

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

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

*Original Submission Date: November 16, 2012 (Phase 1)*

*Revision Submission Date: November 26, 2012 (Phase 1)*

*Final Submission: December 31, 2012 (Phase 2)*

*Final Submission with HHSC Correction: March 8, 2013 (Final HHSC)*

### ***Regional Health Plan - REGION 20***

**RHP Lead Contact:** *Nancy Cadena, Interim Director  
Webb County Indigent Health Care Services  
1620 Santa Ursula Ave  
Laredo, Texas 78040  
956-523-4747 (Office)  
956-523-4748 (Fax)  
ncadena@webbcountytexas.gov*

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## Instructions

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

### Timeline:

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

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

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

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

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

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

Please mail RHP Plan packets to:

Laela Estus, MC-H425  
Texas Health and Human Services Commission  
Healthcare Transformation Waiver Operations  
11209 Metric Blvd.  
Austin, Texas 78758

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

## Section I. RHP Organization

RHP Participant Type	Texas Provider Identifier (TPI)	Texas Identification Number (TIN)	Ownership Type (state owned, non-state public, private)	Organization Name	Lead Representative	Lead Representative Contact Information (address, email, phone number)
<b><u>Anchoring Entity</u></b>						
County Governmental Entity	N/A	17460015872050	Non-state public	Webb County	Nancy Cadena Interim Director, Webb County Indigent Health Care Services	1620 Santa Ursula Avenue Laredo, Texas 78040 <a href="mailto:ncadena@webbcountytx.gov">ncadena@webbcountytx.gov</a> 965-523-4747
<b><u>IGT Entities</u></b>						
County Governmental Entity	N/A	17460015872050	Non-state public	Webb County	Nancy Cadena, Interim Director, Webb County Indigent Health Care Services	1620 Santa Ursula Avenue Laredo, Texas 78040 <a href="mailto:ncadena@webbcountytx.gov">ncadena@webbcountytx.gov</a> 965-523-4747
County Governmental Entity	086286401	17460030780004	Non-state public	Zapata County	Eddie Martinez, County Commissioner	200 E. 7 <sup>th</sup> Avenue, Suite 115 Zapata, Texas 78076 <a href="mailto:eddiecpa@att.net">eddiecpa@att.net</a> 956-765-8449
County Governmental Entity	001016051	17460010717004	Non-state public	Jim Hogg County	Sandalio Ruiz, County Commissioner	P.O. Box 729 Hebbronville, Texas 78361 <a href="mailto:Rosa.gonzalez@jim-hogg.tx.us">Rosa.gonzalez@jim-hogg.tx.us</a>

<b>RHP Participant Type</b>	<b>Texas Provider Identifier (TPI)</b>	<b>Texas Identification Number (TIN)</b>	<b>Ownership Type</b> (state owned, non-state public, private)	<b>Organization Name</b>	<b>Lead Representative</b>	<b>Lead Representative Contact Information</b> (address, email, phone number)
						361-527-5840
County Hospital District	N/A	17460006046000	Non-state public	Nueces County Hospital District	Johnny Hipp, Administrator	555 N. Carancahua St., Suite 950 Corpus Christi, Texas 78401-0835 <a href="mailto:Johnny.hipp@nchdcc.org">Johnny.hipp@nchdcc.org</a> 361-808-3300
City Governmental Entity	137917402	17460015732021	Non-state public	City of Laredo Health Department	Hector F. Gonzalez, M.D., Director	2600 Cedar St. Laredo, Texas 78043 <a href="mailto:hgonzalez@ci.laredo.tx.us">hgonzalez@ci.laredo.tx.us</a> 956-795-4920
State Governmental Agency (Academic Health Science Center)	085144601	17415860315003	State-owned	University of Texas Health Science Center – San Antonio (UTHSC-SA)	Gladys Keen, M.D. Regional Dean	1937 E. Bustamante Laredo, Texas 78041 <a href="mailto:keene@uthscsa.edu">keene@uthscsa.edu</a> 956-523-7475
Governmental Entity	121989102	17429449311000	Non-state public	Border Region Behavioral Health Center	Daniel G. Castillon, Executive Director	1500 Pappas St. Laredo, Texas 78041 <a href="mailto:danielc@borderregion.org">danielc@borderregion.org</a> 956-794-3002
Governmental Entity	121990904	17429517547000	Non-state public	Camino Real Community Services	Emma Garcia, Executive Director	19965 FM 3175 N. Lytle, Texas 78052 <a href="mailto:emmag@caminorealcs.org">emmag@caminorealcs.org</a>

<b>RHP Participant Type</b>	<b>Texas Provider Identifier (TPI)</b>	<b>Texas Identification Number (TIN)</b>	<b>Ownership Type</b> (state owned, non-state public, private)	<b>Organization Name</b>	<b>Lead Representative</b>	<b>Lead Representative Contact Information</b> (address, email, phone number)
						210-357-0310
Hospital District Group Practice not associated with academic center	137908303	17460007051003	Non-state public	Maverick County Hospital District	Elcira M. Bares, CEO	3406 Bob Rogers, Suite 140 Eagle Pass, Texas 78852 <a href="mailto:e.bares@mchdep.org">e.bares@mchdep.org</a> 830-757-4990
<b><u>Performing Providers</u></b>						
Private Hospital	162033801	12001755300002	Private	Laredo Texas Hospital Company, L.P. d/b/a Laredo Medical Center	Tim Schmidt, CEO	1700 E. Saunders St. Laredo, Texas 78043 <a href="mailto:Tim_schmidt@chs.net">Tim_schmidt@chs.net</a> 956-796-4100
Private Children's Hospital	132812205	<a href="https://www.texas.gov/lookup/lookup.aspx?table=TIN&amp;value=17425777467000">17425777467000</a>	Private	Driscoll Children's Hospital	Shane Casady, Administrative Resident	3533 South Alameda Corpus Christi, Texas 78411 <a href="mailto:Shane.casady@dchstx.org">Shane.casady@dchstx.org</a> 361-694-6523

<b>RHP Participant Type</b>	<b>Texas Provider Identifier (TPI)</b>	<b>Texas Identification Number (TIN)</b>	<b>Ownership Type</b> (state owned, non-state public, private)	<b>Organization Name</b>	<b>Lead Representative</b>	<b>Lead Representative Contact Information</b> (address, email, phone number)
State Governmental Agency (Academic Health Science Center)	085144601	17415860315003	State-owned	University of Texas Health Science Center – San Antonio (UTHSC-SA)	Gladys Keen, M.D. Regional Dean	1937 E. Bustamante Laredo, Texas 78041 <a href="mailto:keene@uthscsa.edu">keene@uthscsa.edu</a> 956-523-7475
Governmental Entity	121989102	17429449311000	Non-state public	Border Region Behavioral Health Center  (Local Mental Health Authority)	Daniel G. Castillon, Executive Director	1500 Pappas St. Laredo, Texas 78041 <a href="mailto:danielc@borderregion.org">danielc@borderregion.org</a> 956-794-3002 (Office)
Governmental Entity	121990904	17429517547000	Non-state public	Camino Real Community Services  (Local Mental Health Authority)	Emma Garcia, Executive Director	19965 FM 3175 N. Lytle, Texas 78052 <a href="mailto:emmag@caminorealcs.org">emmag@caminorealcs.org</a> 210-357-0310 (Office)

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City Governmental Entity	137917402	17460015732021	Non-state public	City of Laredo Health Department	Hector F. Gonzalez, M.D., Director	2600 Cedar St. Laredo, Texas 78043 <a href="mailto:hgonzalez@ci.laredo.tx.us">hgonzalez@ci.laredo.tx.us</a> 956-795-4901
Hospital District Group Practice not associated with academic center	137908303	17460007051003	Non-state public	Maverick County Hospital District	Elcira M. Bares, CEO	3406 Bob Rogers, Suite 140 Eagle Pass, Texas 78852 <a href="mailto:e.bares@mchdep.org">e.bares@mchdep.org</a> 830-757-4990
<b><u>UC-only Hospitals</u></b>						
Private Hospital	110803703	12330445300004	Private	Fort Duncan Regional Medical Center (FDRMC)	Richard Prati, CEO	3333 N. Foster Maldonado Blvd. Eagle Pass, Texas 78852 <a href="mailto:Richard.prati@uhsinc.com">Richard.prati@uhsinc.com</a> 830-872-2500
Private Hospital	094186602	12329954130501	Private	Laredo Regional Medical Center, d/b/a Doctors Hospital of Laredo	Rene Lopez, CEO	10700 McPherson Rd. Laredo, Texas 78041 <a href="mailto:Rene.Lopez@uhsinc.com">Rene.Lopez@uhsinc.com</a> 956-523-2001

<b>RHP Participant Type</b>	<b>Texas Provider Identifier (TPI)</b>	<b>Texas Identification Number (TIN)</b>	<b>Ownership Type</b> (state owned, non-state public, private)	<b>Organization Name</b>	<b>Lead Representative</b>	<b>Lead Representative Contact Information</b> (address, email, phone number)
<b><u>Other Stakeholders</u></b>						
Medical Association	N/A	N/A	N/A	Maverick County Medical Association	Hector Trevino, M.D., President	2116 East Garrison Eagle Pass, Texas 78852 <a href="mailto:postmaster@mavcms.org">postmaster@mavcms.org</a> 830-773-3353

## **Section II. Executive Overview of RHP Plan**

Region 20 is a small region and consists of only four counties, with a total population of approximately 330,000. However, the poverty and needs are substantial.

