt – 45% of remaining enrollees will make a successful quit attempt Data Source: Primary data collection, including expired CO and self-report data collected from enrollees and stored in program databases. Outcome Improvement Target 2 Estimated Incentive Payment: $705,461.01
Year 2 Estimated Outcome Amount: $148,768.62	Year 3 Estimated Outcome Amount: $150,223.01	Year 4 Estimated Outcome Amount: $226,804.10	Year 5 Estimated Outcome Amount: $705,461.01

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Unique CAT 3 ID: *112672402.3.4*	*Reference Number for RHP PP:* *3.IT-11.6*	*Other Outcome Improvement Target (Smoking Cessation – Staying Quit)*	
Performing Provider Name: The University of Texas MD Anderson Cancer Center			*TPI - 112672402*
Related Category 1 or 2 Projects:	*Unique Category 2 project identifier – 112672402.2.7*		
Starting Point/Baseline:	*To be determined*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3** (10/1/2013 – 9/30/2014)	**Year 4** (10/1/2014 – 9/30/2015)	**Year 5** (10/1/2015 – 9/30/2016)
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)*: $1,231,257			

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Title of Outcome Measure (Improvement Target): IT-11.6 – Other Outcome Improvement Target

Unique RHP outcome identification number(s): 112672402.3.5

Outcome Measure Description:

IT-11.6 – Other Outcome Improvement Target (Improve utilization rates of the tobacco prevention and cessation program [ASPIRE] in adolescents aged 11 to 18 years.) Numerator: TBD by performing provider (# of 7 counties' adolescents in ASPIRE program)

Process Milestones:

- DY2:
  - P-1 – Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-3 – Develop and test data systems
- DY3:
  - P-3 – Develop and test data systems

Outcome Improvement Targets for each year:

- DY4: IT – 11.6 Numerator: 25% of HIV+ smokers will be abstinent at the time of follow-up
- DY5: IT – 11.6 Numerator: 25% of HIV+ smokers will be abstinent at the time of follow-up

Rationale:

Process milestones P-1 and P-3 were chosen due to the lack of accurate reports and resources currently available to measure and monitor the provision of smoking cessation services provided to HIV+ smokers. In order to report accurate data and establish baselines, P-1 and P-3 must be approached in DY2-DY3.

Improvement target percentages will be based on the timeframe in which the intervention will occur and expectations based on research of similar interventions for what is achievable during the start-up period of a smoking cessation program for HIV+ smokers.

Outcome Measure Valuation:

We valued our Outcome Measures equally within each DY based on our percent allocation for Category 3 per DY (10%, 10%, 15%, and 33%). Within each Outcome Measure, milestones and improvement targets received equal estimated incentive payments based on the total number of milestones and improvement targets within that DY.

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<table>
<tr><td>Unique CAT 3 ID:
112672402.3.5</td><td>Reference Number for RHP PP:
3.IT-11.6</td><td colspan="2">Other Outcome Improvement Target (Improve utilization rates of the tobacco prevention and cessation program [ASPIRE] in adolescents aged 11 to 18 years)</td></tr>
<tr><td colspan="3">Performing Provider Name: The University of Texas MD Anderson Cancer Center</td><td>TPI - 112672402</td></tr>
<tr><td>Related Category 1 or 2 Projects:</td><td colspan="3">Unique Category 2 project identifier – 112672402.2.7</td></tr>
<tr><td>Starting Point/Baseline:</td><td colspan="3">To be determined</td></tr>
<tr><th>Year 2
(10/1/2012 – 9/30/2013)</th><th>Year 3
(10/1/2013 – 9/30/2014)</th><th>Year 4
(10/1/2014 – 9/30/2015)</th><th>Year 5
(10/1/2015 – 9/30/2016)</th></tr>
<tr><td>Process Milestone 1 [P-1]: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
Data Source: EHR reports; Stakeholder meeting summaries; Staff meeting summaries

Process Milestone 1 Estimated Incentive Payment: $148,768.62

Process Milestone 2 [P-3]: Develop and test data systems
Data Source: EHR reports; Stakeholder meeting summaries; Staff meeting summaries

Process Milestone 2 Estimated Incentive Payment: $148,768.62</td><td>Process Milestone 3 [P-3]: Develop and test data systems
Data Source: EHR reports; Stakeholder meeting summaries; Staff meeting summaries

Process Milestone 3 Estimated Incentive Payment: $300,446.02</td><td>Outcome Improvement Target 1 [IT-11.6]: Other Outcome Improvement Target (Improve utilization rates of the tobacco prevention and cessation program [ASPIRE] in adolescents aged 11 to 18 years.)
Baseline/Goal: TBD/
Improvement Target: Enroll 10% of 7 counties' adolescents in ASPIRE program
Data Source: ASPIRE data system

Outcome Improvement Target 1 Estimated Incentive Payment: $453,608.19</td><td>Outcome Improvement Target 2 [IT-11.6]: Other Outcome Improvement Target (Improve utilization rates of the tobacco prevention and cessation program [ASPIRE] in adolescents aged 11 to 18 years.
Baseline/Goal: DY 4 baseline/
Improvement Target: Enroll 15% of 7 counties' adolescents in ASPIRE program
Data Source: ASPIRE data system

Outcome Improvement Target 2 Estimated Incentive Payment: $1,410,922.01</td></tr>
<tr><td>Year 2 Estimated Outcome Amount: $4,725,000</td><td>Year 3 Estimated Outcome Amount: $4,728,150</td><td>Year 4 Estimated Outcome Amount: $4,728,150</td><td>Year 5 Estimated Outcome Amount: $4,728,150</td></tr>
<tr><td colspan="4">TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5): $18,909,450</td></tr>
</table>

DRAFT

Title of Outcome Measure (Improvement Target): IT-11.1 – Improvement in Clinical Indicator in identified disparity group

Unique RHP outcome identification number(s): 112672402.3.6

Outcome Measure Description:
IT-11.1 Improvement in Clinical Indicator in identified disparity group
- Numerator: Number of women that are assessed for eligibility for a screening mammogram, during the clinic intake

Process Milestones:
- DY2:
  - P-1 – Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-3 – Develop and test data systems
- DY3:
  - P-3 – Develop and test data systems

Outcome Improvement Targets for each year:
- DY4: IT – 11.1 Numerator: Number of women that are assessed for eligibility for a screening mammogram, during the clinic intake – Improvement percent TBD
- DY5: IT – 11.1 Number of women that are assessed for eligibility for a screening mammogram, during the clinic intake – Improvement percent TBD

Rationale:
Process milestones P-1 and P-3 were chosen due to the lack of accurate reports and resources currently available to measure and monitor the screening of eligibility for screening mammograms. In order to report accurate data and establish baselines, P-1 and P-3 must be approached in DY2-DY3.

Improvement target percentages will be based on the timeframe in which the intervention will occur and expectations based on research of similar interventions for what is achievable during the start-up period of a screening mammography program.

Outcome Measure Valuation:
We valued our Outcome Measures equally within each DY based on our percent allocation for Category 3 per DY (10%, 10%, 15%, and 33%). Within each Outcome Measure, milestones and improvement targets received equal estimated incentive payments based on the total number of milestones and improvement targets within that DY.

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Unique CAT 3 ID: *112672402.3.6*	*Reference Number for RHP PP:* *3.IT-11.1*	*Improvement in Clinical Indicator in identified disparity group*	
Performing Provider Name: The University of Texas MD Anderson Cancer Center			*TPI - 112672402*
Related Category 1 or 2 Projects:	*Unique Category 2 project identifier – ~~112672402.1.1~~ 112672402.2.7*		
Starting Point/Baseline:	*To be determined*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: EHR reports/Patient Records; Stakeholder meeting summaries; Staff meeting summaries Process Milestone 1 Estimated Incentive Payment: $74,384.31 **Process Milestone 2** [P-3]: Develop and test data systems Data Source: EHR reports/Patient Records; Stakeholder meeting summaries; Staff meeting summaries Process Milestone 2 Estimated Incentive Payment: $74,384.31	**Process Milestone 3 [P-3]:** Develop and test data systems Data Source: EHR reports; Stakeholder meeting summaries; Staff meeting summaries Process Milestone 3 Estimated Incentive Payment: $150,223.01	**Outcome Improvement Target 1** [IT-11.1]: Improvement in Clinical Indicator in identified disparity group (Number of women that are assessed for eligibility for a screening mammogram, during the clinic intake). Baseline/Goal: TBD/ Improvement Target: Number of women that are assessed for eligibility for a screening mammogram, during the clinic intake Data Source: EHR reports/Patient Records Outcome Improvement Target 1 Estimated Incentive Payment: $226,804.10	**Outcome Improvement Target 2** [IT-11.1]: Improvement in Clinical Indicator in identified disparity group (Number of women that are assessed for eligibility for a screening mammogram, during the clinic intake). Baseline/Goal: DY 4 baseline/ Improvement Target: Number of women that are assessed for eligibility for a screening mammogram, during the clinic intake increased by 10% Data Source: EHR reports/Patient Records Outcome Improvement Target 2 Estimated Incentive Payment: $705,461.01
Year 2 Estimated Outcome Amount: $148,768.62	Year 3 Estimated Outcome Amount: $150,223.01	Year 4 Estimated Outcome Amount: $226,804.10	Year 5 Estimated Outcome Amount: $705,461.01
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)*: $1,231,257			

DRAFT

Title of Outcome Measure (Improvement Target): IT-12.1 – Breast Cancer Screening (HEDIS 2012)

Unique RHP outcome identification number(s): 112672402.3.7

Outcome Measure Description:

IT-12.1 Breast Cancer Screening (HEDIS 2012)

- Numerator: Number of women aged 40 to 69 that have received an annual mammogram during the reporting period.

Process Milestones:

- DY2:
  - P-1 – Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P-3 – Develop and test data systems
- DY3:
  - P-3 – Develop and test data systems

Outcome Improvement Targets for each year:

- DY4: IT – 12.1 Numerator: Number of women aged 40 to 69 that have received an annual mammogram during the reporting period – Improvement percent TBD
- DY5: IT – 12.1 Number of women aged 40 to 69 that have received an annual mammogram during the reporting period.) – Improvement percent TBD

Rationale:

Process milestones P-1 and P-3 were chosen due to the lack of accurate reports and resources currently available to measure and monitor the provision of breast cancer screening services. In order to report accurate data and establish baselines, P-1 and P-3 must be approached in DY2-DY3.

Improvement target percentages will be based on the timeframe in which the intervention will occur and expectations based on research of similar interventions for what is achievable during the start-up period of a breast cancer screening program.

Outcome Measure Valuation:

We valued our Outcome Measures equally within each DY based on our percent allocation for Category 3 per DY (10%, 10%, 15%, and 33%). Within each Outcome Measure, milestones and improvement targets received equal estimated incentive payments based on the total number of milestones and improvement targets within that DY.

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Unique CAT 3 ID: *112672402.3.7*	*Reference Number for RHP PP:* *3.IT-12.1*	*Breast Cancer Screening (HEDIS 2012)*	
Performing Provider Name: The University of Texas MD Anderson Cancer Center			*TPI - 112672402*
Related Category 1 or 2 Projects:	*Unique Category 2 project identifier – 112672402.2.7*		
Starting Point/Baseline:	*To be determined*		
Year 2 (10/1/2012 – 9/30/2013)	**Year 3** (10/1/2013 – 9/30/2014)	**Year 4** (10/1/2014 – 9/30/2015)	**Year 5** (10/1/2015 – 9/30/2016)
Process Milestone 1 [P-1]: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: EHR reports/Patient Records; Stakeholder meeting summaries; Staff meeting summaries Process Milestone 1 Estimated Incentive Payment: $74,384.31 **Process Milestone 2** [P-3]: Develop and test data systems Data Source: EHR reports/Patient Records; Stakeholder meeting summaries; Staff meeting summaries Process Milestone 2 Estimated Incentive Payment: $74,384.31	**Process Milestone 3 [P-3]:** Develop and test data systems Data Source: EHR reports/Patient Records; Stakeholder meeting summaries; Staff meeting summaries Process Milestone 3 Estimated Incentive Payment: $150,223.01	**Outcome Improvement Target 1** [IT-12.1]: Breast Cancer Screening (HEDIS 2012) Baseline/Goal: TBD Improvement Target: Number of women aged 40 to 69 that have received an annual mammogram during the reporting period. Data Source: EHR reports/Patient Records Outcome Improvement Target 1 Estimated Incentive Payment: $226,804.10	**Outcome Improvement Target 2** [IT-12.1]: Breast Cancer Screening (HEDIS 2012) Baseline/Goal: TBD Improvement Target: Number of women aged 40 to 69 that have received an annual mammogram during the reporting period. Data Source: EHR reports/Patient Records Outcome Improvement Target 2 Estimated Incentive Payment: $705,461.01
Year 2 Estimated Outcome Amount: $148,768.62	Year 3 Estimated Outcome Amount: $150,223.01	Year 4 Estimated Outcome Amount: $226,804.10	Year 5 Estimated Outcome Amount: $705,461.01
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)*: $1,231,257			

DRAFT

University of Texas M.D. Anderson Cancer Center

Pass 2

<u>Title of Outcome Measure (Improvement Target)</u>: IT-11.1 – Improvement in Clinical Indicator in identified disparity group (Smoking Cessation – Staying Quite)

<u>Unique RHP outcome identification number(s)</u>: 112672402.3.8 / Pass 2

<u>Outcome Measure Description</u>:

IT-11.1 – Improvement in Clinical Indicator in identified disparity group (Smoking Cessation – Staying Quit)

- Numerator: Number of smokers enrolled in Quitline treatment that will be abstinent at the time of follow-up

Process Milestones:

- DY2:
  - P-1 – Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans (protocol)
  - P-3 – Develop and test data systems
- DY3:
  - P-3 – Develop and test data systems

Outcome Improvement Targets for each year:

- DY4: IT – 11.1
  - Numerator: Number of smokers enrolled in treatment that will be abstinent at the time of follow-up – Improvement percent: 28%
  - Denominator: Number of smokers enrolled in treatment
  - Data Source: Data from EHR, Alere reports, expired CO and self-report data collected from participants and stored in program databases.

- DY5: IT – 11.1
  - Numerator: Number of smokers enrolled in treatment that will be abstinent at the time of follow-up – Improvement percent: TBD based on baseline and DY4
  - Denominator: Number of smokers enrolled in treatment
  - Data Source: Data from EHR, Alere reports, and project data bases

<u>Rationale</u>:

The selected Category 3 Outcome Improvement Target is smokers enrolled in Quitline cessation treatment that will be abstinent at time of follow-up. At 6-months post completion of the cessation treatment, patients will be contacted by phone to assess smoking status. The SRNT Smoking Abstinence Questionnaire will be used. To confirm cessation, participants will be mailed a carbon monoxide test with a self-addressed envelope. Based on Quitline data and the literature, 28% of smokers enrolled in Quitline treatment are abstinent at 6-month follow-up.

Process milestones P-1 and P-3 were chosen due to the lack of accurate reports and resources currently available to measure and monitor the provision of smoking cessation services provided to smokers in FQHCs. In order to report accurate data and establish baselines, P-1 and P-3 must be approached in DY2-DY3.

This outcome measure corresponds to the overarching goal of the proposed project, to deliver evidence-based smoking cessation treatment to smokers seeking care in FQHCs and to ultimately reduce tobacco-related morbidity and mortality, particularly among individuals who are disproportionately burdened with the disease.

Outcome Measure Valuation:

We valued our Outcome Measures equally within each DY based on our percent allocation for Category 3 per DY (10%, 10%, 15%, and 33%). Within each Outcome Measure, milestones and improvement targets received equal estimated incentive payments based on the total number of milestones and improvement targets within that DY.

Unique CAT 3 ID: 112672402.3.8	*Reference Number for RHP PP:* 3.IT-11.1	*Other Outcome Improvement Target (Smoking Cessation – Staying Quit)*	
Performing Provider Name: The University of Texas MD Anderson Cancer Center			***TPI*** *- 112672402*
Related Category 1 or 2 Projects:	***Unique Category 2 project identifier*** *– 112672402.2.7*		
Starting Point/Baseline:	*To be determined*		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: EHR reports; Alere reports; Project database reports; Stakeholder meeting summaries; Staff meeting summaries Process Milestone 1 Estimated Incentive Payment*:* $8,702.89 **Process Milestone 2** [P-3]: Develop and test data systems Data Source: EHR reports; Alere reports; Project database reports; Stakeholder meeting summaries; Staff meeting summaries Process Milestone 2 Estimated Incentive Payment: $8,702.89	**Process Milestone 3 [P-3]:** Develop and test data systems Data Source: EHR reports; Alere reports; Project database reports; Stakeholder meeting summaries; Staff meeting summaries Process Milestone 3 Estimated Incentive Payment: $18,831.90	**Outcome Improvement Target 1** [IT 11.1]: Improvement in Clinical Indicator in identified disparity group Improvement Target: Number smokers enrolled in Quitline cessation treatment that will be abstinent at time of follow-up: 28% Data Source: EHR reports; Alere reports; self-report and CO test results in project databases Outcome Improvement Target 1 Estimated Incentive Payment*:* $30,857.78	**Outcome Improvement Target 2** [IT 11.1]: Improvement in Clinical Indicator in identified disparity group Improvement Target: Number smokers enrolled in Quitline cessation treatment that will be abstinent at time of follow-up: TBD based on baseline and DY4 Data Source: EHR reports; Alere reports; self-report and CO results in project databases Outcome Improvement Target 2 Estimated Incentive Payment*:* $91,491.99
Year 2 Estimated Outcome Amount: $17,405.78	Year 3 Estimated Outcome Amount: $18,831.90	Year 4 Estimated Outcome Amount: $30,857.78	Year 5 Estimated Outcome Amount: $91,491.99
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD *(add outcome amounts over DYs 2-5)***: $158,587.45**			

Title of Outcome Measure (Improvement Target):

IT-11.6 - Other Outcome Improvement Target (Smoking Cessation – Quit Attempts)

Unique RHP outcome identification number(s): 112672402.3.9 / Pass 2

Outcome Measure Description:

IT-11.6 - Other Outcome Improvement Target (Smoking Cessation – Quit Attempts)

- Numerator: Number of smokers enrolled in Quitline treatment that make a quit attempt

Process Milestones:

- DY2:
  - P-1 – Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans (protocol)
  - P-3 – Develop and test data systems
- DY3:
  - P-3 – Develop and test data systems

Outcome Improvement Targets for each year:

- DY4: IT – 11.6
  - Numerator: Number of smokers enrolled in treatment that make a quit attempt – Improvement percent: 50%
  - Denominator: Number of smokers enrolled in treatment
  - Data Source: Data from EHR, Alere reports, expired CO and self-report data collected from participants and stored in program databases.

- DY5: IT – 11.6
  - Numerator: Number of smokers enrolled in treatment that make a quit attempt – Improvement percent: TBD based on baseline and DY4
  - Denominator: Number of smokers enrolled in treatment
  - Data Source: Data from EHR, Alere reports, expired CO and self-report data collected from participants and stored in program databases.

Rationale:

The selected Category 3 Outcome Improvement Target is smokers enrolled in Quitline cessation treatment that make a quit attempt. At 6-months post completion of the cessation treatment, patients will be contacted by phone to assess smoking status. The SRNT Smoking Abstinence Questionnaire will be used. To confirm cessation, participants will be mailed a carbon monoxide test with a self-addressed envelope. Based on our previous experience with AAC, at least 50% of smokers enrolled in Quitline treatment will make a quit attempt.

Process milestones P-1 and P-3 were chosen due to the lack of accurate reports and resources currently available to measure and monitor the provision of smoking cessation services provided to smokers in FQHCs. In order to report accurate data and establish baselines, P-1 and P-3 must be approached in DY2-DY3.

This outcome measure corresponds to the overarching goal of the proposed project, to deliver evidence-based smoking cessation treatment to smokers seeking care in FQHCs and to ultimately reduce tobacco-related morbidity and mortality, particularly among individuals who are disproportionately burdened with the disease.

Outcome Measure Valuation:

We valued our Outcome Measures equally within each DY based on our percent allocation for Category 3 per DY (10%, 10%, 15%, and 33%). Within each Outcome Measure, milestones and improvement targets received equal estimated incentive payments based on the total number of milestones and improvement targets within that DY.

Unique CAT 3 ID: *112672402.3.9*	*Reference Number for RHP PP:* *3.IT-11.6*	*Other Outcome Improvement Target (Smoking Cessation –Quit Attempts)*	
Performing Provider Name: The University of Texas MD Anderson Cancer Center			***TPI** - 112672402*
Related Category 1 or 2 Projects:	***Unique Category 2 project identifier** – 112672402.2.7*		
Starting Point/Baseline:	*To be determined*		
Year 2 **(10/1/2012 – 9/30/2013)**	**Year 3** **(10/1/2013 – 9/30/2014)**	**Year 4** **(10/1/2014 – 9/30/2015)**	**Year 5** **(10/1/2015 – 9/30/2016)**
Process Milestone 1 [P-1]: Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans Data Source: EHR reports; Alere reports; Project database reports; Stakeholder meeting summaries; Staff meeting summaries Process Milestone 1 Estimated Incentive Payment*:* $8,702.89 **Process Milestone 2** [P-3]: Develop and test data systems Data Source: EHR reports; Alere reports; Project database reports; Stakeholder meeting summaries; Staff meeting summaries Process Milestone 2 Estimated Incentive Payment: $8,702.89	**Process Milestone 3** [P-3]: Develop and test data systems Data Source: EHR reports; Alere reports; Project database reports; Stakeholder meeting summaries; Staff meeting summaries Process Milestone 3 Estimated Incentive Payment: $18,831.90	**Outcome Improvement Target 1** [IT 11.6]: Other Outcome Improvement Target (Smoking Cessation – Staying Quit) Improvement Target: Number smokers enrolled in Quitline cessation treatment that make a quit attempt: 50% Data Source: EHR reports; Alere reports; self-report and CO test results in project databases Outcome Improvement Target 1 Estimated Incentive Payment: $30,857.78	**Outcome Improvement Target 2** [IT 11.6]: Other Outcome Improvement Target (Smoking Cessation – Staying Quit) Improvement Target: Number smokers enrolled in Quitline cessation treatment that make a quit attempt: TBD based on baseline and DY4 Data Source: EHR reports; Alere reports; self-report and CO test results in project databases Outcome Improvement Target 2 Estimated Incentive Payment*:* $91,491.99
Year 2 Estimated Outcome Amount: $17,405.78	Year 3 Estimated Outcome Amount: $18,831.90	Year 4 Estimated Outcome Amount: $30,857.78	Year 5 Estimated Outcome Amount: $91,491.99
TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD ***(add outcome amounts over DYs 2-5):*** **$158,587.45**			

West Houston Medical Center

Pass 1

Title of Outcome Measure (Improvement Target):
OD-3: IT 3.3.1: Potentially Preventable Readmissions

Unique RHP outcome identification number(s): 094187402.3.1

Outcome Measure Description:

HCA chose this outcome to accompany its project to create a Senior Care Coordinator position in its West Houston facility, who will engage in senior patient navigation of the healthcare continuum. HCA believes one result of that project will be a reduction in potentially preventable readmissions (PPRs) for patients enrolled in the navigator program. HCA expects this result because improved access to primary and preventative care, support, and education are evidence-based methods for reducing deterioration of patients' conditions upon discharge from an inpatient stay. Too often seniors do not have access to these services, and as a result their health outcomes are negatively impacted and the systemic cost of treating these patients in increased.

Process Milestones:

HCA chose its DY2 and DY3 process milestones in order to develop a system for measuring improvement and to establish a baseline by which to measure improvement in DYs 4-5.

Outcome Improvement Targets for each year:

HCA chose its improvement targets in order to measure the reduction in PPRs once the Senior Care Coordination program has gone into effect. The amount of improvement is TBD until DY3, when HCA will have established a baseline, and can determine a reasonable yet meaningful target for improvement.

Rationale:

HCA selected this outcome measure and improvement target because HCA has identified geriatric patients as one population with a high rate of PPRs. As of the second quarter of 2012, West Houston Medical Center had a 14.3% readmission rate for all cause readmissions within 30 days for the Medicare population for the previous twelve months. This rate represents a performance that is lower than the average for Medicare patients. HCA believes that improving the rate of PPRs will improve patient outcomes, and will reduce the cost of providing care to geriatric patients. The goals of the Waiver are to make healthcare more patient-centered, less episodic and more consistent, and to reduce the cost of care in order to provide services to the ever increasing population of Medicaid and uninsured patients requiring services. This outcome reflects each of these Waiver goals.

Outcome Measure Valuation:

The valuation of each Spohn Category 3 outcome takes into account the degree to which the project accomplishes the triple-aims of the Waiver, addresses community needs, benefits the population served by the project, and the investment required to implement the project. Spohn determined the value of this outcome by assessing the potential impact of increased availability of psychiatric nurse practitioners within the Region, though recognizing that even with an aggressive schedule the first matriculation would not occur until the last year of the Waiver.

<table>
<tr><td>094187402.3.1</td><td>IT-3.1</td><td colspan="2">30 Day All Cause Potentially Preventable Admissions (for geriatric patients)</td></tr>
<tr><td colspan="3">HCA – West Houston Medical Center</td><td>094187402</td></tr>
<tr><td>Related Category 1 or 2 Projects::</td><td colspan="3">094187402.2.1</td></tr>
<tr><td>Starting Point/Baseline:</td><td colspan="3">Potentially Preventable Readmissions</td></tr>
<tr><th>Year 2

(10/1/2012 – 9/30/2013)</th><th>Year 3

(10/1/2013 – 9/30/2014)</th><th>Year 4

(10/1/2014 – 9/30/2015)</th><th>Year 5

(10/1/2015 – 9/30/2016)</th></tr>
<tr><td><u>Process Milestone 1</u>

[P-3]: Develop and test data systems: HCA will develop a method for identifying geriatric patients, measuring the rate of PPRs for these patients, and cross-referencing that data with patients enrolled in HCA's new Senior Care Coordination program.

<u>Data Source:</u> Hospital data reports

Process Milestone 1 Estimated Incentive Payment (maximum amount): $379,176</td><td><u>Process Milestone 2</u>

[P-2]: Establish a baseline – HCA will establish a baseline rate of 30 day PPRs for geriatric in-patients discharged from the hospital, for all causes, in order to measure progress going forward

<u>Data Source:</u> Hospital records, EHR

Process Milestone 2 Estimated Incentive Payment: $439,514</td><td>Outcome Improvement Target 1[IT 3.1] – All Cause, 30 day PPRs

Improvement Target: Decrease the number of PPRs for geriatric patients treated at HCA's West Houston facility by an amount TBD under baseline established in DY3.

<u>Data Source:</u> Hospital admission records

Outcome Improvement Target 1 Estimated Incentive Payment: $705,267</td><td>Outcome Improvement Target 2[IT-3.1]: All Cause, 30 day PPRs

Improvement Target: Decrease the number of PPRs for geriatric patients treated at HCA's West Houston facility by an amount TBD under baseline established in DY3.

<u>Data Source:</u> Loan documentation

Outcome Improvement Target 2 Estimated Incentive Payment: $1,686,509</td></tr>
<tr><td>Year 2 Estimated Outcome Amount: $379,176</td><td>Year 3 Estimated Outcome Amount: $439,514</td><td>Year 4 Estimated Outcome Amount: $705,267</td><td>Year 5 Estimated Outcome Amount: $1,686,509</td></tr>
<tr><td colspan="4">TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5): $3,210,466</td></tr>
</table>

D. Category 4 Narratives

El Campo Memorial Hospital

Category 4 Population-Focused Improvements - Narrative

Performing Provider Name: El Campo Memorial Hospital (ECMH)
Performing Provider TPI #: 131045004

Domain 1: Potentially Preventable Admissions (8 measures)

- **Description** – The population at ECMH of the 8 measures listed under Doman 1 is not anticipated to be sufficiently large to produce statistically valid data. However, ECMH will report this information annually as required by HHSC since the definition of the terminology "sufficiently large" has not been defined at this time. ECMH expects that its implementation of the Patient Experience Training Program will have a positive impact on the number of potentially preventable admissions for patients by focusing on reducing patient anxiety and increasing patient compliance with discharge instructions and follow-up health care. It is expected that patients will become healthier which will minimize admissions.

- **Valuation Rationale/Justification** – The value ECMH placed on this domain is based upon the value the hospital attributes to understanding the causes of and health/financial impacts of potentially preventable admissions. The goals of the Waiver are to reduce the cost of providing care and to improve patient health outcomes. Understanding our starting point and tracking our improvement is essential to making progress. Potentially preventable admissions 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 potentially preventable admissions at ECMH will have a beneficial impact on individual patient outcomes and significantly reduce the financial burden of paying for potentially preventable admissions. ECMH values this reporting domain at $15,819 over DY 3-5, requiring local funding of $6,358.

Domain 2: 30-day readmissions (7 measures)

- **Description** – The population at ECMH of the 7 measures listed under Doman 2 is not anticipated to be sufficiently large to produce statistically valid data. However, ECMH will report this information annually as required by HHSC since the definition of the terminology "sufficiently large" has not been defined at this time. ECMH expects that its implementation of the Patient Experience Training Program will have a positive impact on the number of potentially preventable 30-day readmissions for patients by focusing on reducing patient anxiety and increasing patient compliance with discharge instructions and follow-up health care. If patients follow their recommended plan of care, it is expected that they are less likely to be readmitted within 30 days for the same condition.

- **Valuation Rationale/Justification** – The value ECMH 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. The goals of the Waiver are to reduce the cost of providing care and to improve patient health outcomes. Understanding our starting point and tracking our improvement is essential to making progress. Potentially preventable

30-day readmissions 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 30-day admissions at ECMH will have a beneficial impact on individual patient outcomes and significantly reduce the financial burden of paying for 30-day readmissions. ECMH values this reporting domain at $15,819 over DY 3-5, requiring local funding of $6,358.

Domain 3: Potentially Preventable Complications (64 measures)

- **Description** – The population at ECMH of the 64 measures listed under Doman 3 is not anticipated to be sufficiently large to produce statistically valid data. However, ECMH will report this information annually as required by HHSC since the definition of the terminology "sufficiently large" has not been defined at this time. ECMH suffers from shortages of space, staffing, equipment, and protocols for preventing complications like the measures in this domain. However, ECMH is dedicated to assuring that it takes all possible steps to improve its provision of healthcare where indicated. Through the implementation of the Patient Experience Training Program, ECMH expects to reduce patient anxiety and increase patient compliance with discharge instructions and follow-up health care which is expected to improve patient satisfaction and ultimately health outcomes.

- **Valuation Rationale/Justification** – The value ECMH 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 ECMH to evaluate its own performance and will allow for organizational change that will be invaluable for ECMH's patients. The goals of the Waiver are to reduce the cost of providing care and to improve patient health outcomes. Understanding our starting point and tracking our improvement is essential to making progress. ECMH values this reporting domain at $10,925 over DY 3-5, requiring local funding of $4,391.

Domain 4: Patient-Centered Healthcare (2 measures)

- **Description** – ECMH will report on Patient Satisfaction and Medication Management under this domain in an effort to gauge how well ECMH 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. ECMH is committed to preventing this from happening. Additionally, medication management is a primary function that ECMH's providers need to engage in with patients to avoid readmissions, complications and to promote improved health outcomes outside of the hospital setting. ECMH expects that its implementation of the Patient Experience Training Program will have a positive impact on patient satisfaction and medication management by focusing on reducing patient anxiety which is expected to increase patient compliance with discharge instructions, follow-up health care and living a healthy lifestyle.

- **Valuation Rationale/Justification** – The value ECMH placed on this domain is based upon the value the hospital attributes to understanding how patients perceive the care

they receive from ECMH and how well ECMH performs its function of promoting medication management. The goals of the Waiver are to reduce the cost of providing care and to improve patient health outcomes. Understanding our starting point and tracking our improvement is essential to making progress. The potential result of tracking and improving patient satisfaction and medication management at ECMH will have a beneficial impact on individual patient outcomes and significantly reduce overall healthcare costs. ECMH values this reporting domain at $15,819 over DY 3-5, requiring local funding of $6,358.

Domain 5: Emergency Department (1 measure)

- **Description** – ECMH will measure the admit decision time to ED departure for admitted patients. ECMH expects that its implementation of the Patient Experience Training Program will have a positive impact on established patients by reducing their anxiety and in turn increasing their healthcare compliance such as seeking preventative health care and living healthy lifestyles. This is expected to reduce the number of visits to the ED by established patients in the ECMH system which would in turn reduce the number of admissions from the ED and ultimately reduce overall healthcare costs.

- **Valuation Rationale/Justification** – The value ECMH placed on this domain is based upon the value the hospital attributes to knowing how well it is currently performing in the ED and to making goals for self-improvement. Long ED wait times can lead to complications, poor outcomes and patient dissatisfaction. The goals of the Waiver are to reduce the cost of providing care and to improve patient health outcomes. Understanding our starting point and tracking our improvement is essential to making progress. ECMH values this reporting domain at $15,820 over DY 3-5, requiring local funding of $6,360.

Gulf Coast Medical Center

Performing Provider Name: Gulf Coast Medical Center
Performing Provider TPI #: 178815001

Domain 1: Potentially Preventable Admissions

- **Description:**
  - This performing provider will report on the eight (8) potentially preventable admissions as defined in the Category 4 population –focused improvements.
  - Findings for this domain will begin being reported to HHSC in year 3.
  - **Domain Description**: Potentially Preventable Admissions relates to this performing provider's Category 1 Project (Establish Adult Inpatient Psychiatric Unit) in a variety of ways. Common diseases such as those included in this Domain affect individuals of all ages and are frequently a co morbidity of those individuals with mental illnesses. Congestive Heart Failure, Diabetes, Chronic Obstructive Pulmonary Disease and Hypertension are the diagnoses in this Domain that may have the greatest impact with regard to preventing admissions. Those patients with a mental disorder/s that are not under the care of a mental health practitioner and have medical co morbidities are at risk for non-compliance of their treatment plan which results in admission. With the availability of treatment for mental disorders through our project those patients with co morbidities are more likely to be compliant with treatment plans thus preventing an admission.
  - Expected improvement for DY2-DY5 is difficult to determine but it is anticipated to decrease the number of potentially preventable admissions of adult psychiatric patients that have received treatment and have additional medical co morbidities.
  - **Valuation:**

    The following valuation for this domain for DY3 through DY5 is as follows for a total of $79,500.
    DY 3 $24,500
    DY 4 $27,500
    DY 5 $27,500

    Areas considered when determining valuation for this domain have been addressed in the domain description.

Domain 2- RD-2 30 Day Readmissions

- This performing provider will report on the seven (7) focus areas for 30 day readmissions.
- Findings for this domain will begin being reported to HHSC in year 3.
- **Domain Description:** 30 Day Readmissions relates to this performing provider's Category 1 Project (Establish An Adult Inpatient Psychiatric Unit) similar to the relation outlined for potentially preventable admission. Individuals with mental health disorders that have not received treatment or are non-compliant with the treatment plan for the mental illness may also be non-complaint with the treatment plan for existing co morbidities thus resulting in readmission. It is anticipated that the 30 readmission measure –behavioral health and substance abuse- will show the highest impact with regard to readmissions as a result of this performing provider's Category 1 Project. This provider has selected the Category 3 Outcome Improvement IT-1.18 Follow up

after Hospitalization for Mental Illness as it relates to the Category 1 Project. A baseline will be established in year 3 with improvement targets established for year 4 and 5 utilizing baseline findings.

- Expected Improvement for Y2 to Y5 will be defined from baseline data for the target outcome specifically selected to measure outcomes for the providers Category 1 Project.
- **Domain Valuation:**

  The following valuation for this domain for DY3 through DY5 is as follows for a total of $79,500.

  DY 3 $24,500
  DY 4 $27,500
  DY 5 $27,500

  Areas considered when determining valuation for this domain have been addressed in the domain description.

Domain 3- RD-3 Potentially Preventable Complications

- A total of 64 potentially preventable complications will be reported by Gulf Coast Medical Center.
- Findings for this domain will begin being reported to HHSC in year 4.
- **Domain Description:** Potentially Preventable Complications relates to our chosen Category 1 Project involving the establishment of an adult inpatient psychiatric unit. All patients admitted to the proposed unit that have existing co morbidities which are left untreated could possibly have resulting complications. Individuals admitted to the proposed psychiatric unit with co morbidities will receive treatment for their additional medical diagnoses to prevent potential complications.
- Anticipated improvement in year Y3-Y5 is a decrease in the number of preventable complications.
- **Domain Valuation:**

  The following valuation for this domain for DY4 and DY5 is as follows for a total of $55,000.

  DY 4 $27,500
  DY 5 $27,500

Areas considered when determining valuation for this domain have been addressed in the domain description.

Domain 4- RD-4 Patient Centered Healthcare

- This performing provider will report on the two (2) patient-centered healthcare measures as defined in the Category 4 population –focused improvements..
  - **Domain Description:**
    - Patient Satisfaction: The following themes will be reported to include your care from doctors, your care from nurses, the hospital environment and when you left the hospital.
      - Reporting will begin DY 2 with baseline targets from the acute care settings for this performing provider. .

- Medication Management: All patients discharged from the inpatient setting will be included in reporting of data from this measure. Two measures will be reported by this performing provider to include medications to be taken by the patient and medications not to be taken by the patient.
  - Reporting will begin DY 2 with baseline targets from the acute care settings for this performing provider.

- **Domain Valuation:**
  The following valuation for this domain for DY3 through DY5 is as follows for a total of $79,500.
  DY 3 $24,500
  DY 4 $27,500
  DY 5 $27,500

Areas considered when determining valuation for this domain have been addressed in the domain description.

Domain 5 –RD-5 Emergency Department

- **Domain Description:** This performing provider will report on admit decision time to ED departure time for admitted patients (NQF 497).
  - Decision time to transfer an emergency patient to another facility ie, decision to make the first call from arrival in transferring ED until call initiatied.
  - Threshold of <1 hour for critical patients.
  - This domain does not relate to this performing provider Category 1 Project.

- **Domain Valuation:**
  The following valuation for this domain for DY3 through DY 5 is as follows for a total of $79,500.
  DY 3 $24,500
  DY 4 $27,500
  DY 5 $27,500

Areas considered when determining valuation for this domain have been addressed in the domain description.

Harris County Hospital District / Ben Taub Hospital

Performing Provider Name: **Harris Health System**
Performing Provider TPI #: **133355104**

Domain 1: Potentially Preventable Admissions (8 measures)

- **Description** – Harris Health System will report on the 8 measures in this domain in an effort to gain information on and understanding of the health status of its patients with regard to potentially preventable admissions, which are often linked with poor chronic disease management and lack of access to appropriate outpatient healthcare. Harris Health System expects that expanding services into primary care clinics will reroute patients away from emergent and inpatient settings and allow for better optimization of care.

- **Valuation** – The Harris Health System placed an equal value on all domains reported based on the number of domains per distribution year. As the goal of the Waiver is to reduce cost, improve access, and improve quality outcomes, the Harris Health System will utilize the required Category 4 Population-Focused Improvements as an internal key indicator to drive strategy and review impact of all projects implemented. All initiatives submitted will have beneficial impacts on majority of the domains reported within an appropriate timeline identified.

Domain 2: Potentially Preventable Readmissions – 30 days (7 measures)

- **Description** – Harris Health System 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. Harris Health System expects that the assignment of clinical case managers upon discharge will increase patient access to follow-up care and support in the community, thereby preventing the likelihood of a preventable readmission.

- **Valuation** – The Harris Health System placed an equal value on all domains reported based on the number of domains per distribution year. As the goal of the Waiver is to reduce cost, improve access, and improve quality outcomes, the Harris Health System will utilize the required Category 4 Population-Focused Improvements as an internal key indicator to drive strategy and review impact of all projects implemented. All initiatives submitted will have beneficial impacts on majority of the domains reported within an appropriate timeline identified.