Region 20 faces numerous challenges as more fully described in the Community Needs section of this Plan. The Region has been described in a report titled “Healthy Laredo: Evolution and Future of Health Disparity Community” as a “disadvantaged, minority community with health, educational and economic disparities, the length of the list and range of needs is not surprising.” The goals of the Region 20 Healthcare Transformation and Quality Improvement Program are to prioritize the local resources available to access the federal matching funds being allocated to the Region and target those resources where patients and the overall health care delivery system will improve outcomes and quality of life for the residents. The health care environment is challenging given the socio-economics for the area and the need for better integration and capacity within the medical community. The combination of limited access to health care, poverty, and low levels of education all impact the provision of the health care system.

Region 20 plans to use the Transformation and Quality Improvement Program to improve the coordination of care to reduce the access barriers; expand the infrastructure for selected primary and specialty care where great need exists; and to integrate psychiatric and primary care in ways that have previously not been feasible. To address the on-going challenge to improve health care knowledge and understanding additional initiatives will focus on enhancing disease self-management efforts.

It is important to note that Region 20 does not have a large public hospital with substantial capacity to provide Intergovernmental Transfer funds necessary to access federal funds allocated to Region 20 for strategic “transformation and quality improvement projects”. The goal of Region 20 is to seek State Legislative support during the second year of the waiver which, if provided, would allow the Region to amend this Plan to more effectively develop additional DSRIP projects.

The projects described in the following tables describe some of these key strategies which are currently financially feasible for the Region.

## 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
<b>Category 1: Infrastructure Development</b>			
121989102.1.1 Border Region Behavioral Health Center (121989102)  1.11 Implement technology-assisted services (telehealth, telemonitoring, telementoring, or telemedicine) to support, coordinate, or deliver behavioral health services	Establish telemedicine service in Webb County to provide access to psychiatric and medical services for Adult Mental Health and Children’s Mental Health clients for residents in Jim Hogg, Zapata and Webb counties.	OD-2 Potentially Preventable Admissions:  IT-2.4 Behavioral Health/Substance Abuse (BH/SA) Admission Rate	\$232,752
121989102.1.2 Border Region Behavioral Health Center (121989102)  1.2 Develop Workforce enhancement initiatives to support access to behavioral health providers in underserved markets and areas	Recruit, hire or contract, and train Licensed Professional Counselor, psychiatrists, Registered Nurses for residents in Jim Hogg, Zapata and Webb counties.	OD-2 Potentially Preventable Admissions:  IT-2.4 Behavioral Health/Substance Abuse (BH/SA) Admission Rate	\$5,469,663
121989102.1.3 (Pass 2) Border Region Behavioral Health Center (121989102)  1.13. Development of behavioral health crisis stabilization services as alternatives to hospitalization.	Border Region Behavioral Health Center will define and address gaps in the current crisis management system.	OD- 9 Right Care, Right Setting  IT-9.2 ED appropriate utilization	\$2,464,507

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
<p>137917402.1.1 City of Laredo Health Department (137917402)</p> <p>1.1 Expand Primary Care Capacity</p>	<p>Increase and enhance more preventive health care clinic services already being provided by the City of Laredo Health Department (CLHD) clinics. These will serve as an extension to Laredo Medical Center (LMC), Doctors Hospital of Laredo (DHL) and other private providers, building a network for early detection and screening services. This would allow the CLHD to provide additional services in additional new areas of need in the city and county.</p>	<p>OD-2 Potentially Preventable Admissions:</p> <p>IT-2.7 Diabetes Short Term Complication Admission Rate</p>	<p>\$2,000,000</p>
<p>085114601.1.1 University of Texas Health Science Center – San Antonio (085114601)</p> <p>1.9 Expand Specialty Care Capacity</p>	<p>The goal of this project is to develop a mechanism to deliver epilepsy care to underserved areas. The main focus of the outreach program will be to provide expanded outpatient care to people with epilepsy, both insured and indigent who are predominately Latinos.</p>	<p>OD-9 Right Care, Right Setting</p> <p>IT-9.2 ED Appropriate Utilization</p>	<p>\$2,674,925</p>
<p>121990904.1.1 (<b>Pass 2</b>) Camino Real Community Services (121990904)</p> <p>1.13 Development of Behavioral Health Crisis Stabilization Services as alternatives to hospitalization</p>	<p>The project proposed by Camino Real is to develop local crisis stabilization services for persons in psychiatric crisis. This program will be designed and staffed to provide acute psychiatric intervention comparable to that received at remote psychiatric inpatient hospitals. This community based alternative will have a dramatic impact on frequency, duration and cost associated with usage of local hospital Emergency Rooms.</p>	<p>OD-9, Right Care Right Setting.</p> <p>IT-9.4 Decrease Mental Health Admissions and Re-Admissions of persons needing crisis stabilization services to institutional facilities</p>	<p>\$6,909,549</p>

<b>Project Title</b> (include unique RHP project ID number for each project.)	<b>Brief Project Description</b>	<b>Related Category 3 Outcome Measure(s)</b> (include unique Category 3 Improvement Target (IT) Identifier specific to RHP and outcome title)	<b>Estimated Incentive Amount (DSRIP) for DYs 2-5</b>
<p>137908303.1.1 Maverick County Hospital District (137908303)</p> <p>1.9 Expand Specialty Care Capacity</p>	<p>The goal of this project is to expand oncology services to improve access to needed services. This project will expand oncology/hematology services to provide patient consultations and chemotherapy therapy services to our community with special provisions to our indigent population.</p>	<p>OD-6 Patient Satisfaction</p> <p>IT-6.1 Percent Improvement over baseline of patient satisfaction scores.</p>	<p>\$253,569</p>
<b>Category 2: Program Innovation and Redesign</b>			
<p>121989102.2.1 Border Region Behavioral Health Center (121983102)</p> <p>2.1 Design, implement, and evaluate projects that provide integrated primary and behavioral health care services.</p>	<p>Identify clients with co-morbid conditions and provide integrated primary and behavioral services for residents in Jim Hogg, Zapata and Webb counties.</p>	<p>OD-2 Potentially Preventable Admissions:</p> <p>IT-2.4 Behavioral Health/Substance Abuse (BH/SA) Admission Rate</p>	<p>\$5,935,165</p>
<p>121989102.2.2 (<b>Pass 2</b>) Border Region Behavioral Health Center (121989102)</p> <p>2.13 Provide an intervention for a targeted behavioral health population to prevent unnecessary use of services in a specified setting (i.e., the criminal justice system, ER, urgent care etc.)</p>	<p>Border Region Behavioral Health Center will provide an intervention for a target behavioral health population to prevent unnecessary use of services in a specified setting.</p>	<p>OD- 9 Right Care, Right Setting</p> <p>IT-9.2 ED appropriate utilization</p>	<p>\$3,696,763</p>