Domain 3: Potentially Preventable Complications (64 measures)

- **Description** – Harris Health System 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 Harris Health System is dedicated to assuring that it takes all

possible steps to improve its provision of healthcare where indicated. Harris Health System expects that its expansion of primary care and follow-up of chronic diseases in the primary care setting will reduce the volume of unnecessary utilization of hospital services which can be associated with an unnecessary complication.

- **Valuation** – The Harris Health System placed an equal value on all domains reported based on the number of domains per distribution year. As the goal of the Waiver is to reduce cost, improve access, and improve quality outcomes, the Harris Health System will utilize the required Category 4 Population-Focused Improvements as an internal key indicator to drive strategy and review impact of all projects implemented. All initiatives submitted will have beneficial impacts on majority of the domains reported within an appropriate timeline identified.

Domain 4: Patient-Centered Healthcare (2 measures)

- **Description** – Harris Health System 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. Harris Health System 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. Harris Health System expects improved patient satisfaction in the hospital setting and effective medication management protocols for patients to correlate with Harris Health System's projects oriented toward expansion of primary care and optimization of chronic disease management.

- **Valuation** – The Harris Health System placed an equal value on all domains reported based on the number of domains per distribution year. As the goal of the Waiver is to reduce cost, improve access, and improve quality outcomes, the Harris Health System will utilize the required Category 4 Population-Focused Improvements as an internal key indicator to drive strategy and review impact of all projects implemented. All initiatives submitted will have beneficial impacts on majority of the domains reported within an appropriate timeline identified.

Domain 5: Emergency Department (1 measure)

- **Description** – Harris Health System will measure the admit decision time to ED departure time for admitted patients. This measure is important because patients often languish in hospital EDs due to lack of systemic cooperation between hospitals, their departments, and other types of providers, and the patients experience poor health outcomes as a result. Harris Health System will expand primary care to accommodate patients that utilize the emergency center for primary care. There will also be establishment of urgent care clinics for patients needing acute care after-hours.

- **Valuation** – The Harris Health System placed an equal value on all domains reported based on the number of domains per distribution year. As the goal of the Waiver is to reduce cost, improve access, and improve quality outcomes, the Harris Health System will utilize the required Category 4 Population-Focused Improvements as an internal key indicator to drive strategy and review impact of all projects implemented. All initiatives submitted will have beneficial impacts on majority of the domains reported within an appropriate timeline identified.

HCA Bayshore Hospital

Performing Provider Name: **HCA Bayshore Medical Center ("Bayshore")**
Performing Provider TPI #: **094187402**

Domain 1: Potentially Preventable Admissions (8 measures)

- **Description** – Bayshore will report on the 8 measures in this domain in an effort to gain information on and understanding of the health status of its patients with regard to potentially preventable admissions, which are often linked with poor chronic disease management and lack of access to appropriate outpatient healthcare. Bayshore expects that its expansion of OB/Gyn services in its community clinics will have a positive impact on the number of PPAs for women with manageable obstetric/gynecological conditions that can be treated and/or managed outside of the hospital setting with proper access to primary care. Additionally, the physicians providing the OB/Gyn care can provide patients with detection and management of other conditions that lead to PPAs for clients who are otherwise unable to access primary care.

- **Valuation Rationale/Justification** – The value Bayshore placed on this domain is based upon the value the hospital attributes to understanding the causes of and health/financial impacts of potentially preventable admissions. The goals of the Waiver are to reduce the cost of providing care and to improve patient access and health outcomes. Understanding our starting point and tracking our improvement is essential to making progress. PPAs negatively impact patient outcomes (including overall health, satisfaction, and quality of life), which can have short- and long-term consequences for the cost of delivering care to patients. The potential result of tracking and reducing PPAs in at Bayshore will have a beneficial impact on individual patient outcomes and significantly reduce the financial burden of paying for PPAs. Bayshore values this reporting domain at $663,020 over Demonstration Years 3-5, requiring local funding of $266,533.

Domain 2: Potentially Preventable Readmissions – 30 days (7 measures)

- **Description** – Bayshore 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. Bayshore expects that the use of telemedicine in HCA's local EDs could lead to a reduction in PPRs for BH/SA patients because the project aims to place BH/SA patients into the appropriate care setting as quickly and effectively as possible. If these patients receive the care they need during and after hospitalization, they are much less likely to be readmitted within 30 days for the same condition.

- **Valuation Rationale/Justification** - The value Bayshore 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 for Bayshore patients will have a beneficial impact on individual patient outcomes and significantly reduce the financial burden of paying for PPRs. Bayshore values this reporting domain at $663,020 over Demonstration Years 3-5, requiring local funding of $266,533.

Domain 3: Potentially Preventable Complications (64 measures)

- **Description** – Bayshore 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 Bayshore is dedicated to assuring that it takes all possible steps to improve its provision of healthcare where indicated.

- **Valuation Rationale/Justification** - The value Bayshore 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. Bayshore values this reporting domain at $457,913 over Demonstration Years 3-5, requiring local funding of $184,080.

Domain 4: Patient-Centered Healthcare (2 measures)

- **Description** – Bayshore 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. Bayshore 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. Bayshore hopes that implementing the telepsychiatry into the local HCA facilities will improve satisfaction for BH/SA patients, who currently spend extended amounts of time in the ED when they seek services at the hospital.

- **Valuation Rationale/Justification** - The value Bayshore placed on this domain is based upon the value the hospital attributes to understanding how patients perceive the care they receive from Bayshore and how well Bayshore performs its function of promoting medication management. Bayshore 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 and lack of care coordination for traditionally underserved patients in Houston is costly to patients' health and to the delivery system, and Bayshore 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. Bayshore values this reporting domain at $663,020 over Demonstration Years 3-5, requiring local funding of $266,533.

Domain 5: Emergency Department (1 measure)

- **Description** – Bayshore will measure the admit decision time to ED departure time for admitted patients. This measure is important because patients often languish in hospital EDs due to lack of systemic cooperation between hospitals, their departments, and other types of providers, and the patients experience poor health outcomes as a result. Bayshore's telepsychiatry project in the local HCA EDs will seek to improve the admit decision time to ED departure time for BH/SA patients, who often wait days for appropriate placement due to a shortage of providers to perform assessments.

- **Valuation Rationale/Justification** - The value Bayshore placed on this domain is based upon the value the hospital attributes to knowing how well it is currently performing in the ED and to making goals for self-improvement. Long ED wait times can lead to complications, poor outcomes, and patient dissatisfaction with their care. The goals of the Waiver are to reduce the cost of providing care and to improve patient access and health outcomes. Understanding our starting point and tracking our improvement is essential to making progress. Bayshore values this reporting domain at $663,018 over Demonstration Years 3-5, requiring local funding of $266,533.

HCA West Houston Medical Center

Performing Provider Name: **HCA West Houston Medical Center ("WHMC")**
Performing Provider TPI #: **094187402**

Domain 1: Potentially Preventable Admissions (8 measures)

- **Description** – WHMC will report on the 8 measures in this domain in an effort to gain information on and understanding of the health status of its patients with regard to potentially preventable admissions, which are often linked with poor chronic disease management and lack of access to appropriate outpatient healthcare. WHMC expects that assigning care coordinators to seniors who visit WHMC through its Category 1 project will result in senior patients receiving expanded primary care services in the community, reducing the number of PPAs going forward for those patients. More specifically, WHMC hopes that senior patients with chronic diseases will be better able to engage in self-management goals and activities of daily living with the support, education, and services that primary care providers participating with WHMC in this project can offer to a currently underserved patient population.

- **Valuation Rationale/Justification** – The value WHMC placed on this domain is based upon the value the hospital attributes to understanding the causes of and health/financial impacts of potentially preventable admissions. The goals of the Waiver are to reduce the cost of providing care and to improve patient access and health outcomes. Understanding our starting point and tracking our improvement is essential to making progress. PPAs negatively impact patient outcomes (including overall health, satisfaction, and quality of life), which can have short- and long-term consequences for the cost of delivering care to patients. The potential result of tracking and reducing PPAs in at WHMC will have a beneficial impact on individual patient outcomes and significantly reduce the financial burden of paying for PPAs. WHMC values this reporting domain at $284,151 over Demonstration Years 3-5, requiring local funding of $114,228.

Domain 2: Potentially Preventable Readmissions – 30 days (7 measures)

- **Description** – WHMC 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. WHMC expects that the assignment of senior hospital patients to Senior Care Coordinators upon discharge will increase their access to follow-up care and support in the community, thereby preventing the likelihood of a PPR. WHMC's Category 3 Outcome is based upon accomplishing a percentage reduction in the number of PPRs for geriatric patients by the end of DY5, by a percentage to be established in DY3.

- **Valuation Rationale/Justification** - The value WHMC 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 for WHMC patients will have a beneficial impact on individual patient outcomes and significantly reduce the financial burden of paying for PPRs. WHMC values this reporting domain at $284,151 over Demonstration Years 3-5, requiring local funding of $114,228.

Domain 3: Potentially Preventable Complications (64 measures)

- **Description** – WHMC 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 WHMC is dedicated to assuring that it takes all possible steps to improve its provision of healthcare where indicated. WHMC expects that its Category 1 project to add a "Senior Care Entrance" to the hospital and provide special beds for geriatric patients will have a positive impact on the PPC rate for the geriatric population seen in the hospital.

- **Valuation Rationale/Justification** - The value WHMC 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. WHMC values this reporting domain at $196,248 over Demonstration Years 3-5, requiring local funding of $78,891.

Domain 4: Patient-Centered Healthcare (2 measures)

- **Description** – WHMC 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. WHMC 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. WHMC expects improved patient satisfaction in the hospital setting and effective medication management protocols for seniors to correlate with WHMC's Category 1 project to provide geriatric-oriented hospital accommodations and care coordination.

- **Valuation Rationale/Justification** - The value WHMC placed on this domain is based upon the value the hospital attributes to understanding how patients perceive the care they receive from WHMC and how well WHMC performs its function of promoting medication management. WHMC 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 and lack of care coordination for traditionally underserved patients (such as the elderly) in Houston is costly to patients' health and to the delivery system, and WHMC 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. WHMC values this reporting domain at $284,151 over Demonstration Years 3-5, requiring local funding of $114,228.

Domain 5: Emergency Department (1 measure)

- **Description** – WHMC will measure the admit decision time to ED departure time for admitted patients. This measure is important because patients often languish in hospital EDs due to lack of systemic cooperation between hospitals, their departments, and other types of providers, and the patients experience poor health outcomes as a result.

- **Valuation Rationale/Justification** - The value WHMC placed on this domain is based upon the value the hospital attributes to knowing how well it is currently performing in the ED and to making goals for self-improvement. Long ED wait times can lead to complications, poor outcomes, and patient dissatisfaction with their care. The goals of the Waiver are to reduce the cost of providing care and to improve patient access and health outcomes. Understanding our starting point and tracking our improvement is essential to making progress. WHMC values this reporting domain at $284,151 over Demonstration Years 3-5, requiring local funding of $114,228.

Memorial Hermann Hospital

Performing Provider Name: Memorial Hermann Hospital
Performing Provider TPI #: 137805107

Domain 1: Potentially Preventable Admissions (8 measures)

- **Description** – Memorial Hermann Hospital ("Memorial") will report on the 8 measures in this domain in an effort to gain information on and understanding of the health status of its patients with regard to potentially preventable admissions, which are often linked with poor chronic disease management and lack of access to appropriate outpatient healthcare. Memorial plans to implement Category 1 DSRIP projects with the goal of addressing the root causes of potentially preventable admissions. Specifically, this project will expand regional primary care capacity by establishing primary care clinics. Memorial expects that this project will reduce potentially preventable admissions by making it easier for more patients to receive the primary care they need in appropriate outpatient settings rather than inpatient or emergent settings. Memorial also believes that the increased availability of primary care services in the community will allow potentially harmful and expensive health conditions to be detected and treated early and inexpensively.

- **Valuation Rationale/Justification** – The value Memorial has placed on this domain is based upon the value the hospital attributes to understanding the causes of and health/financial impacts of potentially preventable admissions. The goals of the Waiver are to reduce the cost of providing care and to improve patient access and health outcomes. Understanding our starting point and tracking our improvement is essential to making progress. PPAs negatively impact patient outcomes (including overall health, satisfaction, and quality of life), which can have short- and long-term consequences for the cost of delivering care to patients. The potential result of tracking and reducing PPAs at Memorial will have a beneficial impact on individual patient outcomes and significantly reduce the financial burden of paying for PPAs. Memorial values this reporting domain at $2,497,998 over Demonstration Years 3-5.

Domain 2: Potentially Preventable Readmissions – 30 days (7 measures)

- **Description** – Memorial will report on the 7 measures in this domain in an effort to gain information on and understanding of the health status of patients it has treated, discharged, and then readmitted for the same principal diagnosis. Too many patients are released from the hospital into the community with no follow-up or support, and end up back in the hospital inpatient setting soon thereafter. Memorial expects that its improvement of access to primary care services through establishing additional primary care clinics will allow patients recently discharged from the hospital to access follow-up care and support, thereby preventing the likelihood of a PPR.

- **Valuation Rationale/Justification** - The value Memorial placed on this domain is based upon the value the hospital attributes to understanding the causes of and health/financial impacts of 30-day readmissions. Specifically, the measures are targeted towards prevalent chronic diseases (e.g., diabetes and congestive heart failure) and then allow for a broad measure of readmissions, which will allow the hospital to gauge the potential causes of these rates in conjunction with each other and as a whole. The goals of the

Waiver are to reduce the cost of providing care and to improve patient access and health outcomes. Understanding our starting point and tracking our improvement is essential to making progress. The potential result of tracking and reducing PPRs at Memorial will have a beneficial impact on individual patient outcomes and significantly reduce the financial burden of paying for PPRs. Memorial values this reporting domain at $2,497,998 over Demonstration Years 3-5.

Domain 3: Potentially Preventable Complications (64 measures)

- **Description** – Memorial will report on the 64 measures in this domain in an effort to understand the most prevalent causes of PPCs and to use the information to make institutional reforms toward reducing the rates. Hospitals suffer from shortages of space, staffing, equipment, and protocols for preventing complications like the measures in this domain, and Memorial is dedicated to assuring that it takes all possible steps to improve its provision of healthcare where indicated. Memorial expects that its expanded provision of primary care and of follow-up care for chronic diseases will reduce the volume of unnecessary utilization of hospital services, thus alleviating one of the problems which can result in unnecessary complications for inpatients. The ongoing quality improvement activities which constitute an essential part of Memorial's Category 3 projects will also help to ensure that error rates and complications are reduced at all levels of care throughout Memorial.

- **Valuation Rationale/Justification** - The value Memorial placed on this domain is based upon the value the hospital attributes to understanding the causes of and health/financial impacts of potentially preventable complications. Reporting on this domain will require the hospital to evaluate its own performance, and will allow for institutional change that will be invaluable for the hospital's patients and the hospital's operating costs. The goals of the Waiver are to reduce the cost of providing care and to improve patient access and health outcomes. Understanding our starting point and tracking our improvement is essential to making progress. Memorial values this reporting domain at $1,724,544 over Demonstration Years 3-5.

Domain 4: Patient-Centered Healthcare (2 measures)

- **Description** – Memorial 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. Memorial 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. Memorial expects improved patient satisfaction in the hospital setting and effective medication management protocols for inpatients to correlate with Memorial's projects to strengthen primary care access in the community and to promote and facilitate management of chronic conditions, because satisfied

patients recently discharged from the hospital will be more likely to seek and receive the support they need to maintain their health upon discharge (including medication management).

- **Valuation Rationale/Justification** - The value Memorial placed on this domain is based upon the value the hospital attributes to understanding how patients perceive the care they receive from Memorial and how well Memorial performs its primary care and post-discharge functions. Memorial is committed to improving patient outcomes, and therefore places a high value on these measures. The goals of the Waiver are to reduce the cost of providing care and to improve patient access and health outcomes. Understanding our starting point and tracking our improvement is essential to making progress. Prevalent chronic disease in our community is costly to patients' health and to the delivery system, and Memorial believes that its hospital services must leave these patients satisfied and confident in the healthcare delivery system, in order for the expansion of primary care to have the maximum beneficial impact for the community. Memorial values this reporting domain at $2,497,998 over Demonstration Years 3-5.

Domain 5: Emergency Department (1 measure)

- **Description** – Memorial will measure the admit decision time to ED departure time for admitted patients. This measure is important because patients often languish in hospital EDs due to lack of systemic cooperation between hospitals, their departments, and other types of providers, and the patients experience poor health outcomes as a result. This reporting domain ties in with one of the overall aims of the waiver: to reduce inappropriate use of the ED. One cause of extended ED departure times results from an overcrowded ED. Memorial intends to expand access to primary care for patients who currently are unable to access primary care due to factors such as the lack of primary care providers in the community, and to improve follow-up care for discharged patients diagnosed with chronic health conditions, which Memorial expects will reduce the number of inappropriate ED visits and therefore allow for better management of ED processes such as admit decisions.

- **Valuation Rationale/Justification** - The value Memorial placed on this domain is based upon the value the hospital attributes to knowing how well it is currently performing in the ED and to making goals for self-improvement. Long ED wait times can lead to complications, poor outcomes, and patient dissatisfaction with their care. The goals of the Waiver are to reduce the cost of providing care and to improve patient access and health outcomes. Understanding our starting point and tracking our improvement is essential to making progress. Memorial values this reporting domain at $2,497,998 over Demonstration Years 3-5.

Memorial Hermann Hospital System

Performing Provider Name: **Memorial Hermann Hospital System**
Performing Provider TPI #: **020834001**

Domain 1: Potentially Preventable Admissions (8 measures)

- **Description** – Memorial Hermann Hospital System ("Memorial") will report on the 8 measures in this domain in an effort to gain information on and understanding of the health status of its patients with regard to potentially preventable admissions, which are often linked with poor chronic disease management and lack of access to appropriate outpatient healthcare. Memorial plans to implement Category 1 DSRIP projects with the goal of addressing the root causes of potentially preventable admissions. Specifically, this project will expand regional primary care capacity by establishing primary care clinics. Memorial expects that this project will reduce potentially preventable admissions by making it easier for more patients to receive the primary care they need in appropriate outpatient settings rather than inpatient or emergent settings. Memorial also believes that the increased availability of primary care services in the community will allow potentially harmful and expensive health conditions to be detected and treated early and inexpensively.

- **Valuation Rationale/Justification** – The value Memorial has placed on this domain is based upon the value the hospital attributes to understanding the causes of and health/financial impacts of potentially preventable admissions. The goals of the Waiver are to reduce the cost of providing care and to improve patient access and health outcomes. Understanding our starting point and tracking our improvement is essential to making progress. PPAs negatively impact patient outcomes (including overall health, satisfaction, and quality of life), which can have short- and long-term consequences for the cost of delivering care to patients. The potential result of tracking and reducing PPAs at Memorial will have a beneficial impact on individual patient outcomes and significantly reduce the financial burden of paying for PPAs. Memorial values this reporting domain at $2,446,921 over Demonstration Years 3-5.

Domain 2: Potentially Preventable Readmissions – 30 days (7 measures)

- **Description** – Memorial will report on the 7 measures in this domain in an effort to gain information on and understanding of the health status of patients it has treated, discharged, and then readmitted for the same principal diagnosis. Too many patients are released from the hospital into the community with no follow-up or support, and end up back in the hospital inpatient setting soon thereafter. Memorial expects that its improvement of access to primary care services through establishing additional primary care clinics will allow patients recently discharged from the hospital to access follow-up care and support, thereby preventing the likelihood of a PPR.

- **Valuation Rationale/Justification** - The value Memorial placed on this domain is based upon the value the hospital attributes to understanding the causes of and health/financial impacts of 30-day readmissions. Specifically, the measures are targeted towards prevalent chronic diseases (e.g., diabetes and congestive heart failure) and then allow for a broad measure of readmissions, which will allow the hospital to gauge the potential causes of these rates in conjunction with each other and as a whole. The goals of the

Waiver are to reduce the cost of providing care and to improve patient access and health outcomes. Understanding our starting point and tracking our improvement is essential to making progress. The potential result of tracking and reducing PPRs at Memorial will have a beneficial impact on individual patient outcomes and significantly reduce the financial burden of paying for PPRs. Memorial values this reporting domain at $2,446,921 over Demonstration Years 3-5.

Domain 3: Potentially Preventable Complications (64 measures)

- **Description** – Memorial will report on the 64 measures in this domain in an effort to understand the most prevalent causes of PPCs and to use the information to make institutional reforms toward reducing the rates. Hospitals suffer from shortages of space, staffing, equipment, and protocols for preventing complications like the measures in this domain, and Memorial is dedicated to assuring that it takes all possible steps to improve its provision of healthcare where indicated. Memorial expects that its expanded provision of primary care and of follow-up care for chronic diseases will reduce the volume of unnecessary utilization of hospital services, thus alleviating one of the problems which can result in unnecessary complications for inpatients. The ongoing quality improvement activities which constitute an essential part of Memorial's Category 3 projects will also help to ensure that error rates and complications are reduced at all levels of care throughout Memorial.

- **Valuation Rationale/Justification** - The value Memorial placed on this domain is based upon the value the hospital attributes to understanding the causes of and health/financial impacts of potentially preventable complications. Reporting on this domain will require the hospital to evaluate its own performance, and will allow for institutional change that will be invaluable for the hospital's patients and the hospital's operating costs. The goals of the Waiver are to reduce the cost of providing care and to improve patient access and health outcomes. Understanding our starting point and tracking our improvement is essential to making progress. Memorial values this reporting domain at $1,690,652 over Demonstration Years 3-5.

Domain 4: Patient-Centered Healthcare (2 measures)

- **Description** – Memorial 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. Memorial 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. Memorial expects improved patient satisfaction in the hospital setting and effective medication management protocols for inpatients to correlate with Memorial's projects to strengthen primary care access in the community and to promote and facilitate management of chronic conditions, because satisfied

patients recently discharged from the hospital will be more likely to seek and receive the support they need to maintain their health upon discharge (including medication management).

- **Valuation Rationale/Justification** - The value Memorial placed on this domain is based upon the value the hospital attributes to understanding how patients perceive the care they receive from Memorial and how well Memorial performs its primary care and post-discharge functions. Memorial is committed to improving patient outcomes, and therefore places a high value on these measures. The goals of the Waiver are to reduce the cost of providing care and to improve patient access and health outcomes. Understanding our starting point and tracking our improvement is essential to making progress. Prevalent chronic disease in our community is costly to patients' health and to the delivery system, and Memorial believes that its hospital services must leave these patients satisfied and confident in the healthcare delivery system, in order for the expansion of primary care to have the maximum beneficial impact for the community. Memorial values this reporting domain at $2,446,921 over Demonstration Years 3-5.

Domain 5: Emergency Department (1 measure)

- **Description** – Memorial will measure the admit decision time to ED departure time for admitted patients. This measure is important because patients often languish in hospital EDs due to lack of systemic cooperation between hospitals, their departments, and other types of providers, and the patients experience poor health outcomes as a result. This reporting domain ties in with one of the overall aims of the waiver: to reduce inappropriate use of the ED. One cause of extended ED departure times results from an overcrowded ED. Memorial intends to expand access to primary care for patients who currently are unable to access primary care due to factors such as the lack of primary care providers in the community, and to improve follow-up care for discharged patients diagnosed with chronic health conditions, which Memorial expects will reduce the number of inappropriate ED visits and therefore allow for better management of ED processes such as admit decisions.

- **Valuation Rationale/Justification** - The value Memorial placed on this domain is based upon the value the hospital attributes to knowing how well it is currently performing in the ED and to making goals for self-improvement. Long ED wait times can lead to complications, poor outcomes, and patient dissatisfaction with their care. The goals of the Waiver are to reduce the cost of providing care and to improve patient access and health outcomes. Understanding our starting point and tracking our improvement is essential to making progress. Memorial values this reporting domain at $2,446,921 over Demonstration Years 3-5.

Matagorda Regional Medical Center

Performing Provider Name: **Matagorda Regional Medical Center (MRMC)**
Performing Provider TPI #: **1679678767**

Domain 1: Potentially Preventable Admissions (8 measures)

- **Description** – MRMC will report on the 8 measures in this domain in an effort to gain information on and understanding of the health status of its patients with regard to potentially preventable admissions, which are often linked with poor chronic disease management and lack of access to appropriate outpatient healthcare. MRMC expects that its establishment of a Chronic Disease Specialty Clinic (CDSC) in its community will have a positive impact on the number of PPAs for patients with chronic disease conditions by focusing on providing access to specialty services and physicians that support care for a number of key chronic conditions. Through the establishment of the CDSC, patient compliance with specialty referral visits will improve and the ability to manage chronic disease conditions on an ambulatory basis will improve.

- **Valuation Rationale/Justification** – The value MRMC placed on this domain is based upon the value the hospital attributes to understanding the causes of and health/financial impacts of potentially preventable admissions. The goals of the Waiver are to reduce the cost of providing care and to improve patient access and health outcomes. Understanding our starting point and tracking our improvement is essential to making progress. PPAs negatively impact patient outcomes (including overall health, satisfaction, and quality of life), which can have short- and long-term consequences for the cost of delivering care to patients. The potential result of tracking and reducing PPAs at MRMC will have a beneficial impact on individual patient outcomes and significantly reduce the financial burden of paying for PPAs. MRMC values this reporting domain at $92,230 over Demonstration Years 3-5, requiring local funding of $37,076.

Domain 2: Potentially Preventable Readmissions – 30 days (7 measures)

- **Description** – MRMC 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. MRMC expects that the establishment of the Chronic Disease Speciality Clinic (CDSC) will provide a centralized location for determining best practice management of patients with the targeted disease categories. By creating the clinic with the respective specialists, information systems and care coordination will allow patients and their primary care providers to have ready access to expertise that will reduce issues with noncompliance, reduce out of control health crises, and therefore reduce hospital readmissions and unnecessary visits to the emergency department. If these patients receive the care they need during and after hospitalization, they are much less likely to be readmitted within 30 days for the same condition.

- **Valuation Rationale/Justification** - The value MRMC 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 for MRMC patients will have a beneficial impact on individual patient outcomes and significantly reduce the financial burden of paying for PPRs. MRMC values this reporting domain at $92,231 over Demonstration Years 3-5, requiring local funding of $37,077.

Domain 3: Potentially Preventable Complications (64 measures)

- **Description** – MRMC 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 MRMC is dedicated to assuring that it takes all possible steps to improve its provision of healthcare where indicated. MRMC through the Chronic Disease Speciality Clinic (CDSC) will strive to transform the health care delivery from a disease focused model of episodic care to a patient-centered coordinated delivery model that improves patient satisfaction and health outcomes.

- **Valuation Rationale/Justification** - The value MRMC 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. MRMC values this reporting domain at $63,699 over Demonstration Years 3-5, requiring local funding of $25,607.

Domain 4: Patient-Centered Healthcare (2 measures)

- **Description** – MRMC 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. MRMC 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. MRMC hopes that implementing the Chronic Disease Speciality Clinic will improve satisfaction for MRMC patients, by coordinating care with providing access and early intervention and preventing patients from getting "lost" in the health care system.

- **Valuation Rationale/Justification** - The value MRMC placed on this domain is based upon the value the hospital attributes to understanding how patients perceive the care they receive from MRMC and how well MRMC performs its function of promoting medication management. MRMC 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 and lack of care coordination for traditionally underserved patients in Matagorda County is costly to patients' health and to the delivery system, and MRMC believes that its hospital services must leave these patients satisfied and confident in the healthcare delivery system, in order for the expansion of primary and specialty care to have the maximum beneficial impact for the community. MRMC values this reporting domain at $92,231 over Demonstration Years 3-5, requiring local funding of $37,077.

Domain 5: Emergency Department (1 measure)

- **Description** – MRMC will measure the admit decision time to ED departure time for admitted patients. This measure is important because patients often languish in hospital EDs due to lack of systemic cooperation between hospitals, their departments, and other types of providers, and the patients experience poor health outcomes as a result. MRMC's Chronic Disease Speciality Clinic project will assist ED providers by decreasing the number of disease related crisis visits to the ED and transforming care for the targeted populations from one of fragmented resources to an organized system of followup for primary and specialty services. MRMC will seek to improve the admit decision time to ED departure time for MRMC patients, who often wait days for appropriate placement due to a shortage of providers to perform assessments.

- **Valuation Rationale/Justification** - The value MRMC placed on this domain is based upon the value the hospital attributes to knowing how well it is currently performing in the ED and to making goals for self-improvement. Long ED wait times can lead to complications, poor outcomes, and patient dissatisfaction with their care. The goals of the Waiver are to reduce the cost of providing care and to improve patient access and health outcomes. Understanding our starting point and tracking our improvement is essential to making progress. MRMC values this reporting domain at $92,231 over Demonstration Years 3-5, requiring local funding of $37,077.

OakBend Medical Center

Performing Provider Name: **OakBend Medical Center**
Performing Provider TPI #: **127303903**

Domain 1: Potentially Preventable Admissions (8 measures)

- **Description** – OakBend Medical Center ("OakBend") will report on the 8 measures in this domain in an effort to gain information on and understanding of the health status of its patients with regard to potentially preventable admissions, which are often linked with poor chronic disease management and lack of access to appropriate outpatient healthcare. OakBend plans to implement a Category 2 DSRIP project with the goal of addressing the root causes of potentially preventable admissions. Specifically, this project will provide navigational services to targeted patients who are at high risk of disconnect from institutionalized healthcare. OakBend expects that this project will reduce potentially preventable admissions by making it easier for more patients to receive the primary care they need in appropriate outpatient settings rather than inpatient or emergent settings. OakBend also believes that this project will allow expensive health conditions to be detected and treated early and inexpensively.

- **Valuation Rationale/Justification** – The value OakBend has placed on this domain is based upon the value the hospital attributes to understanding the causes of and health/financial impacts of potentially preventable admissions. The goals of the Waiver are to reduce the cost of providing care and to improve patient access and health outcomes. Understanding our starting point and tracking our improvement is essential to making progress. PPAs negatively impact patient outcomes (including overall health, satisfaction, and quality of life), which can have short- and long-term consequences for the cost of delivering care to patients. The potential result of tracking and reducing PPAs at OakBend will have a beneficial impact on individual patient outcomes and significantly reduce the financial burden of paying for PPAs. OakBend values this reporting domain at $484,722 over Demonstration Years 3-5.

Domain 2: Potentially Preventable Readmissions – 30 days (7 measures)

- **Description** – OakBend 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. OakBend expects that its improvement of access to primary care services through establishing additional primary care providers will allow patients recently discharged from the hospital to access follow-up care and support, thereby preventing the likelihood of a PPR.,

- **Valuation Rationale/Justification** - The value OakBend placed on this domain is based upon the value the hospital attributes to understanding the causes of and health/financial impacts of 30-day readmissions. Specifically, the measures are targeted towards prevalent chronic diseases (e.g., diabetes and congestive heart failure) and then allow for a broad measure of readmissions, which will allow the hospital to gauge the potential causes of these rates in conjunction with each other and as a whole. The goals of the Waiver are to reduce the cost of providing care and to improve patient access and health

outcomes. Understanding our starting point and tracking our improvement is essential to making progress. The potential result of tracking and reducing PPRs at OakBend will have a beneficial impact on individual patient outcomes and significantly reduce the financial burden of paying for PPRs. OakBend values this reporting domain at $484,722 over Demonstration Years 3-5.

Domain 3: Potentially Preventable Complications (64 measures)

- **Description** – OakBend 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 OakBend is dedicated to assuring that it takes all possible steps to improve its provision of healthcare where indicated. OakBend expects that its expanded provision of primary care and of follow-up care for chronic diseases will reduce the volume of unnecessary utilization of hospital services, thus alleviating one of the problems which can result in unnecessary complications for inpatients. The ongoing quality improvement activities which constitute an essential part of OakBend's Category 3 projects will also help to ensure that error rates and complications are reduced at all levels of care throughout OakBend.

- **Valuation Rationale/Justification** - The value OakBend 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. OakBend values this reporting domain at $335,074 over Demonstration Years 3-5.

Domain 4: Patient-Centered Healthcare (2 measures)

- **Description** – OakBend 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. OakBend 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. OakBend expects improved patient satisfaction in the hospital setting and effective medication management protocols for inpatients to correlate with OakBend's projects to strengthen primary care access in the community and to promote and facilitate management of chronic conditions, because satisfied

patients recently discharged from the hospital will be more likely to seek and receive the support they need to maintain their health upon discharge (including medication management).

- **Valuation Rationale/Justification** - The value OakBend placed on this domain is based upon the value the hospital attributes to understanding how patients perceive the care they receive from OakBend and how well OakBend performs its primary care and post-discharge functions. OakBend 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 is costly to patients' health and to the delivery system, and OakBend 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. OakBend values this reporting domain at $484,722 over Demonstration Years 3-5.

Domain 5: Emergency Department (1 measure)

- **Description** – OakBend will measure the admit decision time to ED departure time for admitted patients. This measure is important because patients often languish in hospital EDs due to lack of systemic cooperation between hospitals, their departments, and other types of providers, and the patients experience poor health outcomes as a result. This reporting domain ties in with one of the overall aims of the waiver: to reduce inappropriate use of the ED. One cause of extended ED departure times results from an overcrowded ED. OakBend intends to expand access to primary care for patients who currently are unable to access primary care due to factors such as the lack of primary care providers in the community, and to improve follow-up care for discharged patients diagnosed with chronic health conditions, which OakBend expects will reduce the number of inappropriate ED visits and therefore allow for better management of ED processes such as admit decisions.

- **Valuation Rationale/Justification** - The value OakBend placed on this domain is based upon the value the hospital attributes to knowing how well it is currently performing in the ED and to making goals for self-improvement. Long ED wait times can lead to complications, poor outcomes, and patient dissatisfaction with their care. The goals of the Waiver are to reduce the cost of providing care and to improve patient access and health outcomes. Understanding our starting point and tracking our improvement is essential to making progress. OakBend values this reporting domain at $484,722 over Demonstration Years 3-5.

Rice Medical Center

Performing Provider Name: **Rice Medical Center ("Rice")**
Performing Provider TPI #: **212060201**

Domain 1: Potentially Preventable Admissions (8 measures)

- **Description** – Rice will report on the 8 measures in this domain in an effort to gain information on and understanding of the health status of its patients with regard to potentially preventable admissions, which are often linked with poor chronic disease management and lack of access to appropriate outpatient healthcare. Rice expects that its provision of expanded primary and specialty care services through the Family Practice Obstetrician project, the establishment of the Wallis clinic, the use of telemedicine for specialty consults, the addition of ENT specialty services at Rice, and the expansion of the East Bernard Clinic will reduce the number of PPAs over the life of the Waiver. Additionally, Rice hopes that its project to conduct outreach to patients with chronic diseases and its project to create a Certified Diabetes Teaching Center will enable targeted patients to engage in self-management goals and activities of daily living that are essential to preventing PPAs. Finally, Rice intends for its ImmTrack project to reduce the number of PPAs related to flu and other illnesses that can be prevented through immunizations.

- **Valuation Rationale/Justification** – The value Rice placed on this domain is based upon the value the hospital attributes to understanding the causes of and health/financial impacts of potentially preventable admissions. The goals of the Waiver are to reduce the cost of providing care and to improve patient access and health outcomes. Understanding our starting point and tracking our improvement is essential to making progress. PPAs negatively impact patient outcomes (including overall health, satisfaction, and quality of life), which can have short- and long-term consequences for the cost of delivering care to patients. The potential result of tracking and reducing PPAs in Colorado and Wharton Counties will have a beneficial impact on individual patient outcomes and significantly reduce the financial burden of paying for PPAs. Rice values this reporting domain at $236,577 over Demonstration Years 3-5, requiring local funding of $97,730.

Domain 2: Potentially Preventable Readmissions – 30 days (7 measures)

- **Description** – Rice 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. Rice expects that its outreach activities will allow chronically ill patients recently discharged from the hospital to access follow-up care and support, thereby preventing the likelihood of a PPR. With specific regard to diabetic patients, Rice expects its Certified Diabetes Teaching Center to assist diabetic patients in addressing the short- and long-term complications that led to their hospitalizations, and prevent subsequent relapses. Finally, the expanded number and size of clinics in the community will increase the resources available to patients upon discharge from an inpatient stay.

- **Valuation Rationale/Justification** - The value Rice 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 Colorado County will have a beneficial impact on individual patient outcomes and significantly reduce the financial burden of paying for PPRs. Many hospitalizations at Rice can be linked to manageable chronic diseases that Rice intends to address with its project to expand access to primary care. Rice values this reporting domain at $236,577 over Demonstration Years 3-5, requiring local funding of $97,730.

Domain 3: Potentially Preventable Complications (64 measures)

- **Description** – Rice 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 Rice is dedicated to assuring that it takes all possible steps to improve its provision of healthcare where indicated. Rice expects that its Category 1 project to expand access to primary care will reduce the strain on Rice's hospital resources (including staff, space, and equipment). Rice also hopes that its ImmTrack project will have a positive impact on PPCs that can be related to duplicative or missed immunizations.

- **Valuation Rationale/Justification** - The value Rice 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. Rice values this reporting domain at $158,067 over Demonstration Years 3-5, requiring local funding of $65,298.

Domain 4: Patient-Centered Healthcare (2 measures)

- **Description** – Rice 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. Rice 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. Rice expects improved patient satisfaction in the hospital setting and effective medication management protocols for inpatients to correlate with Rice's Category 1 project to expand primary care access, and its projects targeting chronic diseases, because satisfied patients recently discharged from the hospital will be more likely to seek and receive the support they need to maintain their health upon discharge (including medication management).

- **Valuation Rationale/Justification** - The value Rice placed on this domain is based upon the value the hospital attributes to understanding how patients perceive the care they receive from Rice and how well Rice performs its function of promoting medication management. Rice 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 Colorado County is costly to patients' health and to the delivery system, and Rice 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. Rice values this reporting domain at $236,577 over Demonstration Years 3-5, requiring local funding of $97,730.

Domain 5: Emergency Department (1 measure)

- **Description** – Rice will measure the admit decision time to ED departure time for admitted patients. This measure is important because patients often languish in hospital EDs due to lack of systemic cooperation between hospitals, their departments, and other types of providers, and the patients experience poor health outcomes as a result. This reporting domain ties in with Rice's Category 2 project to reduce inefficiencies the ED, because an effect of this project's successful implementation will be to reduce overall ED treatment, admit, and discharge times. One cause of extended ED departure times is an overcrowded ED, so Rice also intends to expand access to primary care in the community and to provide support to chronically ill patients, which Rice expects will reduce the number of inappropriate ED visits.

- **Valuation Rationale/Justification** - The value Rice placed on this domain is based upon the value the hospital attributes to knowing how well it is currently performing in the ED and to making goals for self-improvement. Long ED wait times can lead to complications, poor outcomes, and patient dissatisfaction with their care. The goals of the Waiver are to reduce the cost of providing care and to improve patient access and health outcomes. Understanding our starting point and tracking our improvement is essential to making progress. Rice values this reporting domain at $236,577 over Demonstration Years 3-5, requiring local funding of $97,730.

St. Joseph's Medical Center

Performing Provider Name: St. Joseph's Medical Center
Performing Provider TPI #: 181706601

Domain 1 – Potentially Preventable Admissions (PPAs)

PROJECT RELATIONSHIPS TO DOMAIN		
Category 1	**Category 2**	**Category 3**
	2.17 – Care transitions from mental health/substance abuse (Partial Hospital Program) 2.15 – Integrate Primary & Behavioral Care Services (Medical-Psych Unit)	OD-1/IT-1.18 Follow up for Hospitalization for Mental Illness OD-9 – IT-9.4 Right care, right setting

- **Description:** Category 4 focuses on reporting six (6) key measure sets designed to gain information and understanding on the health needs of low-income, Medicaid or uninsured patients and their families. St. Joseph Medical Center has selected two Behavioral Health projects (Medical-Psychiatric Unit and Partial Hospitalization Program for Behavioral Health/Substance Abuse) which in turn will facilitate the reduction of unnecessary hospitalizations for those disease conditions which are prevalent in Harris County and the surrounding regions. In Texas, potentially preventable admissions have been linked to secondary diagnoses of mental illness/substance abuse or in the following medical conditions: Congestive Heart Failure (CHF), Diabetes , Chronic Obstructive Pulmonary Disease (COPD) – 44.4% of patients admitted to a hospital with this diagnosis had a secondary diagnosis of mental illness/substance abuse; Asthma – 37.0% of patients admitted to a hospital with this diagnosis had a secondary diagnosis of mental illness/substance abuse; Bacterial Pneumonia – 32.5% of patients admitted to a hospital with this diagnosis had a secondary diagnosis of mental illness/substance abuse (Texas Health and Human Services Commission, 2012), Influenza Immunization.