<b>Project Title</b> (include unique RHP project ID number for each project.)	<b>Brief Project Description</b>	<b>Related Category 3 Outcome Measure(s)</b> (include unique Category 3 Improvement Target (IT) Identifier specific to RHP and outcome title)	<b>Estimated Incentive Amount (DSRIP) for DYs 2-5</b>
<p>121990904.2.1 Camino Real Community Services (121990904)</p> <p>2.15 Integrate Primary and Behavioral Health Care Services</p>	<p>The project is to co-locate primary care and behavioral health care services in order to improve integration of care and improve access to needed services. The importance of addressing both the physical health needs and the behavioral health needs of individuals has become recognized over the past three decades.</p>	<p>OD-6 Patient Satisfaction:</p> <p>IT-6.1 Percent Improvement over Baseline of Patient Satisfaction Scores</p>	<p>\$2,378,695</p>
<p>137917402.2.1 City of Laredo Health Department (137917402)</p> <p>2.2 Expand Chronic Care Management Models</p>	<p>Will increase disease self-management services already in existence through the City of Laredo Health Department, local hospitals and other providers. These disease self-management activities will be integrated into clinical preventive care services and early detection and screening services stated in Category I. This will help maximize care and prevention.</p>	<p>OD-1 Primary Care and Chronic Disease Management:</p> <p>IT-1.11 Diabetes Care: BP Control</p>	<p>\$500,000</p>
<p>132812205.2.1 Driscoll Children’s Hospital (132812205)</p> <p>2.7 Implement Evidence-based Disease Prevention Programs</p>	<p>Increased access to Maternal Fetal Medicine clinics/outreach programs will provide the ability to establish early prenatal diagnosis which allows for optimal postnatal management and helps reduce the medical costs for mother and baby.</p>	<p>OD-8 Perinatal Outcome:</p> <p>IT-8.9 Early Detection of Fetal Anomalies</p>	<p>\$2,970,000</p>
<p>162033801.2.2 Laredo Medical Center (162033801)</p> <p>2.4 Redesign to Improve Patient Experience</p>	<p>Laredo Medical Center will work to improve the patient experience and the patient’s satisfaction with the care provided by the Zapata Family Medical Clinic in Zapata, Texas. Such improvement will require a redesign of primary care to meet the needs of patients. Focus will be on</p>	<p>OD-6 Patient Satisfaction:</p> <p>IT-6.1 Percent Improvement over Baseline of Patient Satisfaction Scores</p>	<p>\$5,780,392</p>

<b>Project Title</b> (include unique RHP project ID number for each project.)	<b>Brief Project Description</b>	<b>Related Category 3 Outcome Measure(s)</b> (include unique Category 3 Improvement Target (IT) Identifier specific to RHP and outcome title)	<b>Estimated Incentive Amount (DSRIP) for DYs 2-5</b>
	timely, patient-centered, continuous, and coordinated care and increased access to care. Processes will be implemented to measure and improve the patient experience.		
162033801.2.3 Laredo Medical Center (162033801)  2.7.5 Implement innovative evidence-based strategies to reduce and prevent obesity in children and adolescents.	Laredo Medical Center will work to provide quarterly patient education sessions on obesity reduction and prevention for Zapata residents. Specifically, attendees will learn about nutrition and self-management so that they are equipped with knowledge and tools to make their and their families' lifestyles healthier. In conjunction with Project 162033801.2.1 to redesign the patient experience, we expect that clinic patients will be better able to access satisfactory preventative and primary care at the Zapata Family Medical Clinic as a result.	OD-6 Patient Satisfaction:  IT-6.1 Percent Improvement over Baseline of Patient Satisfaction Scores	\$1,235,460

## Section III. Community Needs Assessment

### Development Process

In order to develop this assessment, Region 20 reviewed and identified the regional priorities through data analysis and review of appropriate reference materials on health care capacity, behavioral health and chronic diseases in conjunction with socioeconomic conditions in the Region and unique demographic trends within the Region. RHP 20 Providers and stakeholders contributed information as well. All of the above variables have substantial impact on the provision of health care in Region 20.

### Findings

The following priorities were identified as the Region's top community health needs and are addressed in the RHP 20 Plan DSRIP projects:

- **CN 1: Capacity – Primary and Specialty Care** - The demand for primary and specialty care services exceeds that of available medical physicians in these areas and prevents adequate access to care and management or specialized treatment for prevalent health condition and preventative health conditions.
- **CN 2: Behavioral Health Services** – Existing behavioral health services resources are insufficient to meet the current population needs and the projected population growth.
- **CN 3: Chronic Disease and Disease Self-Management Initiatives** – Many individuals in South Texas suffer from chronic diseases that are becoming more prevalent within the area.
- **CN 4: Patient Navigation and Coordination** – Due to the complex needs of the community and the medically underserved status, it is important to emphasize care coordination and navigation. The need is further demonstrated because of the poverty in the Region.
- **CN 5: Specialized Children's Health Needs** – The Region currently lacks a tertiary children's hospital and there is a need for specialized children's care coordination and support.

### Section I. Demographics and Regional Description

Region 20 is a young, Latino community with a disproportionate number of residents living below the poverty level with limited health care access and low level of education. Over the past several years, growth, development and commerce within the Region continue to change the social and demographic face of the population and consequently health care, disease control,

prevention and wellness. In population, Texas is the second largest state in the nation with more than 25 million people. From 2000 to 2010, Texas experienced a 20% growth in population, as compared to only a 9.7% increase nationally. Region 20 encompasses a four county area including Webb, Zapata, Maverick and Jim Hogg counties, of which three are along the Texas/Mexico border. Laredo is the county seat of Webb County and is the main inland port of entry. These four South Texas counties include a total population of over 330,000 based on 2011 census data.<sup>1</sup> The population change has been very significant during the past decade with a population increase of over 116% from 2000 to 2010.<sup>2</sup> The overall poverty and high concentration of under age 18 poverty levels create substantial limitations on the healthcare delivery system to start special reform initiatives. However, given the limited availability of state matching funds necessary to access the Region's DSRIP allocation, the Region is proposing strategic DSRIP initiatives that address these Regional priorities with the funds projected to be available.

As of 2011, Webb County encompasses a total area of 3,376 sq. mi. and has a population of approximately 256,000 with over 95% of the population being of Hispanic or Latino origin.<sup>3</sup> Zapata County encompasses a total area of 1,058 sq. mi. and has a population of just over 14,000 with approximately 93% being of Hispanic or Latino origin.<sup>4</sup> Maverick County encompasses a total area of 1,058 sq. mi. and has a population of approximately 55,400 with 95% being of Hispanic or Latino origin.<sup>5</sup> Jim Hogg County encompasses a total area of 1,136 sq. mi. and has a population of just over 5,000 with approximately 92% being of Hispanic or Latino origin.<sup>6</sup> The population for each of the counties is projected to continue to increase at a substantial rate.<sup>7</sup>

The average percentage of persons who have graduated from high school for the region is almost 60% compared to the state average of 80.4%.<sup>8</sup> The average percentage of persons who continued their education and obtained a bachelor's degree or higher for the region is 12.05% compared to the state average of 26.1%.<sup>9</sup> RHP 20 has an unemployment rate of 9.325% ranging from 6.5% in Jim Hogg County to 14.2 % in Maverick County.<sup>10</sup>

The percent of the total population living below poverty of ranged from 12% in Jim Hogg County to over 37% in Zapata County, compared to the stateside percent 16.8%. The under age 18 percentages are much greater in the Region.<sup>11</sup> As of 2009, the state average for under age 18 population living below poverty was 17.1% while the under age 18 population living below

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<sup>1</sup> US Census Data. [www.census.gov](http://www.census.gov), 2011.

<sup>2</sup> *ibid.*

<sup>3</sup> *ibid.*

<sup>4</sup> *ibid.*

<sup>5</sup> *ibid.*

<sup>6</sup> *ibid.*

<sup>7</sup> Texas State Data Center. Accessed November, 2012.

<sup>8</sup> US Census Data. [www.census.gov](http://www.census.gov), 2011.

<sup>9</sup> US Census Data. [www.census.gov](http://www.census.gov), 2011.

<sup>10</sup> Texas Workforce Commission. <http://www.tracer2.com/>

<sup>11</sup> Texas Department of State Health Services 2009 Health Facts Profiles for Texas. <http://www.dshs.state.tx.us/chs/cfs/Texas-Health-Facts-Profiles.doc>.

poverty in Region 20 ranged from 33.5% in Jim Hogg County to 42.5% in Webb County.<sup>12</sup> Median household income from 2006-2012 in Texas was \$46,646.<sup>13</sup> In Region 20, median household income ranged from \$24,496 in Zapata County to \$40,000 in Jim Hogg County.<sup>14</sup> Region 20 unemployment statistics ranged from 7.8% in Jim Hogg County to over 14% in Maverick County compared to the state average of 7.6%.<sup>15</sup> All of these baseline socio-economic conditions have a substantial impact on access to effective health care.