    - St. Joseph Medical Center recognizes that there is a high prevalence of co-occurring mental health and medical issues in the United States. Currently patients with medical illnesses develop depression 10-14% of the time. The rate increases as the severity of illness increases. In many cases, the diagnosis of depression is missed 50% of the time in primary care settings. Likewise, people with a mental illness experience greater distress, an increase in impaired functioning and less ability to follow medical regimens, thus hindering the treatment of any other medical conditions. Taking into account the lack of beds in Harris County and the surrounding areas, St. Joseph Medical Center has chosen to open new services designed to provide behavioral health patients with better wrap around services. The Medical-Psychiatric Unit will provide the right care in the

right setting. This unit will care for those patients who previously did not receive needed behavioral health care because their medical diagnosis became a priority. It can also care for patients who did not have their medical needs addressed due to their overriding psychiatric disease. The Partial Hospitalization Program will provide behavioral health and/or substance abuse patients with the support and skills to care for themselves in the residential setting.

- **Valuation:** The valuation of the Medical-Psychiatric Unit and the Partial Hospitalization Program takes into account the degree to which the projects accomplish community needs, the population served (both number of people served and complexity of patient needs), and investment required to implement the projects. The projects seek to reduce the cost of delivering inpatient care in the community by addressing quality of care in a cost efficient model and attempting to reduce unnecessary admissions through better health outcomes for patients. It is the expectation that the opening of a 12 bed Medical-Psychiatric Unit to treat patients with co-occurring medical and psychiatric needs and the Partial Hospitalization Program that will teach patients the skills to care for themselves in the residential setting and will decrease the number of admissions to the hospital.

- *St. Joseph Medical Center will not submit data related to Pediatric Asthma as we do not have a Pediatric Unit. Pediatric patients requiring admission are transferred to one of the Pediatric Hospitals located in the Houston area.

Domain 2 – Potentially Preventable Readmissions (PPRs)

PROJECT RELATIONSHIPS TO DOMAIN		
Category 1	**Category 2**	**Category 3**
	2.17 – Care transitions from mental health/substance abuse (Partial Hospital Program) 2.15 – Integrate Primary & Behavioral Care Services (Medical-Psych Unit)	OD-1/IT-1.18 Follow up for Hospitalization for Mental Illness OD-9 – IT-9.4 Right care, right setting

- **Description:** Currently, there are two medical-psychiatric units in Houston. There is the unit at Ben Taub and another unit at Memorial Southwest. According to statements both by their own staff and from referrers within the community, these units stay consistently full and it is virtually impossible to get a patient from another facility to either one of these units. St. Joseph Medical Center has selected two Behavioral Health projects (Medical-Psychiatric Unit and Partial Hospitalization Program for Behavioral Health/Substance Abuse) with the underserved population in mind. Both of these programs will facilitate the reduction of unplanned readmissions to the Hospital within 30 days of discharge for those disease conditions which are identified. In Texas, potentially preventable readmissions within 30 days have been linked to secondary

diagnoses of mental illness/substance abuse or in the following medical conditions: Congestive Heart Failure (CHF) , Diabetes , Chronic Obstructive Pulmonary Disease (COPD) – Patients with COPD have multiple readmissions to the hospital and many have a secondary diagnosis of mental illness/substance abuse, Stroke – 10-27% of stroke survivors develop depression that lasts about one year, All Cause readmissions within 30 days of discharge – Medical disorders may contribute biologically to depression and readmissions.

- St. Joseph Medical Center recognizes that there is a high prevalence of co-occurring mental health and medical issues in the United States. Currently patients with medical illnesses develop depression 10-14% of the time. The rate increases as the severity of illness increases. In many cases, the diagnosis of depression is missed 50% of the time in primary care settings. Likewise, people with a mental illness experience greater distress, an increase in impaired functioning and less ability to follow medical regimens, thus readmissions to the Hospital for reassessment of a continuing condition or for the treatment of other medical conditions occurs more frequently. Taking into account the lack of beds in Harris County and the surrounding areas, St. Joseph Medical Center has chosen to open new services designed to provide behavioral health patients with better wrap around services. The Medical-Psychiatric Unit will provide the right care in the right setting for the those patients who previously did not receive needed behavioral health care because their medical diagnosis became a priority. It also can care for those patients who did not have their medical needs addressed due to their overriding psychiatric disease. The Partial Hospitalization Program will provide behavioral health and/or substance abuse patients with the support and skills to care for themselves in the residential setting. The Program focuses on medication compliance, living situation stability, therapy and aftercare needs. It is expected that these two new programs working together will reduce the recidivism and/or readmissions to the Hospital.

- **Valuation:** The valuation of the Medical-Psychiatric Unit and the Partial Hospitalization Program takes into account the degree to which the projects accomplish community needs, the population served (both number of people served and complexity of patient needs), and investment required to implement the projects. The projects seek to reduce the cost of delivering inpatient care in the community by addressing quality of care in a cost efficient model and attempting to reduce unplanned readmissions through better health outcomes for patients. It is the expectation that the opening of a 12 bed Medical-Psychiatric Unit to treat patients with co-occurring medical and psychiatric needs and the Partial Hospitalization Program that will teach patients the skills to care for themselves in the residential setting will decrease the number of readmissions to the Hospital. It is foreseen that any reduction in readmissions in any population will result in cost savings and appropriate utilization of resources. The baseline goal will be determined by opportunity analysis and needs assessment results.

- *St. Joseph Medical Center will not submit data related to Pediatric Asthma as we do not have a Pediatric Unit. Pediatric patients requiring admission are transferred to one of the Pediatric Hospitals located in the Houston area.

Domain 3 – Potentially Preventable Complications (PPCs)

PROJECT RELATIONSHIPS TO DOMAIN		
Category 1	**Category 2**	**Category 3**
	2.17 – Care transitions from mental health/substance abuse (Partial Hospital Program) 2.15 – Integrate Primary & Behavioral Care Services (Medical-Psych Unit)	OD-1/IT-1.18 Follow up for Hospitalization for Mental Illness OD-9 – IT-9.4 Right care, right setting

- **Description:** Congestive heart failure, chronic obstructive pulmonary disease, diabetes, stroke, behavioral diseases, etc. are chronic diseases. Individuals must learn self-management skills and make lifestyle changes to effectively manage these illnesses to avoid or delay complications. For these reasons self-management education and medical management are the cornerstone of treatment for people with chronic diseases. Enhancing the chronic disease inpatient programs and developing new outpatient programs designed to help individuals manage their illness will result in improved patient outcomes for this population. In addition, the implementation of *Lean* methodology will be instrumental in the improvement of patient care and safety, the reduction of hospital-acquired conditions, and increased staff efficiency through the promotion of evidence based medical and nursing practice at the facility. Domain 3 focuses on multiple quality outcome measures and specifically on Sepsis Mortality (#35 on PPC list) as a potentially preventable condition / healthcare acquired condition. Research on sepsis reveals that there is a wide variation in healthcare practice in different geographical areas which have not kept in pace with the evolving science of healthcare to ensure evidence based practice. Treatment for sepsis is an example of how variation in healthcare can be reduced. This, in turn, will have an effect on mortality and the number of patients developing infections and/or potentially preventable complications. St. Joseph Medical Center aspires to reduce the sepsis mortality rate by utilizing the nationally recommended "Bundle" concept included in the Surviving Sepsis Campaign which is a global initiative.

- **Valuation:** Based on HealthGrades data regarding the average cost of treating a sepsis patient and the average length of stay for a sepsis patient at St. Joseph Medical Center, it is projected that reducing the number of complications in the aforementioned diagnoses will facilitate improvement and can potentially save $4,012,000 over a five (5) year period.

Domain 4 – Patient Centered Healthcare

PROJECT RELATIONSHIPS TO DOMAIN		
Category 1	**Category 2**	**Category 3**

	2.17 – Care transitions from mental health/substance abuse (Partial Hospital Program) 2.15 – Integrate Primary & Behavioral Care Services (Medical-Psych Unit)	OD-1/IT-1.18 Follow up for Hospitalization for Mental Illness OD-9 – IT-9.4 Right care, right setting

- **Description:** This project has been designed to improve patient care and patient satisfaction through the provision of adequate services, adequate hours, adequate resources, and optimal healthcare services reflective of evidence based practice standards. These factors will also have a positive impact when receiving the right care in the right setting. Through sustained utilization of the HCAHPS patient satisfaction tools and reports during this project's subsequent years, St. Joseph Medical Center will monitor the results and continue to identify opportunities for improvement. Appropriate corrective actions will be developed for the provision of appropriate patient centered care, whereby patient satisfaction will be maintained and improved. A secondary focus of this project is appropriate Medication Management. The *Lean* methodology will facilitate the redesign and implementation of an improved patient centered medication management program limited to the inpatient setting. This program will promote patient safety through the appropriate prescribing, dispensing, administering, and, in particular, using of prescribed medications upon discharge from the hospital.

- **Valuation:** Patient satisfaction is a major determinant of return "business" for a healthcare facility and is also a factor which influences reimbursement for services rendered. Applying the efficiency, effectiveness, and safety aspects of the *Lean* methodology to the medication management process will eliminate numerous non-value steps in the current process which in turn will promote cost savings.

Domain 5 – Emergency Department (ED)

PROJECT RELATIONSHIPS TO DOMAIN		
Category 1	**Category 2**	**Category 3**
	2.17 – Care transitions from mental health/substance abuse (Partial Hospital Program) 2.15 – Integrate Primary & Behavioral Care Services (Medical-Psych Unit)	OD-1/IT-1.18 Follow up for Hospitalization for Mental Illness OD-9 – IT-9.4 Right care, right setting

- **Description:** The purpose of expanding primary care services includes the goal of reducing the number of potentially avoidable visits to the St. Joseph Medical Center's Emergency Department and provide the right care in the right setting. People with depression or other behavioral disease experience greater distress, an increase in impaired functioning and less ability to follow medical regimens, thus hindering the treatment of any other medical conditions. In addition, depression occurs in 10 to 27 percent of stroke survivors and usually lasts about one year. It occurs in 40=65% of patients who have a heart attack and in 25% of cancer patients. People with bipolar disorder are also at higher risk for thyroid disease, migraine headaches, heart disease, diabetes, obesity, and other physical illnesses. Baseline data indicates that these diagnoses are among the most frequently recorded non-emergent ED visits which can actually be cared for in the primary care system. When these same patients arrive in our ED, they will be screened for a secondary diagnosis of mental health illness and, if this diagnosis is potentially present, the patient will be given diagnosis-specific education and then be directed to the most appropriate primary or inpatient care setting that provides mental health resources for follow up. This may be our Medical-Psychiatric Unit, our Partial Hospitalization Program for outpatient treatment or to Intake for inpatient behavioral health care. This realignment will result in better health outcomes, patient satisfaction, appropriate ED utilization, and reduced cost of services.

- **Valuation:** It is projected that the number of patients screened for mental health illness in the ED will increase by 2-3% over the baseline number. A primary goal is to measure the results of strategies identified. It is anticipated that education of the frequent ED patients will assist them in identifying and accessing those healthcare provider services most appropriate for their care in the future; this, in turn, will promote cost savings and proper provider utilization. In addition, it will promote more timely treatment of those patients presenting to the ED with more serious medical conditions.

Domain 6 – Children and Adult Core Measures (Optional)

PROJECT RELATIONSHIPS TO DOMAIN		
Category 1	**Category 2**	**Category 3**
	2.17 – Care transitions from mental health/substance abuse (Partial Hospital Program) 2.15 – Integrate Primary & Behavioral Care Services (Medical-Psych Unit)	OD-1/IT-1.18 Follow up for Hospitalization for Mental Illness OD-9 – IT-9.4 Right care, right setting

- **Description:** It is the intent of St. Joseph Medical Center to report on *RD-6. Optional Domain: Initial Core Set of Health Care Quality Measures* which will require the collection and submission of data on hospital services provided for children in the

Medicaid and CHIP programs, as well as Medicaid eligible adults. In addition, data analysis will be performed with resultant recommendations communicated for corrective actions to be taken related to those measures which indicate opportunities for improvement.

- **Valuation:** The significant values of this reporting domain will be healthcare cost savings, appropriate healthcare utilization, improved patient outcomes, and improved patient satisfaction.

- *St. Joseph Medical Center will not submit data related to Pediatric Intensive Care Unit as we do not have a Pediatric Care Unit. Pediatric patients requiring admission to an ICU are transferred to one of the Pediatric Hospitals located in the Houston area.

References

Texas Health and Human Services Commission (2012). *Adult potentially preventable hospitalizations in Texas.* Regional Healthcare Partnership Planning Summit held on August 8, 2012, Austin, Texas.

Graban, M. (2012). Lean hospitals: *Improving quality, patient safety, and employee engagement.* Boca Raton, FL: CRC Press.

St. Luke's Episcopal Hospital

Performing Provider Name: **St. Luke's Episcopal Hospital**
Performing Provider TPI #: **127300503**

Domain 1: Potentially Preventable Admissions (8 measures)

- **Description** Most measures require the number of residents age 18 or older living in the RHP counties to determine the denominator. This data would need to be provided by the state. Behavioral health and substance abuse admission rate would not be measurable since our facility does not provide psychiatric or substance abuse services.
- **Valuation - $507,703**
- **Rationale/Justification -** One of the goals of the project, as well as the Region's goals, is to increase reliance on primary care settings. This project assists patients in finding a medical home for CHF patients. The valuation was divided equally between the reporting years.

Domain 2: Potentially Preventable Readmissions – 30 days (7 measures)

- **Description** We will be able to report data for all areas in this domain with the exception of behavioral health and substance abuse admission 30-day readmission rate. Since we do not provide psychiatric or substance abuse services, we would not be able to report this data.
- **Valuation – $507,703**
- **Rationale/Justification -** The impact of the project can be tracked through readmissions. The goal would be to reduce readmissions. The valuation was divided equally between the reporting years.

Domain 3: Potentially Preventable Complications (64 measures)

- **Description** We will be able to report data for all areas in this domain.
- **Valuation - $351,064**
- **Rationale/Justification** – The value 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. Understanding the starting point and tracking improvements is essential to making progress. The valuation was divided equally between the reporting years.

Domain 4: Patient-Centered Healthcare (2 measures)

- **Description** We will be able to report data for all areas in this domain.
- **Valuation - $507,703**
- **Rationale/Justification -** The value placed on this domain is based upon the value the hospital attributes to understanding how well is it serving its patients and the health/financial impacts of patient satisfaction in improving self-management, patient follow up and perceived quality of life and care. Understanding the starting point and tracking improvements is essential to making progress. The valuation was divided equally between the reporting years.

Domain 5: Emergency Department (1 measure)

- **Description** We will be able to report data for all areas in this domain.
- **Valuation - $507,706**
- **Rationale/Justification -** The value placed on this domain is based upon the value the hospital attributes to understanding how well the emergency department is functioning and how efficiently patients are being triaged and appropriately routed. Understanding the starting point and tracking improvements is essential to making progress. The valuation was divided equally between the reporting years.

Optional Domain 6: Children and Adult Core Measures (8 measures) N/A

- **Description** We have opted out of reporting for this domain.
- **Valuation**
- **Rationale/Justification**

Texas Children's Hospital

Performing Provider Name: **Texas Children's Hospital**
Performing Provider TPI #: **139135109**

Domain 1: Potentially Preventable Admissions: RD1

- Texas Children's Hospital, located in Houston, is the largest free standing children's hospital in the county specializing in the care of medically fragile children in Houston and across the country as a regional safety net provider. We currently are licensed for 564 beds at our main campus and West Houston facilities. In 2011 we had over 2.7 million patient encounters. Our mission is to provide the finest possible pediatric patient care, education, and research. Texas Children's is an integrated delivery system comprising of a health plan for Medicaid and CHIP pregnant women and children, the nation's largest general pediatrician group and two world class hospitals. Texas Children's supports a commitment to quality service and cost-effective care to enhance the health and well-being of children locally, nationally and internationally.
    - **RD1.1, 1.2, 1.4, 1.5 and 1.7 are not applicable to the patient population we serve. When using the denominator of Patients over age 18 years old acute care facilities you will get the sickest patients of our pediatric group who are still cared for under our system in that mix (cardiac, CF, Neuro). Other acute care hospital over the age of 18 are generally a healthier population.**

    - RD1.3 Behavior Health and Substance Abuse Admission Rate- As a core pediatric principle in preventative medicine and for any patient accessing care through the Pavilion for Women early recognition of abuse patterns is critical for better health outcomes. The expansion of access allowed for through our Category 1 and 2 projects provides us with the opportunity to diagnose our patient population earlier to mitigate behavioral or substance abuse issues.

    - RD1.6 Pediatric Asthma- Transitions of care for any chronic disease population such as those we are working to expand access for in our Category 1 and 2 projects, would benefit from a measure such as emergency center utilization for asthma care. Our anticipated result is that we will see a decrease in this utilization as we increase correct asthma plan implementation.

    - RD1.8 Influenza Immunization- Texas Children's has a process in place to remind all patients the need to get an influenza immunization. Additionally, we provide free vaccines to all parents of in our inpatient population. We will continue to monitor influenza vaccinations to ensure our high risk populations are protected.

- **Domain Valuation:** All of our project's values are based on the benefits related to cost avoidance of medical expenses and improved quality of life. For example, increased provider capacity leads to reduction in emergency room visits and reduction in inpatient

hospital visits.[392] Studies show the link between access to appropriate pediatric subspecialty care and decrease in hospital visits, both inpatient and emergency room.[3]Our valuation also includes an increase in the patient's quality of life. We are using a conservative Quality Adjusted Life Year ("QALY") per year and a percentage of that QALY for the pediatric population.[393] The QALY is used as a one-time improvement in the quality of life, even though we know the patient's quality of life will be improved for many years. We recognize that this is a government funded waiver and thus we chose to have conservative valuations out of respect for the taxpayer funded program. 5-10% of the total valuation for each project we allocated as the value of reporting the category 4 quality metrics.

Domain 2: Potentially Preventable Readmissions:

o Texas Children's Hospital, located in Houston, is the largest free standing children's hospital in the county specializing in the care of medically fragile children in Houston and across the country as a regional safety net provider. We currently are licensed for 564 beds at our main campus and West Houston facilities. In 2011 we had over 2.7 million patient encounters. Our mission is to provide the finest possible pediatric patient care, education, and research. Texas Children's is an integrated delivery system comprising of a health plan for Medicaid and CHIP pregnant women and children, the nation's largest general pediatrician group and two world class hospitals. Texas Children's supports a commitment to quality service and cost-effective care to enhance the health and well-being of children locally, nationally and internationally.

- RD2.1, 2.2, 2.3, 2.4 and 2.5 are not applicable to the patient population we serve. When using the denominator of Patients over age 18 years old acute care facilities you will get the sickest patients of our pediatric group who are still cared for under our system in that mix (cardiac, Cystic Fibrosis, Neuro). Other acute care hospital over the age of 18 are generally a healthier population.
- RD2.6 Pediatric Asthma is a high priority of Texas Children's because we see such a large high risk population of children. We expect to have a reduction in our 30 day readmission rate specifically those seen in our Category 1 and 2 expansion projects (e.g. pulmonology, allergy and immunology). Our expansion to subspecialty care will help drive patients to the right level of care.
- RD2.7- When using the denominator of Patients over age 18 years old acute care facilities you will get the sickest patients of our pediatric group who are still cared for under our system in that mix (cardiac, CF, Neuro). Other acute care hospital over the age of 18 are generally a healthier population.