Insurance coverage and dependency on Medicaid coverage is substantial throughout the health care delivery sector. Webb, Zapata and Jim Hogg Counties do not have a public hospital or hospital district. Maverick County Hospital District operates a clinic but does not operate a hospital. In addition, there is substantial uncompensated care impact on the health care provider sector. For some critical support to many children's health services, Driscoll Children's Hospital, based in Nueces County, provides support services to the Region. All four counties in RHP 20 have a greater uninsured population than the statewide percentage of uninsured population or 26%. The uninsured population in RHP 20 ranges from 29% in Jim Hogg County to 36% in Webb County.<sup>16</sup> As of June 2012, total Medicaid enrollment in Region 20 was 82,994.<sup>17</sup> Total enrollment in Children's Medicaid was 60,709.<sup>18</sup> Per County Health Rankings, 19% of statewide population was classified as having "poor or fair health."<sup>19</sup> In Region 20, Webb County has 27% and Maverick County 29% of population classified as having "poor or fair health."<sup>20</sup>

Approximately 26% of the statewide population 0-64 years was without health insurance in 2009.<sup>21</sup> This compares to Webb County's rate of 35.8%, Zapata County's rate of 34.8%, Maverick County's rate of 35%, and Jim Hogg County's rate of 29.1%.<sup>22</sup>

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<sup>12</sup> *ibid.*

<sup>13</sup> US Census Data. [www.census.gov](http://www.census.gov), 2011.

<sup>14</sup> *ibid.*

<sup>15</sup> Texas Department of State Health Services 2009 Health Facts Profiles for Texas.

<http://www.dshs.state.tx.us/chs/cfs/Texas-Health-Facts-Profiles.doc>

<sup>16</sup> RHP 20 Health Assessment for 1115 Medicaid Waiver, prepared by Region 20. 2012.

<sup>17</sup> *ibid.*

<sup>18</sup> *ibid.*

<sup>19</sup> *ibid.*

<sup>20</sup> *ibid.*

<sup>21</sup> Texas Department of State Health Services 2009 Health Facts Profiles for Texas.

<http://www.dshs.state.tx.us/chs/cfs/Texas-Health-Facts-Profiles.doc>

<sup>22</sup> *ibid.*

**Figure: RHP 20 Medicaid Enrollment<sup>23</sup>**

<b>Point in Time Count<sup>1</sup> - Medicaid Enrollment by County - June 2012</b>													
	Total Enrollment	Total Enrollment in Children's Medicaid	Total Children Under Age 19 Enrolled in Medicaid	Aged	Disabled & Blind	TANF Adults	TANF Children	Foster Care Children	Pregnant Women	Newborns	Children Age 1-5	Children Age 6-18	Medically Needy
Jim Hogg	1,162	711		188	203	20	75	10			238	313	0
Maverick	13,955	8,985	9,489	2,462	1,838	257	1,015	14	413	689	2,619	4,648	0
Webb	64,412	48,414	51,766	5,293	7,596	1,444	7,193	327	1,665	3,468	14,246	23,180	0
Zapata	3,465	2,599	2,695	347	360	65	332	22		200	861	1,184	0
<b>Region</b>	<b>82,994</b>	<b>60,709</b>	<b>64,737</b>	<b>8,290</b>	<b>9,997</b>	<b>1,786</b>	<b>8,615</b>	<b>373</b>	<b>2,212</b>	<b>4,432</b>	<b>17,964</b>	<b>29,325</b>	<b>0</b>

There are three private medical surgical hospitals in the Region, all of which are safety net hospitals that rely on over 30% coverage from Medicaid. These hospitals are Laredo Medical Center with 326 beds, Doctors Hospital of Laredo with 183 beds, and Fort Duncan Regional Medical Center with 101 beds. Other important infrastructure components include the City of Laredo's Health Department, the Maverick County Hospital District's clinic activities, two Mental Health Authorities (Border Region Behavioral Health Center and Camino Real Community Services), and the University of Texas Health Science Center San Antonio. A major not-for-profit organization, Mercy Ministries, is a critical service delivery component in the Region.

It is noted that Zapata and Jim Hogg Counties do not have any hospital beds and the entire Region 20 has no psychiatric hospital beds.

## **Section II: Capacity**

### **Physician Supply and Physician Availability**

Texas has had, and continues to have, a shortage of many types of mental health care providers, based on supply ratios and the number of federally designated Health Professional Shortage Areas for mental health.<sup>24</sup> Based on past and projected demographic trends, this shortage is expected to continue for the foreseeable future and likely to worsen because of retirements and the lack of new recruits.<sup>25</sup> For many mental health professions, the supply ratios are decreasing, which suggests that the growth in supply is not matching the growth in the population, and some professions are even seeing a decrease in the numbers of providers.<sup>26</sup>

The RHP 20 is greatly affected by the limited physician capacity in primary and specialty care areas. Recruitment and retention of physicians is a challenge for the Region, including selected

<sup>23</sup>ibid.

<sup>24</sup> Texas Department of State Health Services: Highlights: The Supply of Mental Health Professionals in Texas. 2010. <http://www.dshs.state.tx.us/chs/hprc/publicat.shtm>

<sup>25</sup> ibid.

<sup>26</sup> ibid.

specialties that encompass behavioral health related needs. Patient coordination is an on-going challenge for all of the providers in the Region. The City of Laredo's Health Department, the Maverick County Hospital District's clinic, the two Mental Health Authorities and the University of Texas Health Science Center San Antonio all have needs to improve access, improve care coordination and assist patients in navigating the health care system. The ability to attract and retain primary and specialty physicians in the Region is impacted by the high rates of poverty and uninsured and the dependency on Medicaid coverage, which reimburses physicians at low rates.

### **Medically Underserved and Shortage Areas**

Under federal designations, Medically Underserved Areas or Populations, or MUAs/MUPs, are generally defined by the federal government to include areas of populations with a shortage of personal health care services.<sup>27</sup> A health professional shortage area, or HPSA, is a geographic area, population group, or health care facility that has been designated by the Federal government as having a shortage of health professionals. There are three categories of HPSAs: primary care, dental and mental health.<sup>28</sup> Poverty rate, infant mortality rate, fertility rate and physical distance from care are all considerations in scoring for HPSA designation. Each of the four Counties in RHP 20 has been designated as a MUA/MUP and as a HPSA in both primary medical care and mental health.<sup>29</sup>

Primary care physician's ratio statewide is 1,050:1.<sup>30</sup> In Region 20, it ranges from 1,843:1 in Webb County all the way to 6,914:1 in Zapata County.<sup>31</sup>

### **Children/Youth**

The impact of limited primary care and specialty care is significantly profound for children and families in the region. Region 20 has a disproportionate number of persons under the age of 5 years. Statewide, there are 7.6% of persons under age 5 and in the Region 20 the percentage ranges from 8.5% in Jim Hogg County to over 11% in Zapata County.<sup>32</sup> Additionally, the statewide percent of persons under the age of 18 years is just over 27%, whereas in Region 20 the percent ranges from 28.7% in Jim Hogg County to 34.8% in Webb County.<sup>33</sup>

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<sup>27</sup> US Department of Health and Human Services, Health Resources and Services Administration. 2012. <http://bhpr.hrsa.gov/shortage/>

<sup>28</sup> *ibid.*

<sup>29</sup> *ibid.*

<sup>30</sup> *ibid.*

<sup>31</sup> *ibid.*

<sup>32</sup> US Census Data. [www.census.gov](http://www.census.gov), 2011.

<sup>33</sup> *ibid.*

## **Section III: Behavioral Health**

### **Behavioral Health System**

Texas is 50th in mental health funding nationwide, meaning that the funding per person served in Texas, including Region 20, is among the lowest in the nation.<sup>34</sup> More than 4.3 million Texans, including 1.2 million children, live with some form of mental health disorder.<sup>35</sup> Over the past decade, reduced state funding affected Texas' ability to care for patients with mental disorders. The economic impact of mental illness on the state and local governments is more than \$1.5 billion per year.<sup>36</sup> In 2007, state legislators invested \$82 million to redesign the state's mental health crisis system, but the new funds represented about 5 percent of local mental health authorities' (LMHAs') budgets.<sup>37</sup> As mentioned, each of the four Counties in RHP 20 has been designated as a MUA/MUP and as a HPSA in both primary medical care and mental health.<sup>38</sup>

### **Integration between Behavioral Health and Primary Care**

National statistics indicate that persons with mental illness die an average of 25 years earlier than the general population due to poor or inadequate access to primary health care. There is a high incidence of obesity, diabetes, and chronic health conditions that are exacerbated by the mental illness conditions that challenge compliance with prescribed interventions. Currently, services are being rendered in silos; behavioral health care only addresses serious psychiatric conditions (schizophrenia, bi-polar; major depression); primary care addresses chronic illnesses and acute anxiety disorders, mild depression, etc.).