- **Domain Valuation:** All of our project's values are based on the benefits related to cost avoidance of medical expenses and improved quality of life. For example,

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[392]Smith, John T, Price, Christopher, Stevens Peter M., Masters, Kevin S., and Young, Mark. "Selected Topics - Does Pediatric Orthopedic Subspecialization Affect Hospital Utilization and Charges?" *Journal of Pediatric Orthopedics*. 19.4 (1999): 553-555.

[393]Brannon, Ike. "Risk - What Is a Life Worth? Despite Its Prima Facie Callousness, Determining the Value of a Human Life Is Necessary for Good Public Policy." *Regulation*. 27.4 (2004): 60-63.

increased provider capacity leads to reduction in emergency room visits and reduction in inpatient hospital visits.[394] Studies show the link between access to appropriate pediatric subspecialty care and decrease in hospital visits, both inpatient and emergency room.[3]Our valuation also includes an increase in the patient's quality of life. We are using a conservative Quality Adjusted Life Year ("QALY") per year and a percentage of that QALY for the pediatric population.[395] The QALY is used as a one-time improvement in the quality of life, even though we know the patient's quality of life will be improved for many years. We recognize that this is a government funded waiver and thus we chose to have conservative valuations out of respect for the taxpayer funded program. 5-10% of the total valuation for each project we allocated as the value of reporting the category 4 quality metrics.

Domain 3: Potentially Preventable Complications:

- **Description**: Texas Children's Hospital, located in Houston, is the largest free standing children's hospital in the county specializing in the care of medically fragile children in Houston and across the country as a regional safety net provider. We currently are licensed for 564 beds at our main campus and West Houston facilities. In 2011 we had over 2.7 million patient encounters. Our mission is to provide the finest possible pediatric patient care, education, and research. Texas Children's is an integrated delivery system comprising of a health plan for Medicaid and CHIP pregnant women and children, the nation's largest general pediatrician group and two world class hospitals. Texas Children's supports a commitment to quality service and cost-effective care to enhance the health and well-being of children locally, nationally and internationally. Currently we are taking our clinical process models to our Enterprise Data Warehouse (EDW) to better understand and identify gaps in care. We expect that increasing the number of people who have correct access to care will improve the qualtiy of care provided. Our clinical system integration allows us to perform rapid cycle process improvement specific to our high risk patients. These PDSAs allow us to more efficiently and effectively improve care delivery and ultimately outcomes.

- **Domain Valuation:** All of our project's values are based on the benefits related to cost avoidance of medical expenses and improved quality of life. For example, increased provider capacity leads to reduction in emergency room visits and reduction in inpatient hospital visits.[396] Studies show the link between access to appropriate pediatric subspecialty care and decrease in hospital visits, both inpatient and emergency room.[3]Our valuation also includes an increase in the patient's quality of life. We are using a conservative Quality Adjusted Life

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[394]Smith, John T, Price, Christopher, Stevens Peter M., Masters, Kevin S., and Young, Mark. "Selected Topics - Does Pediatric Orthopedic Subspecialization Affect Hospital Utilization and Charges?" *Journal of Pediatric Orthopedics*. 19.4 (1999): 553-555.

[395]Brannon, Ike. "Risk - What Is a Life Worth? Despite Its Prima Facie Callousness, Determining the Value of a Human Life Is Necessary for Good Public Policy." *Regulation*. 27.4 (2004): 60-63.

[396]Smith, John T, Price, Christopher, Stevens Peter M., Masters, Kevin S., and Young, Mark. "Selected Topics - Does Pediatric Orthopedic Subspecialization Affect Hospital Utilization and Charges?" *Journal of Pediatric Orthopedics*. 19.4 (1999): 553-555.

Year ("QALY") per year and a percentage of that QALY for the pediatric population.[397] The QALY is used as a one-time improvement in the quality of life, even though we know the patient's quality of life will be improved for many years. We recognize that this is a government funded waiver and thus we chose to have conservative valuations out of respect for the taxpayer funded program. 5-10% of the total valuation for each project we allocated as the value of reporting the category 4 quality metrics.

Domain 4: Patient Satisfaction

- **Description:** Texas Children's Hospital, located in Houston, is the largest free standing children's hospital in the county specializing in the care of medically fragile children in Houston and across the country as a regional safety net provider. We currently are licensed for 564 beds at our main campus and West Houston facilities. In 2011 we had over 2.7 million patient encounters. Our mission is to provide the finest possible pediatric patient care, education, and research. Texas Children's is an integrated delivery system comprising of a health plan for Medicaid and CHIP pregnant women and children, the nation's largest general pediatrician group and two world class hospitals. Texas Children's supports a commitment to quality service and cost-effective care to enhance the health and well-being of children locally, nationally and internationally. RD4.1 HCAHPS does not apply to our pediatric population. RD4.2 Medication Management- This is a specific target of our process improvement initiative using our electronic medical record to identify medications for all inpatient populations that we serve including all subspecialty populations needing to be transferred.

- **Domain Valuation:** All of our project's values are based on the benefits related to cost avoidance of medical expenses and improved quality of life. For example, increased provider capacity leads to reduction in emergency room visits and reduction in inpatient hospital visits.[398] Studies show the link between access to appropriate pediatric subspecialty care and decrease in hospital visits, both inpatient and emergency room.[3]Our valuation also includes an increase in the patient's quality of life. We are using a conservative Quality Adjusted Life Year ("QALY") per year and a percentage of that QALY for the pediatric population.[399] The QALY is used as a one-time improvement in the quality of life, even though we know the patient's quality of life will be improved for many years. We recognize that this is a government funded waiver and thus we chose to have conservative valuations out of respect for the taxpayer funded program. 5-10% of the total valuation for each project we allocated as the value of reporting the category 4 quality metrics.

Domain 5: Emergency Department

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[397]Brannon, Ike. "Risk - What Is a Life Worth? Despite Its Prima Facie Callousness, Determining the Value of a Human Life Is Necessary for Good Public Policy." *Regulation*. 27.4 (2004): 60-63.

[398]Smith, John T, Price, Christopher, Stevens Peter M., Masters, Kevin S., and Young, Mark. "Selected Topics - Does Pediatric Orthopedic Subspecialization Affect Hospital Utilization and Charges?" *Journal of Pediatric Orthopedics*. 19.4 (1999): 553-555.

[399]Brannon, Ike. "Risk - What Is a Life Worth? Despite Its Prima Facie Callousness, Determining the Value of a Human Life Is Necessary for Good Public Policy." *Regulation*. 27.4 (2004): 60-63.

- **Description:** Texas Children's Hospital, located in Houston, is the largest free standing children's hospital in the county specializing in the care of medically fragile children in Houston and across the country as a regional safety net provider. We currently are licensed for 564 beds at our main campus and West Houston facilities. In 2011 we had over 2.7 million patient encounters. Our mission is to provide the finest possible pediatric patient care, education, and research. Texas Children's is an integrated delivery system comprising of a health plan for Medicaid and CHIP pregnant women and children, the nation's largest general pediatrician group and two world class hospitals. Texas Children's supports a commitment to quality service and cost-effective care to enhance the health and well-being of children locally, nationally and internationally. We are currently initiating this process. We hope to demonstrate stronger links between data management centers and call centers to improve better transfers of patients. It is our hope this will lead to a reduction in time wasted when a patient is transferred in or out of our facility.

- **Domain Valuation:** All of our project's values are based on the benefits related to cost avoidance of medical expenses and improved quality of life. For example, increased provider capacity leads to reduction in emergency room visits and reduction in inpatient hospital visits.[400] Studies show the link between access to appropriate pediatric subspecialty care and decrease in hospital visits, both inpatient and emergency room.[3]Our valuation also includes an increase in the patient's quality of life. We are using a conservative Quality Adjusted Life Year ("QALY") per year and a percentage of that QALY for the pediatric population.[401] The QALY is used as a one-time improvement in the quality of life, even though we know the patient's quality of life will be improved for many years. We recognize that this is a government funded waiver and thus we chose to have conservative valuations out of respect for the taxpayer funded program. 5-10% of the total valuation for each project we allocated as the value of reporting the category 4 quality metrics.

[400]Smith, John T, Price, Christopher, Stevens Peter M., Masters, Kevin S., and Young, Mark. "Selected Topics - Does Pediatric Orthopedic Subspecialization Affect Hospital Utilization and Charges?" *Journal of Pediatric Orthopedics*. 19.4 (1999): 553-555.

[401]Brannon, Ike. "Risk - What Is a Life Worth? Despite Its Prima Facie Callousness, Determining the Value of a Human Life Is Necessary for Good Public Policy." *Regulation*. 27.4 (2004): 60-63.

The Methodist Hospital

Performing Provider Name: **The Methodist Hospital**
Performing Provider TPI #: **137949705**

Patient Data and Quality Reporting: Domains 1 - 5
The Methodist Hospital System (Methodist) has been proactive with regard to federal quality and data reporting requirements. Methodist also currently submits administrative, coded, de-identified data to Texas Health Care Information Collection (THCIC). Once HHSC determines the nature of the data to be reported and the technical specification for reporting, Methodist will develop the appropriate data reporting for Category 4 Domains 1 through 5 and respective measures.
Domain 1, 2, and 3 are based on 3M's APR-DRGs. Methodist is in the process of implementing MIDAS, a software system that is a 3M partner and utilizes its reporting methodology. MIDAS is a staged implementation which is expected to be in place in 2Q 2013. The system covers Inpatient, Outpatient and Emergency Department patient visit details which are chained encounters.
Domain 4 contains two components: a) Patient-centered health care or patient satisfaction data and b) Medicaid Management. These are currently addressed by two separate reporting systems. Patient satisfaction measures are managed by Press Ganey, which utilizes a survey tool that includes the HCAHPS standard questions. The data is reported to CMS for use in Hospital Compare. Medication management is a functionality of MethOD, our electronic medical record (EMR). The EMR contains the following: home medication list, inpatient medication orders, home to inpatient reconciliation, patient transfer medication reconciliation, medication administration, patient refusal of medication administration, and discharge medication documentation. HHSC currently receives reports from providers in XML formats. Methodist has the capability to provide reports in XML. Once HHSC determines the specific data to be collected and reported, Methodist will evaluate the data capture reporting capability.
Domain 5 relates to Emergency Department admit to departure length of time. HHSC will need to determine whether the approach to this is a core measure approach or a patient management approach. In the event that HHSC seeks to capture core measurement information the MIDAS system discussed above would be expected to capture that information. If the data sought is strictly patient management aimed at arrival date/time and date/time of patient disposition then an ED management system, MedHost, could be utilized for the data collection and reporting.

Category 4 Valuation: Methodist will utilize the 10% valuation for Domains 1 – 5 with an equal spread between domains and measures.

Domain Descriptions: A description of how Category 4 measures relate to the project/outcomes. Because the DSRP project submitted relates to Care Coordination for Behavioral Medicine patients seen in the Emergency Department, the following Category 4 Domains are specific to the project which Methodist will design and implement. Data will be collected, analyzed and interventions developed for care coordination to reduce admissions, readmissions, patient satisfaction, medication management, complications, and emergency department patient management.

RD-1. Potentially Preventable Admissions

3. Behavioral Health and Substance Abuse Admission rate (based on other selected PPA primary diagnoses)

RD-2. 30-day Readmissions

3. Behavioral health & Substance Abuse: 30-Day Readmissions

RD-3. Potentially Preventable Complications (PPCs)

Hospital performing providers subject to required Category 4 reporting must report on the 64 PPC
measures listed below in DY 4-5: #36 Acute Mental Health Changes

RD-4. Patient-centered Healthcare

1. Patient Satisfaction
2. Medication

management

RD-5. Emergency Department

Admit decision time to ED departure time for admitted patients (NQF 0497)

a. Decision Time to transfer an emergency patient to another facility (not Transport Time), i.e. decision to make the first call from arrival in transferring ED until call initiated. Recommend threshold of < 1 hour for critical patient.

The Methodist Hospital Willowbrook

Performing Provider Name: **Methodist Willowbrook Hospita**
Performing Provider TPI #: **140713201**

Patient Data and Quality Reporting: Domains 1 - 5
The Methodist Hospital System (Methodist) has been proactive with regard to federal quality and data reporting requirements. Methodist also currently submits administrative, coded, de-identified data to Texas Health Care Information Collection (THCIC). Once HHSC determines the nature of the data to be reported and the technical specification for reporting, Methodist will develop the appropriate data reporting for Category 4 Domains 1 through 5 and respective measures.
Domain 1, 2, and 3 are based on 3M's APR-DRGs. Methodist is in the process of implementing MIDAS, a software system that is a 3M partner and utilizes its reporting methodology. MIDAS is a staged implementation which is expected to be in place in 2Q 2013. The system covers Inpatient, Outpatient and Emergency Department patient visit details which are chained encounters.
Domain 4 contains two components: a) Patient-centered health care or patient satisfaction data and b) Medicaid Management. These are currently addressed by two separate reporting systems. Patient satisfaction measures are managed by Press Ganey, which utilizes a survey tool that includes the HCAHPS standard questions. The data is reported to CMS for use in Hospital Compare. Medication management is a functionality of MethOD, our electronic medical record (EMR). The EMR contains the following: home medication list, inpatient medication orders, home to inpatient reconciliation, patient transfer medication reconciliation, medication administration, patient refusal of medication administration, and discharge medication documentation. HHSC currently receives reports from providers in XML formats. Methodist has the capability to provide reports in XML. Once HHSC determines the specific data to be collected and reported, Methodist will evaluate the data capture reporting capability.
Domain 5 relates to Emergency Department admit to departure length of time. HHSC will need to determine whether the approach to this is a core measure approach or a patient management approach. In the event that HHSC seeks to capture core measurement information the MIDAS system discussed above would be expected to capture that information. If the data sought is strictly patient management aimed at arrival date/time and date/time of patient disposition then an ED management system, MedHost, could be utilized for the data collection and reporting.

Category 4 Valuation: Methodist will utilize the 10% valuation for Domains 1 – 5 with an equal spread between domains and measures.

Domain Descriptions: A description of how Category 4 measures relate to the project/outcomes. Because the DSRP project submitted relates to Care Coordination for Behavioral Medicine patients seen in the Emergency Department, the following Category 4 Domains are specific to the project which Methodist will design and implement. Data will be collected, analyzed and interventions developed for care coordination to reduce admissions, readmissions, patient

satisfaction, medication management, complications, and emergency department patient management.

RD-1. Potentially Preventable Admissions

3. Behavioral Health and Substance Abuse Admission rate (based on other selected PPA primary diagnoses)

RD-2. 30-day Readmissions

3. Behavioral health & Substance Abuse: 30-Day Readmissions

RD-3. Potentially Preventable Complications (PPCs)

Hospital performing providers subject to required Category 4 reporting must report on the 64 PPC measures listed below in DY 4-5: #36 Acute Mental Health Changes

RD-4. Patient-centered Healthcare

1. Patient Satisfaction
2. Medication Management

RD-5. Emergency Department

Admit decision time to ED departure time for admitted patients (NQF 0497)

a. Decision Time to transfer an emergency patient to another facility (not Transport Time), i.e. decision to make the first call from arrival in transferring ED until call initiated. Recommend threshold of < 1 hour for critical patient.

The Methodist Hospital Willowbrook

Performing Provider Name: **The University of Texas MD Anderson Cancer Center**
Performing Provider TPI #: **112672402**

Domain 1: Potentially Preventable Admissions (8 measures)

- **Description:** The four DSRIP projects that we are submitting will all be implemented in a community setting. The outcomes of those projects will have no impact on any of the Potentially Preventable Admissions in Reporting Domain 1 (RD-1). We could (with proper documentation) provide the admission rates for the shown items. However it should be noted that we would be creating reports for types of admissions not typically seen in our hospital. We don't have behavioral health admits and other types of admits.
  Reported: Calendar Year
  Source: Texas Health and Human Services Commission

Domain 2: Potentially Preventable Readmissions – 30 days (7 measures)

- The University of Texas MD Anderson Cancer Center is a PPS-exempt cancer hospital and does not have to report on Potentially Preventable Readmissions.

Domain 3: Potentially Preventable Complications (64 measures)

- The four DSRIP projects that we are submitting will all be implemented in a community setting. The outcomes of those projects will have no impact on the 64 measures listed in Potentially Preventable Complications/Reporting Domain 3 (RD-3).
  Reported: Calendar Year
  Source: Texas Health and Human Services Commission

Domain 4: Patient-Centered Healthcare (2 measures)

- Patient satisfaction scores and Medication Management figures are monitored and are reported monthly as a deliverable on the Dash Board in Static.
  Reported: Rolling 24 month cycle
  Source: The University of Texas MD Anderson Cancer Center

Domain 5: Emergency Department (1 measure)

- The number of patients who come to The University of Texas MD Anderson Cancer Center's emergency room that require transfer to another institution is negligible and not large enough to produce statistically valid data.
  Reported: Rolling 24 month cycle
  Source: The University of Texas MD Anderson Cancer Center

Domain Valuation:

The percent allocation for Category 4 was distributed evenly across the all of the reporting measures for each DY. Whereas, the University of Texas MD Anderson Cancer Center is exempt from Domain 2, the percent allocation for each DY has been distributed evenly among the remaining four Domains and their corresponding Milestones and Reporting Domains as applicable.

Tomball Regional Hospital

Performing Provider Name: Tomball Regional Medical Center ("Hospital")
Performing Provider TPI #: 288523801

Domain 1: Potentially Preventable Admissions (8 measures)

- **Description** – Hospital will report on the 8 measures in this domain in an effort to gain information on and understanding of the health status of its patients with regard to potentially preventable admissions, which are often linked with poor chronic disease management and lack of access to appropriate outpatient healthcare. By increasing access to primary care for the indigent and uninsured, this project will improve the quality of health for this population by managing chronic conditions and preventing the cases from escalating to the point of requiring hospital services.

- **Valuation Rationale/Justification** – The value Hospital placed on this domain is based upon the value the hospital attributes to understanding the causes of and health/financial impacts of potentially preventable admissions. The goals of the Waiver are to reduce the cost of providing care and to improve patient access and health outcomes. Understanding our starting point and tracking our improvement is essential to making progress. PPAs negatively impact patient outcomes (including overall health, satisfaction, and quality of life), which can have short- and long-term consequences for the cost of delivering care to patients. The potential result of tracking and reducing PPAs in at Hospital will have a beneficial impact on individual patient outcomes and significantly reduce the financial burden of paying for PPAs. Hospital values this reporting domain at $1,229,452 over Demonstration Years 3-5, requiring local funding of $494,351.

Domain 2: Potentially Preventable Readmissions – 30 days (7 measures)

- **Description** – Hospital 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. Hospital will work with the Indigent Clinic and provide access to medical specialists in order to establish follow-up protocols for the maintenance of chronic conditions, and thereby reduce the readmission rates for these services.

- **Valuation Rationale/Justification** - The value Hospital 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 for Hospital patients will have a beneficial impact on individual patient outcomes and significantly reduce the financial burden of paying for

PPRs. Hospital values this reporting domain at $1,229,452 over Demonstration Years 3-5, requiring local funding of $494,351.

Domain 3: Potentially Preventable Complications (64 measures)

- **Description** – Hospital 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 Hospital is dedicated to assuring that it takes all possible steps to improve its provision of healthcare where indicated.

- **Valuation Rationale/Justification** - The value Hospital 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. Hospital values this reporting domain at $1,229,452 over Demonstration Years 3-5, requiring local funding of $494,351.

Domain 4: Patient-Centered Healthcare (2 measures)

- **Description** – Hospital 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. Hospital 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. Hospital believes that with clinical protocols and discharge education, patients will receive proper follow-up care to improve their overall health and outcomes.

- **Valuation Rationale/Justification** - The value Hospital placed on this domain is based upon the value the hospital attributes to understanding how patients perceive the care they receive from Hospital and how well Hospital performs its function of promoting medication management. Hospital 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 and lack of care coordination for traditionally underserved patients in Houston is costly to patients' health and to the delivery system, and Hospital 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. Hospital values this reporting domain at $1,229,452 over Demonstration Years 3-5, requiring local funding of $494,351.

Domain 5: Emergency Department (1 measure)

- **Description** – Hospital will measure the ED visits quantities for the level I and II evaluation and management services for the defined patient population. This measure is important because patients often languish in hospital EDs due to lack of access to primary care in an outpatient setting. Reducing the unnecessary ED visits will reduce to wait times for more critical patients and thereby improve the health of the community served within the ED.

- **Valuation Rationale/Justification** - The value Hospital placed on this domain is based upon the value the hospital attributes to knowing how well it is currently performing in the ED and to making goals for self-improvement. Long ED wait times can lead to complications, poor outcomes, and patient dissatisfaction with their care. The goals of the Waiver are to reduce the cost of providing care and to improve patient access and health outcomes. Understanding our starting point and tracking our improvement is essential to making progress. Hospital values this reporting domain at $1,229,452 over Demonstration Years 3-5, requiring local funding of $494,351.

Category 4 Tables

Category 4: Population-Focused Measures *El Campo Memorial Hospital / 131045004*				
	Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Capability to Report Category 4	**Milestone:** Status report submitted to HHSC confirming system capability to report Domains 1, 2, 4, 5, and 6.	**Milestone:** Status report submitted to HHSC confirming system capability to report Domains 3.		
Estimated Maximum Incentive Amount	$10,555	$4,894		
Domain 1: Potentially Preventable Admissions (PPAs)				
Planned Reporting Period: 1 or 2		2	2	2
Domain 1 - Estimated Maximum Incentive Amount		$4,894	$5,235	$5,690
Domain 2: Potentially Preventable Readmissions (30-day readmission rates)				
Planned Reporting Period: 1 or 2		2	2	2
Domain 2 - Estimated Maximum Incentive Amount		$4,894	$5,235	$5,690
Domain 3: Potentially Preventable Complications (PPCs) Includes a list of 64 measures identified in the RHP Planning Protocol.				
Planned Reporting Period: 1 or 2			2	2
Domain 3 - Estimated Maximum Incentive Amount			$5,235	$5,690
Domain 4: Patient Centered Healthcare				
Patient Satisfaction - HCAHPS				
Measurement period for report		April 1 – September 30	April 1 – September 30	April 1 – September 30
Planned Reporting Period: 1 or 2		2	2	2
Medication Management				
Measurement period for report		April 1 – September 30	April 1 –	April 1 –

			September 30	September 30
Planned Reporting Period: 1 or 2		2	2	2
Domain 4 - Estimated Maximum Incentive Amount		$4,894	$5,235	$5,690
Domain 5: Emergency Department				
Measurement period for report		April 1 – September 30	April 1 – September 30	April 1 – September 30
Planned Reporting Period: 1 or 2		2	2	2
Domain 5 - Estimated Maximum Incentive Amount		$4,893	$5,236	$5,691
Grand Total Payments Across Category 4	$10,555	$24,469	$26,176	$28,451

Category 4: Population-Focused Measures *Gulf Coast Medical Center/178815001*				
	Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Capability to Report Category 4	**Milestone:** Status report submitted to HHSC confirming system capability to report Domains 1, 2, 4, 5, and 6.	**Milestone:** Status report submitted to HHSC confirming system capability to report Domains 3.		
Estimated Maximum Incentive Amount	$ 33,436	$ 24,500		
Domain 1: Potentially Preventable Admissions (PPAs)				
Planned Reporting Period: 1 or 2		2	2	2
Domain 1 - Estimated Maximum Incentive Amount		$ 24,500	$ 27,500	$ 27,500
Domain 2: Potentially Preventable Readmissions (30-day readmission rates)				
Planned Reporting Period: 1 or 2		2	2	2
Domain 2 - Estimated Maximum Incentive Amount		$ 24,500	$ 27,500	$ 27,500
Domain 3: Potentially Preventable Complications (PPCs)				
Includes a list of 64 measures identified in the RHP Planning Protocol.				

Planned Reporting Period: 1 or 2			2	2
Domain 3 - Estimated Maximum Incentive Amount			$ 27,500	$ 27,500
Domain 4: Patient Centered Healthcare				
Patient Satisfaction - HCAHPS				
Measurement period for report				
Planned Reporting Period: 1 or 2		2	2	2
Medication Management				
Measurement period for report				
Planned Reporting Period: 1 or 2		2	2	2
Domain 4 - Estimated Maximum Incentive Amount		$ 24,500	$ 27,500	$ 27,500
Domain 5: Emergency Department				
Measurement period for report				
Planned Reporting Period: 1 or 2		2	2	2

Domain 5 - Estimated Maximum Incentive Amount		$ 24,500	$ 27,500	$ 27,500
OPTIONAL **Domain 6: Children and Adult Core Measures**				
Initial Core Set of Health Care Quality Measures for Children in Medicaid and CHIP (24 measures)				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults (26 measures)				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Domain 6 - Estimated Maximum Incentive Amount		$ 24,500	$ 27,500	$ 27,500
Grand Total Payments Across Category 4	33436	$ 147,000	$ 165,000	$ 165,000

Category 4: Population-Focused Measures *Harris Health System (aka Harris County Hospital District) / 133355104*				
	Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Capability to Report Category 4	**Milestone:** Status report submitted to HHSC confirming system capability to report Domains 1, 2, 4, 5, and 6.	**Milestone:** Status report submitted to HHSC confirming system capability to report Domains 3.		
Estimated Maximum Incentive Amount	$ 1,321,905	$ 3,867,634		
Domain 1: Potentially Preventable Admissions (PPAs)				
Planned Reporting Period: 1 or 2		2	2	2
Domain 1 - Estimated Maximum Incentive Amount		$ 3,862,369	$ 4,167,662	$ 4,502,847
Domain 2: Potentially Preventable Readmissions (30-day readmission rates)				
Planned Reporting Period: 1 or 2		2	2	2
Domain 2 - Estimated Maximum Incentive Amount		$ 3,862,369	$ 4,167,662	$ 4,502,581
Domain 3: Potentially Preventable Complications (PPCs)				
Includes a list of 64 measures identified in the RHP Planning Protocol.				
Planned Reporting Period: 1 or 2			2	2

Domain 3 - Estimated Maximum Incentive Amount			$ 4,167,662	$ 4,502,582
Domain 4: Patient Centered Healthcare				
Patient Satisfaction - HCAHPS				
Measurement period for report				
Planned Reporting Period: 1 or 2		2	2	2
Medication Management				
Measurement period for report				
Planned Reporting Period: 1 or 2		2	2	2
Domain 4 - Estimated Maximum Incentive Amount		$ 3,862,369	$ 4,167,662	$ 4,502,582
Domain 5: Emergency Department				
Measurement period for report				
Planned Reporting Period: 1 or 2		2	2	2
Domain 5 - Estimated Maximum Incentive Amount		$ 3,862,369	$ 4,167,662	$ 4,502,582

<u>OPTIONAL</u> Domain 6: Children and Adult Core Measures				
Initial Core Set of Health Care Quality Measures for Children in Medicaid and CHIP (24 measures)				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults (26 measures)				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Domain 6 - Estimated Maximum Incentive Amount		$ -	$ -	$ -
Grand Total Payments Across Category 4	$ 1,321,905	$ 19,317,110	$ 20,838,310	$ 22,513,174

Category 4: Population-Focused Measures *HCA Bayshore Medical Center- 020817501*				
	Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Capability to Report Category 4	**Milestone:** Status report submitted to HHSC confirming system capability to report Domains 1, 2, 4, 5, and 6.	**Milestone:** Status report submitted to HHSC confirming system capability to report Domains 3.		
Estimated Maximum Incentive Amount	$ 442,371	$ 205,107		
Domain 1: Potentially Preventable Admissions (PPAs)				
Planned Reporting Period: 1 or 2		1	1	1
Domain 1 - Estimated Maximum Incentive Amount		$ 205,107	$ 219,417	$ 238,496
Domain 2: Potentially Preventable Readmissions (30-day readmission rates)				
Planned Reporting Period: 1 or 2		1	1	1
Domain 2 - Estimated Maximum Incentive Amount		$ 205,107	$ 219,417	$ 238,496
Domain 3: Potentially Preventable Complications (PPCs)				
Includes a list of 64 measures identified in the RHP Planning Protocol.				
Planned Reporting Period: 1 or 2			1	1
Domain 3 - Estimated Maximum Incentive Amount			$ 219,417	$ 238,496
Domain 4: Patient Centered Healthcare				
Patient Satisfaction - HCAHPS				
Measurement period for report		1	1	1
Planned Reporting Period: 1 or		October 1 - September 30	October 1 - September 31	October 1 - September 30

2				
Medication Management				
Measurement period for report		October 1 - September 30	October 1 - September 30	October 1 - September 30
Planned Reporting Period: 1 or 2		1	1	1
Domain 4 - Estimated Maximum Incentive Amount		$ 205,107	$ 219,417	$ 238,496
Domain 5: Emergency Department				
Measurement period for report		October 1 - September 30	October 1 - September 30	October 1 - September 30
Planned Reporting Period: 1 or 2		1	1	1
Domain 5 - Estimated Maximum Incentive Amount		$ 205,107	$ 219,417	$ 238,495
OPTIONAL Domain 6: Children and Adult Core Measures				
Initial Core Set of Health Care Quality Measures for Children in Medicaid and CHIP (24 measures)				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults (26 measures)				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Domain 6 - Estimated Maximum Incentive Amount			$	$
Grand Total Payments Across Category 4	$ 442,371	$ 1,025,534	$ 1,097,083	$ 1,192,480

Category 4: Population-Focused Measures *HCA West Houston Medical Center - 094187402*				
	Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Capability to Report Category 4	**Milestone:** Status report submitted to HHSC confirming system capability to report Domains 1, 2, 4, 5, and 6.	**Milestone:** Status report submitted to HHSC confirming system capability to report Domains 3.		
Estimated Maximum Incentive Amount	$ 189,588	$ 87,903		
Domain 1: Potentially Preventable Admissions (PPAs)				
Planned Reporting Period: 1 or 2		1	1	1
Domain 1 - Estimated Maximum Incentive Amount		$ 87,903	$ 94,036	$ 102,212
Domain 2: Potentially Preventable Readmissions (30-day readmission rates)				
Planned Reporting Period: 1 or 2		1	1	1

Domain 2 - Estimated Maximum Incentive Amount		$ 87,903	$ 94,036	$ 102,212
Domain 3: Potentially Preventable Complications (PPCs)				
Includes a list of 64 measures identified in the RHP Planning Protocol.				
Planned Reporting Period: 1 or 2			1	1
Domain 3 - Estimated Maximum Incentive Amount			$ 94,036	$ 102,212
Domain 4: Patient Centered Healthcare				
Patient Satisfaction - HCAHPS				
Measurement period for report		1	1	1
Planned Reporting Period: 1 or 2		October 1 - September 30	October 1 - September 31	October 1 - September 30
Medication Management				
Measurement period for report		October 1 - September 30	October 1 - September 30	October 1 - September 30
Planned Reporting Period: 1 or 2		1	1	1
Domain 4 - Estimated Maximum Incentive Amount		$ 87,903	$ 94,036	$ 102,212

Domain 5: Emergency Department				
Measurement period for report		October 1 - September 30	October 1 - September 30	October 1 - September 30
Planned Reporting Period: 1 or 2		1	1	1
Domain 5 - Estimated Maximum Incentive Amount		$ 87,903	$ 94,035	$ 102,213
OPTIONAL Domain 6: Children and Adult Core Measures				
Initial Core Set of Health Care Quality Measures for Children in Medicaid and CHIP (24 measures)				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults (26 measures)				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Domain 6 - Estimated Maximum Incentive Amount			$	$

Grand Total Payments Across Category 4	189588	$ 439,515	$ 470,179	$ 511,061

Category 4: Population-Focused Measures Memorial Hermann Hospital – TPI: 137805107				
	Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Capability to Report Category 4	**Milestone:** Status report submitted to HHSC confirming system capability to report Domains 1, 2, 4, 5, and 6.	**Milestone:** Status report submitted to HHSC confirming system capability to report Domains 3.		
Estimated Maximum Incentive Amount	$1,668,256	$773,454		
Domain 1: Potentially Preventable Admissions (PPAs)				
Planned Reporting Period: 1 or 2		1	1	1
Domain 1 - Estimated Maximum Incentive Amount		$773,454	$827,043	$897,501
Domain 2: Potentially Preventable Readmissions (30-day readmission rates)				
Planned Reporting Period: 1 or 2		1	1	1
Domain 2 - Estimated Maximum Incentive Amount		$773,454	$827,043	$897,501
Domain 3: Potentially Preventable Complications (PPCs) -- Includes a list of 64 measures identified in the RHP Planning Protocol.				
Planned Reporting Period: 1 or 2			1	1
Domain 3 - Estimated Maximum Incentive Amount			$827,043	$897,501
Domain 4: Patient Centered Healthcare				
Patient Satisfaction - HCAHPS				
Measurement period for report		Oct. 1 – Sept. 30	Oct. 1 – Sept. 30	Oct. 1 – Sept. 30
Planned Reporting Period: 1 or 2		1	1	1
Medication Management				
Measurement period for report		Oct. 1 – Sept. 30	Oct. 1 – Sept. 30	Oct. 1 – Sept. 30
Planned Reporting Period: 1 or 2		1	1	1

Domain 4 - Estimated Maximum Incentive Amount		$827,043	$897,501	$897,501
Domain 5: Emergency Department				
Measurement period for report		Oct. 1 – Sept. 30	Oct. 1 – Sept. 30	Oct. 1 – Sept. 30
Planned Reporting Period: 1 or 2		1	1	1
Domain 5 - Estimated Maximum Incentive Amount		$773,454	$827,043	$897,501
OPTIONAL Domain 6: Children and Adult Core Measures				
Initial Core Set of Health Care Quality Measures for Children in Medicaid and CHIP (5 measures)				
Measurement period for report		Oct. 1 – Sept. 30	Oct. 1 – Sept. 30	Oct. 1 – Sept. 30
Planned Reporting Period: 1 or 2		1	1	1
Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults (8measures)				
Measurement period for report		Oct. 1 – Sept. 30	Oct. 1 – Sept. 30	Oct. 1 – Sept. 30
Planned Reporting Period: 1 or 2		N/A	N/A	N/A
Domain 6 - Estimated Maximum Incentive Amount				
Grand Total Payments Across Category 4	$1,668,256	$3,867,270	$4,135,215	$4,487,505

Category 4: Population-Focused Measures Memorial Hermann Hospital System – TPI: 020834001				
	Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Capability to Report Category 4	**Milestone:** Status report submitted to HHSC confirming system capability to report Domains 1, 2, 4, 5, and 6.	**Milestone:** Status report submitted to HHSC confirming system capability to report Domains 3.		
Estimated Maximum Incentive Amount	$1,631,034	$756,269		
Domain 1: Potentially Preventable Admissions (PPAs)				
Planned Reporting Period: 1 or 2		1	1	1
Domain 1 - Estimated Maximum Incentive Amount		$756,269	$809,405	$881,247
Domain 2: Potentially Preventable Readmissions (30-day readmission rates)				
Planned Reporting Period: 1 or 2		1	1	1
Domain 2 - Estimated Maximum Incentive Amount		$756,269	$809,405	$881,247
Domain 3: Potentially Preventable Complications (PPCs) -- Includes a list of 64 measures identified in the RHP Planning Protocol.				
Planned Reporting Period: 1 or 2			1	1
Domain 3 - Estimated Maximum Incentive Amount			$809,405	$881,247
Domain 4: Patient Centered Healthcare				
Patient Satisfaction - HCAHPS				

Measurement period for report		Oct. 1 – Sept. 30	Oct. 1 – Sept. 30	Oct. 1 – Sept. 30
Planned Reporting Period: 1 or 2		1	1	1
Medication Management				
Measurement period for report		Oct. 1 – Sept. 30	Oct. 1 – Sept. 30	Oct. 1 – Sept. 30
Planned Reporting Period: 1 or 2		1	1	1
Domain 4 - Estimated Maximum Incentive Amount		$756,269	$809,405	$881,247
Domain 5: Emergency Department				
Measurement period for report		Oct. 1 – Sept. 30	Oct. 1 – Sept. 30	Oct. 1 – Sept. 30
Planned Reporting Period: 1 or 2		1	1	1
Domain 5 - Estimated Maximum Incentive Amount		$756,269	$809,405	$881,247
OPTIONAL Domain 6: Children and Adult Core Measures				
Initial Core Set of Health Care Quality Measures for Children in Medicaid and CHIP (5 measures)				
Measurement period for report		Oct. 1 – Sept. 30	Oct. 1 – Sept. 30	Oct. 1 – Sept. 30
Planned Reporting Period: 1 or 2		1	1	1
Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults (8measures)				
Measurement period for report		Oct. 1 – Sept. 30	Oct. 1 – Sept. 30	Oct. 1 – Sept. 30
Planned Reporting Period: 1 or 2		N/A	N/A	N/A
Domain 6 - Estimated Maximum Incentive Amount				
Grand Total Payments Across Category 4	$1,631,034	$3,781,345	$4,047,025	$4,406,235

Category 4: Population-Focused Measures *Matagorda County Hospital District (dba/Matagorda Regional Medical Center)/TPI #130959304*					
	Year 2 (10/1/2012 – 9/30/2013)		**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Capability to Report Category 4	**Milestone:** Status report submitted to HHSC confirming system capability to report Domains 1, 2, 4, 5, and 6.		**Milestone:** Status report submitted to HHSC confirming system capability to report Domains 3.		
Estimated Maximum Incentive Amount	$ 61,537		$ 28,532		
Domain 1: Potentially Preventable Admissions (PPAs)					
Planned Reporting Period: 1 or 2			1	1	1
Domain 1 - Estimated Maximum Incentive Amount			$ 28,531	$ 30,522	$ 33,177
Domain 2: Potentially Preventable Readmissions (30-day readmission rates)					
Planned Reporting Period: 1 or 2			1	1	1
Domain 2 - Estimated Maximum Incentive Amount			$ 28,532	$ 30,523	$ 33,176
Domain 3: Potentially Preventable Complications (PPCs)					
Includes a list of 64 measures identified in the RHP Planning Protocol.					