According to a recent study released by the Robert Wood Johnson Foundation, only 33% of patients with behavioral health conditions (24% of the adult population) receive adequate treatment. Patients with behavioral health issues experience higher risk of mortality and poor health outcomes, largely due to a lack of preventive health services and poorly controlled co-morbid medical disease. Risk increases with the severity of the behavioral health diagnoses. Behavioral health conditions also account for increased health care expenditures such as higher rates of potentially preventable inpatient admissions. Texas Medicaid data on potentially preventable inpatient readmissions demonstrates that behavioral health conditions are a significant driver of inpatient costs.

Primary care physicians prove to be the major providers of behavioral health care, but reimbursement protocols create a disincentive for comprehensive mental health screening in a system where they are overworked and undervalued.<sup>39</sup> Primary care visits typically last less than

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<sup>34</sup> Nation Alliance on Mental Illness. State Mental Health Cuts: The Continuing Crisis. March 2011.

<sup>35</sup> Texas Medical Association. Mental Health Funding Report. <http://www.texmed.org/template.aspx?id=6491>

<sup>36</sup> *ibid.*

<sup>37</sup> *ibid.*

<sup>38</sup> US Department of Health and Human Services, Health Resources and Services Administration. 2012. <http://bhpr.hrsa.gov/shortage/>

<sup>39</sup> American Academy of Family Physicians, "Mental Health Care Services by Family Physicians (Position Paper)."

fifteen minutes and require the management of multiple patient problems.<sup>40</sup> The detection and management of mental health problems often compete with other priorities such as treating an acute physical illness, monitoring a chronic illness, or providing preventive health services. Moreover, the primary care doctor often has to identify mental health problems that are obscured by physical symptoms or the patient's reluctance to acknowledge them. For example, eighty percent of patients with depression initially present with physical symptoms.<sup>41</sup> The combination of these findings and the fact that Region 20 is recognized as a MUA/MUP and HPSA emphasize the importance of attracting more health care providers in both primary care and behavioral health, and the need to develop better coordination of care.

#### **Section IV: Chronic Disease**

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

In RHP 20, approximately 70% of the population has at least one chronic condition, particularly driven by the high rates of obesity and overweight persons. For example, 36% of the population is overweight, 16% of the school age population has abnormal glucose levels, increase in gestational diabetes and eclampsia, a higher than state diabetes mortality rate and an increase in women's death due to heart disease. The current delivery model is designed to react to patients with chronic conditions upon presentation at the hospital and then to treat within the confines of the hospital setting. With the high prevalence of patients with chronic conditions, the demand for treatment is heavy and ongoing. There is a need for greater connectivity among hospital and primary care providers and community based chronic disease management resources so that patients are able to learn and have support for creating lifestyle changes that can effectively achieve wellness.

#### **Disease Self-Management**

Due to the Region's high rates of uninsured persons and population covered by Medicaid or Medicare that cannot access care due to a health professions shortage area, or to address lack of care due to physicians that do not accept patients on Medicaid, chronic disease self-management, especially integrated into primary preventive care is essential and critically important.

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<sup>40</sup> *ibid.*

<sup>41</sup> *ibid.*

Integrating disease self-management, health education, telemedicine, case management and mental health into preventive primary care services is crucial. Through this integration and community disease self-management the Region can reduce chronic diseases, acute care, improve healthier choices, and reduce chronic and acute disease complications and co-morbidity acute illness. This preventive action can further prevent persons from using hospital services for preventable chronic and acute disease complications, co-morbidities, and acute infections and thus reduce hospitalizations, hospital and health care costs.

By integrating disease self-management (including mental health and case management) into primary care, preventive care and early detection services and enhancing community disease self-management we can improve health outcomes, further prevent disease, reduce risks and co-morbidities, improve healthier nutrition choices and increase physical activity. These actions along with increased preventive care stated in category I will reduce health care costs especially hospitalizations by improving early detection and preventive care.

In a span of five years (2005-2010) RHP 20 experienced a total of 24,159 potentially preventable hospitalizations resulting in over \$600 million in hospital charges. The top five preventable hospitalization diseases for this region were congestive heart failure, bacterial pneumonia, urinary tract infections, diabetes long-term complications and dehydration.<sup>42</sup> It is imperative that any persons with risk factors be well educated in order to reduce them and prevent hospitalizations; however, a lack of easy access to healthcare prevents many residents from this region from obtaining it.

Webb, Maverick and Zapata counties are border cities along the southwest region of Texas. RHP 20 has over 160 colonias within the rural areas of each county with Maverick County having over 70 colonias and Webb County over 60 colonias.<sup>43</sup> Colonia residents lack medical services and face challenging obstacles in obtaining any available healthcare such as traveling far distances and not having insurance coverage; therefore, allowing illnesses to be left untreated.<sup>44</sup>



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<sup>42</sup> DSHS, Potentially Preventable Hospitalizations

<http://www.dshs.state.tx.us/ph/>

<sup>43</sup> Directory of Colonias Located in Texas.

<http://www.sos.state.tx.us/border/colonias/reg-colonias/index.shtml>

<sup>44</sup> <http://www.sos.state.tx.us/border/colonias/faqs.shtml>

Key challenges include a rapid population increase, prevalence of chronic health problems, severe poverty, and ongoing difficulty of attracting and retaining qualified primary and specialty physicians and qualified mental health professionals. In addition, the lack of local financial resources creates an overarching challenge to the provision of health care to the overall Region.

## Summary of Community Needs

Identification Number	Brief Description of Community Needs Addressed through RHP Plan	Data Source for Identified Need
CN.1	<p style="text-align: center;">Capacity – Primary and Specialty Care</p> <p>The demand for primary and specialty care services exceeds that of available medical physicians in these areas, and prevents adequate access to care and management or specialized treatment for prevalent health condition and preventative health conditions.</p>	1, 2, 3, 4, 6, 10
CN.2	<p style="text-align: center;">Behavioral Health Services</p> <p>Existing behavioral health services resources are insufficient to meet the current population needs and the projected population growth.</p>	1, 2, 3, 4, 5, 6, 7, 8, 9, 10
CN.3	<p style="text-align: center;">Chronic Disease and Disease Self-Management</p> <p>Many individuals in South Texas suffer from chronic diseases that are becoming more prevalent within the area.</p>	1, 3, 4, 10
CN.4	<p style="text-align: center;">Patient Navigation and Coordination</p> <p>The Region lacks adequate patient coordination and navigation systems and procedures to promote more effective care.</p>	1, 2, 3, 4
CN.5	<p style="text-align: center;">Specialized Children’s Health Needs</p> <p>The Region has a large number of under-age 18 population and lacks specialized children’s health care services.</p>	1, 2, 4, 10
CN.6	Increase palliative care services	11, 12
CN.7	Need for improvement in adolescent health, with focus on teen pregnancy, suicide, and obesity	13
CN.8	Need for improvement in prenatal and perinatal care	14, 15, 16, 17
CN.9	High costs associated with preventable hospitalization admissions and readmissions	18

## Data Sources

1. Stakeholder Input from RHP 20 Work Group members representing health care providers, consumer advocates, hospital administrators, clinic administrators, physicians, non-profit health care providers, government and elected public officials, and academic health care professionals.
2. US Census Bureau. [www.census.gov](http://www.census.gov). Retrieved October 2012.
3. Texas Department of State Health Services. 2009 Health Facts Profiles for Texas. <http://www.dshs.state.tx.us/chs/cfs/Texas-Health-Facts-Profiles.doc>.
4. RHP 20 Health Assessment for 1115 Medicaid Waiver, prepared by Region 20. 2012.
5. Texas Department of State Health Services: Highlights: The Supply of Mental Health Professionals in Texas. 2010. <http://www.dshs.state.tx.us/chs/hprc/publicat.shtm>
6. US Department of Health and Human Services, Health Resources and Services Administration. 2012. <http://bhpr.hrsa.gov/shortage/>
7. Nation Alliance on Mental Illness, State Mental Health Cuts: The Continuing Crisis. March 2011.
8. Texas Medical Association, Mental Health Funding Report. <http://www.texmed.org/template.aspx?id=6491>
9. American Academy of Family Physicians, “Mental Health Care Services by Family Physicians (Position Paper).”
10. Texas State Data Center. Accessed November, 2012.
11. Center to Advance Palliative Care  
<http://www.capc.org/>
12. National Palliative Care Research Center  
<http://www.npcrc.org/>
13. Texas Office of Adolescent Health  
<http://www.hhs.gov/ash/oah/>
14. County Health Rankings  
<http://www.countyhealthrankings.org/>
15. University of Wisconsin – Population Health Institute

<http://uwphi.pophealth.wisc.edu/>

16. Robert Wood Johnson Foundation

<http://www.rwjf.org/content/rwjf/en/about-rwjf/newsroom/newsroom-content/2010/02/how-healthy-is-your-county.html>

17. Texas Department of Health and Human Services

<http://www.dshs.state.tx.us/mch/default.shtm>

18. Texas Department of State Health Services, Center for Health Statistics

<http://www.dshs.state.tx.us/chs/default.shtm>

## **Section IV. Stakeholder Engagement**

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

The Region 20 participants have been actively engaged in the planning and discussion phases of the Texas Medicaid 1115 Transformation Waiver. Participants held conferences among themselves on numerous occasions and eventually decided on having Webb County serve as the Region 20 Anchor.