Planned Reporting Period: 1 or 2			1	1
Domain 3 - Estimated Maximum Incentive Amount			$ 30,522	$ 33,177
Domain 4: Patient Centered Healthcare				
Patient Satisfaction - HCAHPS				
Measurement period for report		DY 2	DY 3	DY 4
Planned Reporting Period: 1 or 2		1	1	1
Medication Management				
Measurement period for report		DY 2	DY 3	DY 4
Planned Reporting Period: 1 or 2		1	1	1
Domain 4 - Estimated Maximum Incentive Amount		$ 28,532	$ 30,523	$ 33,176
Domain 5: Emergency Department				
Measurement period for report		DY 2	DY 3	DY 4
Planned Reporting Period: 1 or 2		1	1	1

Domain 5 - Estimated Maximum Incentive Amount		$ 28,532	$ 30,522	$ 33,177
<u>OPTIONAL</u> Domain 6: Children and Adult Core Measures				
Initial Core Set of Health Care Quality Measures for Children in Medicaid and CHIP (24 measures)				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults (26 measures)				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Domain 6 - Estimated Maximum Incentive Amount				
Grand Total Payments Across Category 4	61537	$ 142,659	$ 152,612	$ 165,883

Category 4: Population-Focused Measures OakBend Medical Center – TPI: 127303903				
	Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Capability to Report Category 4	**Milestone:** Status report submitted to HHSC confirming system capability to report Domains 1, 2, 4, 5, and 6.	**Milestone:** Status report submitted to HHSC confirming system capability to report Domains 3.		
Estimated Maximum Incentive Amount	$320,070	$149,645		
Domain 1: Potentially Preventable Admissions (PPAs)				
Planned Reporting Period: 1 or 2		1	1	1
Domain 1 - Estimated Maximum Incentive Amount		$149,648	$160,800	$174,274
Domain 2: Potentially Preventable Readmissions (30-day readmission rates)				
Planned Reporting Period: 1 or 2		1	1	1
Domain 2 - Estimated Maximum Incentive Amount		$149,648	$160,800	$174,274
Domain 3: Potentially Preventable Complications (PPCs) -- Includes a list of 64 measures identified in the RHP Planning Protocol.				
Planned Reporting Period: 1 or 2			1	1
Domain 3 - Estimated Maximum Incentive Amount			$160,800	$174,274
Domain 4: Patient Centered Healthcare				
Patient Satisfaction - HCAHPS				
Measurement period for report		Oct. 1 – Sept. 30	Oct. 1 – Sept. 30	Oct. 1 – Sept. 30
Planned Reporting Period: 1 or 2		1	1	1
Medication Management				
Measurement period for report		Oct. 1 – Sept. 30	Oct. 1 – Sept. 30	Oct. 1 – Sept. 30
Planned Reporting Period: 1 or 2		1	1	1

Domain 4 - Estimated Maximum Incentive Amount		$149,648	$160,800	$174,274
Domain 5: Emergency Department				
Measurement period for report		Oct. 1 – Sept. 30	Oct. 1 – Sept. 30	Oct. 1 – Sept. 30
Planned Reporting Period: 1 or 2		1	1	1
Domain 5 - Estimated Maximum Incentive Amount		$149,648	$160,800	$174,274
OPTIONAL Domain 6: Children and Adult Core Measures				
Initial Core Set of Health Care Quality Measures for Children in Medicaid and CHIP (5 measures)				
Measurement period for report		Oct. 1 – Sept. 30	Oct. 1 – Sept. 30	Oct. 1 – Sept. 30
Planned Reporting Period: 1 or 2		N/A	N/A	N/A
Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults (8measures)				
Measurement period for report		Oct. 1 – Sept. 30	Oct. 1 – Sept. 30	Oct. 1 – Sept. 30
Planned Reporting Period: 1 or 2		1	1	1
Domain 6 - Estimated Maximum Incentive Amount				
Grand Total Payments Across Category 4	$320,070	$748,235	$804,000	$871,370

Category 4: Population-Focused Measures Rice Medical Center – TPI: 212060201				
	Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Capability to Report Category 4	**Milestone:** Status report submitted to HHSC confirming system capability to report Domains 1, 2, 4, 5, and 6.	**Milestone:** Status report submitted to HHSC confirming system capability to report Domains 3.		
Estimated Maximum Incentive Amount	$194,724	$78,509		
Domain 1: Potentially Preventable Admissions (PPAs)				
Planned Reporting Period: 1 or 2		1	1	1
Domain 1 - Estimated Maximum Incentive Amount		$78,509	$78,824	$79,244
Domain 2: Potentially Preventable Readmissions (30-day readmission rates)				
Planned Reporting Period: 1 or 2		1	1	1
Domain 2 - Estimated Maximum Incentive Amount		$78,509	$78,824	$79,244
Domain 3: Potentially Preventable Complications (PPCs) -- Includes a list of 64 measures identified in the RHP Planning Protocol.				
Planned Reporting Period: 1 or 2			1	1
Domain 3 - Estimated Maximum Incentive Amount			$78,824	$79,244
Domain 4: Patient Centered Healthcare				
Patient Satisfaction - HCAHPS				
Measurement period for report		Oct. 1 – Sept. 30	Oct. 1 – Sept. 30	Oct. 1 – Sept. 30
Planned Reporting Period: 1 or 2		1	1	1
Medication Management				
Measurement period for report		Oct. 1 – Sept. 30	Oct. 1 – Sept. 30	Oct. 1 – Sept. 30
Planned Reporting Period: 1 or 2		1	1	1
Domain 4 - Estimated Maximum Incentive Amount		$78,509	$78,824	$79,244

Domain 5: Emergency Department				
Measurement period for report		Oct. 1 – Sept. 30	Oct. 1 – Sept. 30	Oct. 1 – Sept. 30
Planned Reporting Period: 1 or 2		1	1	1
Domain 5 - Estimated Maximum Incentive Amount		$78,509	$78,824	$79,244
OPTIONAL Domain 6: Children and Adult Core Measures				
Initial Core Set of Health Care Quality Measures for Children in Medicaid and CHIP (24 measures)				
Measurement period for report		N/A	N/A	N/A
Planned Reporting Period: 1 or 2		N/A	N/A	N/A
Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults (26 measures)				
Measurement period for report		N/A	N/A	N/A
Planned Reporting Period: 1 or 2		N/A	N/A	N/A
Domain 6 - Estimated Maximum Incentive Amount		$0	$0	$0
Grand Total Payments Across Category 4	$194,724	$392,546	$394,119	$396,218

Category 4: Population-Focused Measures
St. Joseph Medical Center - 181706601

	Year 2 (10/1/2012 – 9/30/2013)	Year 3 (10/1/2013 – 9/30/2014)	Year 4 (10/1/2014 – 9/30/2015)	Year 5 (10/1/2015 – 9/30/2016)
Capability to Report Category 4	**Milestone:** Status report submitted to HHSC confirming system capability to report Domains 1, 2, 4, 5, and 6.	**Milestone:** Status report submitted to HHSC confirming system capability to report Domains 3.		
Estimated Maximum Incentive Amount	$310,000	$ 192,000		
Domain 1: Potentially Preventable Admissions (PPAs)				
Planned Reporting Period: 1 or 2				
Domain 1 - Estimated Maximum Incentive Amount		$ 192,000	$ 214,000	$ 211,000
Domain 2: Potentially Preventable Readmissions (30-day readmission rates)				
Planned Reporting Period: 1 or 2				
Domain 2 - Estimated Maximum Incentive Amount		$192,000	$ 214,000	$ 211,000
Domain 3: Potentially Preventable Complications (PPCs) Includes a list of 64 measures identified in the RHP Planning Protocol.				
Planned Reporting Period: 1 or 2				
Domain 3 - Estimated Maximum Incentive Amount			$ 214,000	$ 211,000
Domain 4: Patient Centered Healthcare				
Patient Satisfaction – HCAHPS				
Measurement period for report		?	?	?
Planned Reporting Period: 1 or 2				
Medication Management				
Measurement period for report		?	?	?
Planned Reporting Period: 1 or 2				
Domain 4 - Estimated Maximum Incentive Amount		$ 192,000	$ 214,000	$ 211,000

Domain 5: Emergency Department				
Measurement period for report		?	?	?
Planned Reporting Period: 1 or 2				
Domain 5 - Estimated Maximum Incentive Amount		$ 192,000	$ 214,000	$ 211,000
OPTIONAL Domain 6: Children and Adult Core Measures				
Initial Core Set of Health Care Quality Measures for Children in Medicaid and CHIP (24 measures)				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults (26 measures)				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Domain 6 - Estimated Maximum Incentive Amount		$ 192,000	$ 214,000	$ 211,000
Grand Total Payments Across Category 4	$ 310,000	$ 1,152,000	$1,284,000	$ 1,266,000

Category 4: Population-Focused Measures *St. Luke's Episcopal Hospital/ TPI 127300503*				
	Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Capability to Report Category 4	**Milestone:** Status report submitted to HHSC confirming system capability to report Domains 1, 2, 4, 5, and 6.	**Milestone:** Status report submitted to HHSC confirming system capability to report Domains 3.		
Estimated Maximum Incentive Amount	$ 292,404	$ 156,639		
Domain 1: Potentially Preventable Admissions (PPAs)				
Planned Reporting Period: 1 or 2		2	2	2
Domain 1 - Estimated Maximum Incentive Amount		$ 156,639	$ 168,261	$ 182,803
Domain 2: Potentially Preventable Readmissions (30-day readmission rates)				
Planned Reporting Period: 1 or 2		2	2	2
Domain 2 - Estimated Maximum Incentive Amount		$ 156,639	$ 168,261	$ 182,803

Domain 3: Potentially Preventable Complications (PPCs)				
Includes a list of 64 measures identified in the RHP Planning Protocol.				
Planned Reporting Period: 1 or 2			2	2
Domain 3 - Estimated Maximum Incentive Amount			$ 168,261	$ 182,803
Domain 4: Patient Centered Healthcare				
Patient Satisfaction - HCAHPS				
Measurement period for report		10/1/13-9/30/14	10/1/14-9/30/15	10/1/15-9/30/16
Planned Reporting Period: 1 or 2		2	2	2
Medication Management				
Measurement period for report		10/1/13-9/30/14	10/1/14-9/30/15	10/1/15-9/30/16
Planned Reporting Period: 1 or 2		2	2	2
Domain 4 - Estimated Maximum Incentive Amount		$ 156,639	$ 168,261	$ 182,803
Domain 5: Emergency Department				
Measurement period for report		10/1/13-9/30/14	10/1/14-9/30/15	10/1/15-9/30/16

Planned Reporting Period: 1 or 2		2	2	2
Domain 5 - Estimated Maximum Incentive Amount		$ 156,640	$ 168,262	$ 182,804
<u>OPTIONAL</u> Domain 6: Children and Adult Core Measures				
Initial Core Set of Health Care Quality Measures for Children in Medicaid and CHIP (24 measures)		n/a	n/a	n/a
Measurement period for report		n/a	n/a	n/a
Planned Reporting Period: 1 or 2		n/a	n/a	n/a
Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults (26 measures)		n/a	n/a	n/a
Measurement period for report		n/a	n/a	n/a
Planned Reporting Period: 1 or 2		n/a	n/a	n/a
Domain 6 - Estimated Maximum Incentive Amount			$ -	$ -
Grand Total Payments Across Category 4	$ 292,404	$ 783,196	$ 841,306	$ 914,016

Category 4: Population-Focused Measures *Texas Children's Hospital / 139135109*				
	Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Capability to Report Category 4	**Milestone:** Status report submitted to HHSC confirming system capability to report Domains 1, 2, 4, 5, and 6.	**Milestone:** Status report submitted to HHSC confirming system capability to report Domains 3.		
Estimated Maximum Incentive Amount	$ 1,249,395	$ 2,896,423		
Domain 1: Potentially Preventable Admissions (PPAs)				
Planned Reporting Period: 1 or 2				
Domain 1 - Estimated Maximum Incentive Amount		$ 724,106	$ 619,700	$ 673,587
Domain 2: Potentially Preventable Readmissions (30-day readmission rates)				
Planned Reporting Period: 1 or 2				
Domain 2 - Estimated Maximum Incentive Amount		$ 724,106	$ 619,700	$ 673,587
Domain 3: Potentially Preventable Complications (PPCs)				
Includes a list of 64 measures identified in the RHP Planning Protocol.				
Planned Reporting Period: 1 or 2				

Domain 3 - Estimated Maximum Incentive Amount			$ 619,700	$ 673,587
Domain 4: Patient Centered Healthcare				
Patient Satisfaction - HCAHPS				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Medication Management				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Domain 4 - Estimated Maximum Incentive Amount		$ 724,106	$ 619,700	$ 673,587
Domain 5: Emergency Department				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Domain 5 - Estimated Maximum Incentive Amount		$ 724,106	$ 619,700	$ 673,587

OPTIONAL Domain 6: Children and Adult Core Measures				
Initial Core Set of Health Care Quality Measures for Children in Medicaid and CHIP (24 measures)				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults (26 measures)				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Domain 6 - Estimated Maximum Incentive Amount		$ -	$ -	$ -
Grand Total Payments Across Category 4	1249395		$ 3,098,499	$ 3,367,934

Category 4: Population-Focused Measures *Tomball Regional Medical Center / 288523801*				
	Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Capability to Report Category 4	**Milestone:** Status report submitted to HHSC confirming system capability to report Domains 1, 2, 4, 5, and 6.	**Milestone:** Status report submitted to HHSC confirming system capability to report Domains 3.		
Estimated Maximum Incentive Amount	$ 244,397			
Domain 1: Potentially Preventable Admissions (PPAs)				
Planned Reporting Period: 1 or 2				
Domain 1 - Estimated Maximum Incentive Amount		$ 170,263	$ 211,589	$ 264,486
Domain 2: Potentially Preventable Readmissions (30-day readmission rates)				
Planned Reporting Period: 1 or 2				
Domain 2 - Estimated Maximum Incentive Amount		$ 170,263	$ 211,589	$ 264,486
Domain 3: Potentially Preventable Complications (PPCs)				
Includes a list of 64 measures identified in the RHP Planning Protocol.				
Planned Reporting Period: 1 or 2				

Domain 3 - Estimated Maximum Incentive Amount		$ 170,263	$ 211,589	$ 264,486
Domain 4: Patient Centered Healthcare				
Patient Satisfaction - HCAHPS				
Measurement period for report				
Planned Reporting Period: 1 or 2		$ 170,263	$ 211,589	$ 264,486
Medication Management				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Domain 4 - Estimated Maximum Incentive Amount		$ 170,263	$ 211,589	$ 264,486
Domain 5: Emergency Department				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Domain 5 - Estimated Maximum Incentive Amount	81,466	$ 170,263	$ 211,589	$ 264,486

<u>OPTIONAL</u> Domain 6: Children and Adult Core Measures				
Initial Core Set of Health Care Quality Measures for Children in Medicaid and CHIP (24 measures)				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults (26 measures)				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Domain 6 - Estimated Maximum Incentive Amount			$	$
Grand Total Payments Across Category 4	244,397	510,789	634,766	793,459

Category 4: Population-Focused Measures *The University of Texas MD Anderson Cancer Center / 112672402*				
	Year 2 (10/1/2012 – 9/30/2013)	**Year 3 (10/1/2013 – 9/30/2014)**	**Year 4 (10/1/2014 – 9/30/2015)**	**Year 5 (10/1/2015 – 9/30/2016)**
Capability to Report Category 4	**Milestone:** Status report submitted to HHSC confirming system capability to report Domains 1, 2, 4, 5, and 6.	**Milestone:** Status report submitted to HHSC confirming system capability to report Domains 3.		
Estimated Maximum Incentive Amount	$595,074.47	$454,513.00		
Domain 1: Potentially Preventable Admissions (PPAs)				
Planned Reporting Period: 1 or 2		1	1	1
Domain 1 - Estimated Maximum Incentive Amount		$454,513.00	$453,418	$555,878
Domain 2: Potentially Preventable Readmissions (30-day readmission rates)				
Planned Reporting Period: 1 or 2		EXEMPT	EXEMPT	EXEMPT
Domain 2 - Estimated Maximum Incentive Amount		EXEMPT	EXEMPT	EXEMPT
Domain 3: Potentially Preventable Complications (PPCs) Includes a list of 64 measures identified in the RHP Planning Protocol.				
Planned Reporting Period: 1 or 2			1	1
Domain 3 - Estimated Maximum Incentive Amount			$453,418	$555,878
Domain 4: Patient Centered Healthcare				
Patient Satisfaction – HCAHPS				
Measurement period for report		Rolling 24 months	Rolling 24 months	Rolling 24 months
Planned Reporting Period: 1 or 2		1	1	1
Medication Management				
Measurement period for report		Rolling 24 months	Rolling 24 months	Rolling 24 months
Planned Reporting Period: 1 or 2		1	1	1

Domain 4 - Estimated Maximum Incentive Amount		$454,513.00	$453,418	$555,878
Domain 5: Emergency Department				
Measurement period for report		Rolling 24 months	Rolling 24 months	Rolling 24 months
Planned Reporting Period: 1 or 2		1	1	1
Domain 5 - Estimated Maximum Incentive Amount		$454,513.00	$453,418	$555,878
OPTIONAL Domain 6: Children and Adult Core Measures				
Frequency of ongoing prenatal care				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Timeliness of prenatal care				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Cesarean rate for low-risk first birth women				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Percent of live births weighing <2500 grams				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Pediatric central-line associated bloodstream infection (CLASBI) rates				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Elective delivery prior to 39 weeks completed gestation				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Appropriate use of antenatal steroids				
Measurement period for report				

Planned Reporting Period: 1 or 2				
Postpartum Care Rate				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Domain 6 - Estimated Maximum Incentive Amount	n/a	n/a	n/a	n/a
Grand Total Payments Across Category 4	$595,074.47	$1,818,051	$1,813,673	$2,223,513

Section VI RHP Participation Certifications

Section VII Addendums

A. *Hospital Certifications*

B. *Indigent Care Agreements*

C. *Projects Not Selected Summary*

D. *Collaboration Letters*

E. *Letters of Support*

F. *Additional Information*

i Extrapolated from US prevalence rate in Methodist Hospital Community Needs Assessment 2011

ii Local Plan Review, History and Organizational Review FY 2006-7
iii Mechanic D. Barriers to help-seeking, detection, and adequate treatment for anxiety and mood disorders: implications for health care policy. J Clin Psychiatry, 68 (Suppl 2) (2007), pp. 20–26
iv Trivedi MH, et al. Clinical results for patients with major depressive disorder in the Texas Medication Algorithm Project. Arch Gen Psychiatry. 2004;61:669-680.
v Rush AJ, et al. Depression, IV: STAR*D treatment trial for depression. Am J Psychiatry. 2003;160:237.
vi Rush AJ. The 16-item Quick Inventory of Depressive Symptomatology (QIDS), Clinician Rating (QIDS-C), and Self-Report (QIDS-SR): a psychometric evaluation in patients with chronic major depression. Biological Psychiatry, 54 (2003), pp. 573–583

vii J. Unützer, W. Katon, C.M. Callahan et al. Improving mood-promoting access to collaborative treatment. Collaborative care management of late-life depression in the primary care setting: a randomized controlled trial
JAMA, 288 (22) (2002), pp. 2836–2845

viii J. Schaefer, C. Davis Case management and the chronic care model: a multidisciplinary role Lippincotts Case Manag, 9 (2) (2004), pp. 96–103

ix T.E. Oxman, A.J. Dietrich, H.C. Schulberg. The depression care manager and mental health specialist as collaborators within primary care. Am J Geriatr Psychiatry, 11 (5) (2003), pp. 507–516

x W.J. Katon, M. Von Korff, E. Lin et al. Collaborative management to achieve depression treatment guidelines.
J Clin Psychiatry, 58 (Suppl 1) (1997), pp. 20–23
xi Viggiano T, Pincus HA, Crystal S. Curr Opin Psychiatry. 2012 Sep 20. Care transition interventions in mental health.

[xii] Extrapolated from US prevalence rate in Methodist Hospital Community Needs Assessment 2011

[xiii] Local Plan Review, History and Organizational Review FY 2006-7

[xiv] Mechanic D. Barriers to help-seeking, detection, and adequate treatment for anxiety and mood disorders: implications for health care policy. J Clin Psychiatry, 68 (Suppl 2) (2007), pp. 20–26

[xv] Trivedi MH, et al. Clinical results for patients with major depressive disorder in the Texas Medication Algorithm Project. *Arch Gen Psychiatry.* 2004;61:669-680.

[xvi] Rush AJ, et al. Depression, IV: STAR*D treatment trial for depression. *Am J Psychiatry.* 2003;160:237.

[xvii] Rush AJ. The 16-item Quick Inventory of Depressive Symptomatology (QIDS), Clinician Rating (QIDS-C), and Self-Report (QIDS-SR): a psychometric evaluation in patients with chronic major depression. Biological Psychiatry, 54 (2003), pp. 573–583

[xviii] J. Unützer, W. Katon, C.M. Callahan et al. Improving mood-promoting access to collaborative treatment. Collaborative care management of late-life depression in the primary care setting: a randomized controlled trial
JAMA, 288 (22) (2002), pp. 2836–2845

xix J. Schaefer, C. Davis Case management and the chronic care model: a multidisciplinary role Lippincotts Case Manag, 9 (2) (2004), pp. 96–103

xx T.E. Oxman, A.J. Dietrich, H.C. Schulberg. The depression care manager and mental health specialist as collaborators within primary care. Am J Geriatr Psychiatry, 11 (5) (2003), pp. 507–516

xxi W.J. Katon, M. Von Korff, E. Lin et al. Collaborative management to achieve depression treatment guidelines.
J Clin Psychiatry, 58 (Suppl 1) (1997), pp. 20–23
xxii Viggiano T, Pincus HA, Crystal S. Curr Opin Psychiatry. 2012 Sep 20. Care transition interventions in mental health.