Meetings began early in December 2011 and included major stakeholders in the Region. Extensive discussions were held regarding the configuration of counties to be grouped into specific Regions. Meetings were held in Austin and in the Region to discuss the Region's Counties. On March 13, 2012, the Webb County Commissioners voted for Webb County to be the Region 20 Anchor and authorized a Memorandum of Understanding between Webb, Zapata, Maverick and Jim Hogg Counties. Numerous meetings were scheduled to include public officials and major health care stakeholders. University of Texas San Antonio was also included in the engagement discussions and planning. Meetings included providers, physicians and clinics serving the Region.

As providers involved in the provision and delivery of health care services in the Region, they have reached out to prospective local and State public entities that may desire to provide Intergovernmental Transfer (IGT) matching funds for the private sector health care delivery organizations. These included, for example, Webb County, Zapata County, Jim Hogg County, Nueces County, and Maverick County Hospital District. In addition, outreach and discussions have included the University of Texas Health Science Center San Antonio, both of the Mental Health Authorities providing services in the Region (Border Health and Camino Real), and the City of Laredo. Additional outreach included contacts with Driscoll Children's Hospital, which provides subspecialty and critical tertiary care for children from the Region.

In addition to stakeholders proposing to implement DSRIP projects, outreach and involvement included organizations that may augment and assist a performing provider in accomplishing a DSRIP project through subcontracting opportunities.

Additional outreach and input was sought and continues to be sought from key public policy leaders in the Region and key medical society representatives and organizations focused on improving the quality of health care services in the Region.

Region 20 plans to continue to conduct quarterly meetings with key performing providers and public entities providing necessary Intergovernmental Transfers (IGTs).

## ***B. Public Engagement***

Opportunities for public engagement were accomplished by key leaders in the health care community holding discussions with city, county and state leaders, receiving input from patients they serve on a day to day basis as well as input from the staff of key health care providers.

Organizations and individuals have been afforded the opportunity to have discussions with the key performing providers through their established advisory groups as well as via public notice of the key plans being proposed by the Region. Groups that have been engaged include the area medical societies and key non-profit community health advocates and providers. Letters from key medical societies and groups describing their participation in the overall process are included in the addendum section of this plan.

There have been over sixty (60) meetings held in Region 20 involving local stakeholders and at least nine public meetings held primarily at County Commissioners' Court that were held in most of the counties in the Region which took place on the following dates:

- February 13, 2012- Webb County Commissioners Court Meeting
- March 13, 2012- Webb County Commissioners Court Meeting
- March 26, 2012- Jim Hogg Commissioners Court Meeting
- April 10, 2012- Zapata County Commissioners Court Meeting
- April 19, 2012- Maverick County Hospital District Board Meeting
- August 2, 2012- Webb County Commissioners Court Meeting
- August 13, 2012- Zapata County Commissioner Court Meeting
- November 13, 2012- Webb County Commissioners Court Meeting
- December 10, 2012- Webb County Commissioners Court Meeting

Region 20 Anchor, Webb County, posted on its website ([www.webbcountytexas.gov/IndigentHealthCare/HealthcarePartnership](http://www.webbcountytexas.gov/IndigentHealthCare/HealthcarePartnership)) an overview of the RHP Plan, including a Community Needs Assessment and an initial list of proposed DSRIP projects. During the Commissioners Court meeting's on November 13, 2012 and December 10, 2012, a public comment section was included that allowed the public an opportunity to provide their input on Pass 1 and Pass 2 DSRIP projects being proposed for RHP 20. Subsequent public notices for additional public hearings are planned. The process for the public comment also included emails to be directly sent to the anchor's email ([indigenthealth@webbcountytexas.gov](mailto:indigenthealth@webbcountytexas.gov)).

In addition to the Region's individual efforts, appropriate State wide medical organizations have participated at the statewide level with the Texas Health and Human Services' Executive Review Committee established for the development of the Waiver's details. Region 20 has plans to establish on-going engagement meetings with public stakeholders including posting of key reports and conducting bi-annually meetings.

## **Section V. DSRIP Projects**

### ***A. RHP Plan Development***

#### **Number of Category 1 and 2 Projects in RHP 20**

RHP 20 is characterized as a Tier 4 Region in accordance with the Program Financing and Mechanics Protocol. As a Tier 4 Region, RHP 20 is required to include a minimum of 4 projects from Category 1 and 2 combined, with at least 2 of the 4 projects selected from Category 2. The RHP Plan contains 14 Category 1 or 2 projects.

#### **Project Development Process**

As described in Section IV – Stakeholder Engagement, Participants held conferences among themselves on numerous occasions. Meetings began early in December 2011 and included major stakeholders in the Region. As providers involved in the provision and delivery of health care services in the Region, they have reached out to local and State public entities that may desire to provide Intergovernmental Transfer (IGT) matching funds for the private sector health care delivery organizations. These included, for example, Webb County, Zapata County, Jim Hogg County, Nueces County, and Maverick County Hospital District. In addition, outreach and discussions have been included the University of Texas Health Science Center San Antonio, both of the Mental Health Authorities providing services in the Region (Border Health and Camino Real), and the City of Laredo. Additional outreach included contacts with Driscoll Children’s Hospital, which provides subspecialty and critical tertiary care for children from the Region.

Stakeholders discussed the Waiver general requirements and held numerous discussions regarding the overall health status and needs of the Region. There were also meetings to discuss the limited access to local financial resources necessary to implement provisions of the Waiver.

In addition to stakeholders proposing to implement DSRIP projects within available local resources, outreach and involvement included organizations that may augment and assist a performing provider in accomplishing a DSRIP projects.

Additional outreach and input was sought and continues to be sought from key public policy leaders in the Region and key medical society representatives and organizations focused on improving the quality of health care services in the Region.

Region 20 plans to continue to conduct quarterly meetings with key performing providers and public entities providing necessary Intergovernmental Transfers (IGTs).

Opportunities for public engagement were accomplished by key leaders in the health care community holding discussions with city, county and state leaders; receiving input from patients they serve on a day to day basis; input from the staffs of key health care providers. These organizations and individuals have been afforded the opportunity to have discussions with the

key performing providers through their established advisory groups as well as a public notice of the key plans being proposed by the Region.

Region 20 Anchor, Webb County, has also posted on its website an overview of the RHP Plan, including Community Needs Assessment and an initial list of proposed DSRIP projects. Public hearings were held November 13, 2012 and subsequent public notices for additional public hearings are planned.

### **RHP 20 Project Priorities**

In order to develop this assessment, Region 20 reviewed and identified the regional priorities through data analysis and review of appropriate reference materials on health care capacity, behavioral health and chronic diseases in conjunction with socioeconomic conditions in the Region and unique demographic trends within the Region.

The following priorities were identified as the Region's top community health needs and are addressed in the RHP 20 Plan DSRIP projects:

- **Capacity – Primary and Specialty Care** - The demand for primary and specialty care services exceeds that of available medical physicians in these areas, and prevents adequate access to care and management or specialized treatment for prevalent health condition and preventative health conditions.
- **Behavioral Health Services** – Existing behavioral health services resources are insufficient to meet the current population needs and the projected population growth.
- **Chronic Disease and Disease Self-Management Initiatives** – Many individuals in South Texas suffer from chronic diseases that are becoming more prevalent within the area.
- **Patient Navigation and Coordination** – Due to the complex needs of the community and the medically underserved status, it is important to emphasize care coordination and navigation. The need is further demonstrated because of the poverty in the Region.
- **Specialized Children's Health Needs** – The Region currently lacks a tertiary children's hospital and there is a need for specialized children's care coordination and support.

RHP 20 participants believe the priorities outlined above are consistent with the CMS' aims to improve health care for individuals, improve health care for the population and lower costs through improvements. The RHP 20 DSRIP projects are designed to fit and promote these goals.

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

The RHP 20 Performing Providers considered a number of different valuation approaches. Each performing provider considered and weighed the many factors surrounding valuation and submitted the project values that they believed best aligned with each project. The factors included, for example, the geographic market targeted by the project, the population to be served by the project including how the project may impact low income patients, the complexity of the project, the potential for cost avoidance, the potential that the project could be sustained over a period of time, the consideration of other health services available, and the areas that lacked sufficient provider availability.

Further considerations included clinical care needs, costs for hiring clinicians, costs for high risk populations, consideration for community benefits (improving healthier outcomes, providing disease managed and making healthier choices), accessing better mental health services, reducing hospitalizations and hospital care costs, as well as the lack of local funding for these services.

The combination of the above considerations formed the basis for individual project valuation.

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

#### **Project Summary:**

Unique Project Identifier: 121989102.1.1

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

Provider Description: Border Region Behavioral Health Center provides outpatient in four South Texas counties. Three counties - Webb, Jim Hogg & Zapata – are in Region 20 and one – Starr – is in Region 5.

In Region 20 approximately 2,200 adult and child clients are enrolled at any given time. Region 5 has a combined enrollment of approximately 500.

The overall payer mix is 63% Medicaid, 24% general revenue and 13% other.

Intervention(s): This project will allow for the purchase of telemedicine hardware and maintenance services to expand this service to all counties served by Border Region Behavioral Health Center.

Need for the project (include data as appropriate): Telemedicine will be employed to increase accessibility to specialized services in an area chronically short of licensed health provider. Lack of licensed professional health workers in South Texas is well documented. This delays service delivery and prohibits expansion. Telemedicine will permit sharing of staff with areas that experience a shortage and expand specialty services available, through staff positions or contract telemedicine specialty providers.

Target population (number of patients the project will serve and how many Medicaid/Indigent will benefit from the project): Telemedicine will be available to all Webb, Jim Hogg and Zapata County, Region 20, clients served. Annually, about 850 unique individuals are served, of which 50% have Medicaid and the remaining are indigent.

Category 1 or 2 expected patient benefits: Clients will be afforded a wider variety of specialized consultations, wait times for services will decrease, unnecessary inpatient hospitalizations can be avoided and new programs can be initiated to target persons with behaviors, health issues and co-morbid physical diagnoses.

Estimated Client Impact (clients using telemedicine services: DY12 – 958; DY13-1,557; DY14 – 1587; DY5-1617

Category 3 outcomes expected patient benefits: Possibly preventable admissions will be reduced. Patients will experience greater access to specialty care in their community, thereby reducing inpatient hospitalizations and criminal justice involvement.

## **Identifying Project and Provider Information**

**Project Option:** 1.11.2 Implement Technology Assisted Services to Support, Coordinate, or Deliver Behavioral Health Services

**Unique RHP ID#:** 121989102.1.1

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

## **Project Description**

**Brief Description:** Border Region Behavioral Health Center will expand telemedicine services to all counties of Border Region's rural service area, one of which is in Region 20.

These services will be available for children and adults and will include psychiatric evaluation, medication management and crisis intervention. Because the region is sparsely populated, it is a challenge to provide accessible behavioral health services to the population. The availability of behavioral health providers is extremely limited. Via telemedicine is the only way some parts of Region 20 will have access to behavioral health care.

**Goals and Relationship to Regional Goals:** This project supports the Regional Goal of expanding access to specialty services. These services may only be available via telemedicine services for the foreseeable future. Region 20 has only 21% the rate of psychiatrists per 100,000 workers as the rest of Texas.

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

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

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

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

- Improve the time between initial request for services and first appointment.
- Decrease transportation costs of traveling providers and clients for crisis intervention.
- Reduce staff time lost to travel, and ensure more service delivery and improved billing of staff time.

**Challenges/Issues:** The first challenge in expanding telemedicine service to Jim Hogg and Zapata Counties will be to assure new technologies purchased have compatibility with the telemedicine infrastructure currently in use at the Border Region main office in Webb County

(Region 20). Components and vendors will be selected with the requirement. Component will be tested upon receipt to assure compatibility and not impede the implementation timeline for this project. Vendors will also be evaluated on their ability to provide on-site maintenance and component exchange time.

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

The long distance from the Webb County main office to the clinical in Jim Hogg and Zapata Counties will present challenges to on-site maintenance. To reduce delays in telemedicine service delivery, contracts with Region 20 technicians from the Harlingen/McAllen/Edinburg area may supplement the main office IT personnel.

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

**Five-Year Expected Outcome for Provider and Patients:** We expect to see an increase in the number of patients accessing/receiving behavioral health services through telemedicine and due to the increased availability and ease of access we also expect to see increased patient satisfaction with telemental services.

Estimated Client Impact (clients using telemedicine services: DY12 – 958; DY13-1,557; DY14 – 1587; DY5-1617

### **Starting Point/Baseline**

Border Region currently has in place Telemedicine technology to support Laredo and nearby communities. This project will expand telemedicine technology to Jim Hogg and Zapata Counties, which currently have no capacity for telemedicine. This project will serve the 335 clients in these two counties plus provide specialty consultation for the patient panel selected for the integrated primary/behavioral health care project.

### **Rationale**

This project is required to make other proposed projects feasible. Given the physical distance from the metropolitan area of Laredo (itself designated as Health Professional Shortage Area), and given the difficulty in obtaining on-site psychiatric professionals, the only way to achieve improved access to specialty providers is via telemedicine.

If the additionally proposed projects (expand workforce and implement integrated primary and behavioral healthcare), are not funded this telemedicine project will improve services for clients currently being served. Children and adolescents have no access to a Child Psychiatrist and no timely psychiatric assessment is available in crisis situations.

This project will bring telemedicine options to the Region 20 counties of Jim Hogg and Zapata counties. These counties have historically relied on traveling psychiatrists to provide patient encounter. Telemedicine services are expected to provide the following benefits:

- Improve time between initial request for services and first appointment.
- Provide opportunity for more psychiatrist encounters per year, on parity with Webb County.
- Decrease transportation costs of traveling providers and client transportation for crisis intervention.
- Less staff time lost on travel, more service delivery and billing permitted.

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

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

**Unique community need identification number the project addresses:** This project relates to Community Need Numbers -

(CN 1), Capacity – Primary and Specialty Care and Community Need (CN 2), Behavioral Health Services.

These projects address the shortage of behavioral health professionals and inadequate access to behavioral health care.

**How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:** Residents of Jim Hogg and Zapata Counties have no access to telemedicine services or the access to specialty providers’ telemedicine makes possible. With telemedicine child psychiatry services and timely crisis evaluation become possible. If DSRIP projects for enhancing the workforce and integrated primary and behavioral health are approved, telemedicine will be the cornerstone of bringing more specialty services to Jim Hogg and Zapata Counties.

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

**Unique RHP ID#:** 121989102.1.1

**Performing Provider/TPI:** Border Region Behavioral Health Cater/121989102

OD-2 Potentially Preventable Inpatient Admissions:

IT-2.4 Behavioral Health/Substance Abuse (BH/SA) Admission Rate

**Reasons/rationale for selecting the outcome measure:** Telemedicine technology will help our Community Mental Health clinic in Jim Hogg and Zapata Counties deliver outpatient services at the same level as the Laredo clinic. The Laredo clinic has telemedicine technology operatives. Adult clients at the Region 20 office of Border Region Behavioral Health Center receive 35% less psychiatric visits per year than individuals in Laredo do. Child Clients in Region 20 receive 30% fewer visits than those in Laredo do. By providing more care in the outpatient setting via telemedicine, Border Region will be able to reduce preventable inpatient admissions.

Inpatient admission rates to state behavioral health hospitals for adults and children in Zapata Counties are 19% higher than rates in Webb County. Jim Hogg, with 3 admissions and a total county population of only 5,265 is not statistically comparable to other counties.

### **Relationship to other Projects**

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

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

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

N/A

### **Plan for Learning Collaborative**

We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 20, Webb County. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system. The RHP 20 Anchor will sponsor two learning collaboratives per year.

### **Project Valuation**

The Region 20 area served by Border Region encompasses 5,570 square miles and is populated with 276, 078 of which 90% live in Laredo. This geographic dispersion, of the remaining populace limits access to both physical and behavioral health care and a routine basis, resulting in neglected conditions which usually begin their resolution at the Emergency Room.

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

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

<b>Unique Identifier:</b> 121989102.1.1	<b>RHP PP Reference:</b> 1.11.2	<b>Project Components:</b> 1.11.2 (a-h)	<b>Project Title: Implement Technology Assisted Services to Support, Coordinate, or Deliver Behavioral Health Services</b>	
Performing Provider Name: Border Region Behavioral Health Center			TPI - 121989102	
<b>Related Category 3 Outcome Measure(s):</b>	121989102.3.1	IT-2.4	Behavioral Health/Substance Abuse (BH/SA) Admission Rate	
<b>Year 2</b> (10/1/2012 – 9/30/2013)		<b>Year 3</b> (10/1/2013 – 9/30/2014)		<b>Year 4</b> (10/1/2014 – 9/30/2015)
<b>Year 5</b> (10/1/2015 – 9/30/2016)				
<p><b>Milestone 1 [P-4]:</b> Procurement of telehealth, telemedicine, telementoring, and telemonitoring equipment</p> <p><u>Metric 1 [P- 4.1]:</u> Inventory of new equipment purchased</p> <p>Goal: Establish working telemedicine hardware Estimated clients impacted: 958</p> <p>Data Source: Review of inventory or receipts for purchase of equipment</p> <p>Milestone 1 Estimated Incentive Payment: \$54,927</p>	<p><b>Milestone 2 [P-8]:</b> Training for providers/peers on use of equipment /software</p> <p><u>Metric 1 [P-8.1]:</u> Documentation of completions of training on use of equipment/ software</p> <p>Baseline: Staff have received no training Staff have not received training. Goal: 100% of staff involved in the delivery telemedicine receive training and demonstrate competency. Estimated clients impacted: 1557</p> <p>Data Source: Training roster</p> <p>Milestone 2 Estimated Incentive Payment: \$57,301</p>	<p><b>Milestone 3 [P-11]:</b> Individuals residing in underserved areas that have used telemedicine, telehealth, telementoring, and / or telemonitoring services for treatment of mental illness or alcohol and drug dependence</p> <p><u>Metric 1 [P-11.1]</u> % increase in number of individuals residing in underserved areas of the health partnership region who have used telemedicine, telehealth and telemonitoring services for treatment of mental illness or alcohol and drug dependence.</p> <p>Goal: 50%increase in telemedicine encounters over DY2 Estimated clients impacted: 1557</p> <p>Data Source: Encounter data</p> <p>Milestone 3 Estimated Incentive Payment: \$61,298</p>	<p><b>Milestone 4 [I-15]:</b> Satisfaction with telemental services</p> <p><u>Metric 1 [I-15.1]:</u> % of consumer, peer and provider surveys indicate satisfaction with telemental services</p> <p>Goal: 85% indicate satisfaction with telemedicine services. Estimated clients impact: 1617</p> <p>Data Source: Batched and analyzed survey data</p> <p>Milestone 4 Estimated Incentive Payment: \$29,613</p> <p><b>Milestone 5 [P-11]:</b> Individuals residing in underserved areas that have used telemedicine, telehealth, telementoring, and / or telemonitoring services for treatment of mental illness or alcohol and drug dependence</p> <p><u>Metric 1 [P-11.1]</u> TBD% increase in number of individuals residing in underserved areas of the health partnership region who have used telemedicine, telehealth and</p>	

<b>Unique Identifier:</b> 121989102.1.1	<b>RHP PP Reference:</b> 1.11.2	<b>Project Components:</b> 1.11.2 (a-h)	<b>Project Title: Implement Technology Assisted Services to Support, Coordinate, or Deliver Behavioral Health Services</b>	
Performing Provider Name: Border Region Behavioral Health Center			TPI - 121989102	
<b>Related Category 3 Outcome Measure(s):</b>	121989102.3.1	IT-2.4	Behavioral Health/Substance Abuse (BH/SA) Admission Rate	
<b>Year 2</b> (10/1/2012 – 9/30/2013)	<b>Year 3</b> (10/1/2013 – 9/30/2014)	<b>Year 4</b> (10/1/2014 – 9/30/2015)	<b>Year 5</b> (10/1/2015 – 9/30/2016)	
			telemonitoring services for treatment of mental illness or alcohol and drug dependence.  Goal: <del>TBD</del> 20% increase in telemedicine encounters over DY4 Estimated clients impacted: 1860  Data Source: Encounter data  Milestone 5 Estimated Incentive Payment: \$29,613	
<b>Year 2 Estimated Milestone Bundle Amount: \$54,927</b>	<b>Year 3 Estimated Milestone Bundle Amount: \$57,301</b>	<b>Year 4 Estimated Milestone Bundle Amount: \$61,298</b>	<b>Year 5 Estimated Milestone Bundle Amount: \$59,226</b>	
<b>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5): \$232,752</b>				

**Title of Outcome Measure (Improvement Target)**

**Provider Name:** Border region Behavioral Health Center **TPI:** 121989102  
**Title:** IT-2.4 Behavioral Health/Substance Abuse (BH/SA) Admission Rate  
**Unique RHP ID#:** 121989102.3.1

**Outcome Measure Description**

OD-2 Potentially Preventable Inpatient Admissions:  
IT-2.4 - Reduce preventable admissions for behavioral health/substance abuse.

**Process Milestones:**

- DY2:  
N/A
- DY3:  
P-4 Conduct Plan Do Study Act (PDSA) cycle to improve data collection and intervention activities.

**Outcome Improvement Targets for Each Year:**

- DY4:  
IT-2.4 Behavioral Health/Substance Abuse (BH/SA) Admission Rate (Standalone Measure)
- DY5:  
IT-2.4 Behavioral Health/Substance Abuse (BH/SA) Admission Rate (Standalone Measure)

**Rationale**

The three projects requested in Pass 1 of Region 20 are designed to support the goal of preventing hospital admissions. Specifically this goal refers to State Hospital, private psychiatric hospital and acute medical/surgical hospital admissions.

Outcome measure 2.4 was chosen as it serves as the overarching goal for the project. Other benefits are realized for the population served, but all these ultimately serve the purpose of reducing possible admissions. Inpatient admission represents interruptions in the client’s life and work, and represents the most financially intensive intervention from the providers’ perspective.

Process measures chosen represent management initiatives currently under-practiced. Stakeholders generally do not focus on inpatient admissions and QI activities such as Plan Do Study is traditionally absent from the management culture but need to be implemented.

The Process milestones directly service the Region 20 goal of nurturing a culture of ongoing quality improvement and innovation that maximizes the use of technology and best-practices to improve access and timely utilization of appropriate care, including behavioral health services, particularly in our rural communities.

## **Outcome Measure Valuation**

The population included in this project is the entire adult and child/adolescent client population of Border Region Behavioral Health Center clinic in Jim Hogg and Zapata Counties. The clinic has an active enrollment of approximately 1,500 adult and 700 child/adolescent clients.

The Pass 1 infrastructure projects 1.11.2 and 1.14.1 both support the Program Innovation and Redesign project 2.15.2. The impetus of the infrastructure projects is to make more licensed personnel available in the region. Needed licensed personnel such as LPHAs, nurses and psychiatrists are historically underrepresented in this region. Telecommunication infrastructure will permit contracting services for behavioral health, and in the case of 2.15.1, medical services that cannot be hired or contracted locally.

Estimated client impact: DY2&DY3: No impact on Inpatient admissions. DY4 inpatient admissions decrease by 10% from DY12 to 479 per year. DY5 inpatient admission decrease 15% from DY4 to 407 admissions per year.

Specific description of Adult population served

- a) Adults who have severe and persistent mental illnesses such as schizophrenia, major depression, bipolar disorder, or other severely disabling mental disorders which require crisis resolution or ongoing and long-term support and treatment.
- b) Adult MH Target Population - Adults who have a diagnosis of schizophrenia, bipolar disorder, and severe major depression.
- c) Initial Eligibility:
  - (1) An individual age 18 or older who has a diagnosis of:
    - a) schizophrenia as defined in the following Diagnostic and Statistical Manual, Fourth Edition
    - b) bi-polar disorder as defined in the f DSM-IV TR
    - c) major depression as defined in the f DSM-IV TR; with a Global Assessment of Functioning (GAF) of 50 or below at intake.
  - (2) An individual age 18 or older who has a diagnosis other than those listed in I.B.2.c.1. and whose current Global Assessment of Functioning (GAF) is 50 or less and needs on-going MH services; or
  - (3) An individual age 18 or older who was served in children's MH services and meets the children's MH priority population definition prior to turning 18 is considered eligible for one year.
- d) Individuals with only the following diagnoses are excluded from this provision:
  - (1) Substance Abuse as defined in the DSM-IV TR
  - (2) IDD as defined in the DSM-IV TR diagnostic codes.
  - (3) Pervasive Developmental Disorder as defined in the DSM-IV TR diagnostic codes.

Persons with mental conditions referred by primary care or other providers but not meeting the above criteria may be eligible for services funded under transformation waiver 1115 projects.

Specific description of Child/Adolescent population:

- a) Children/youth ages 3 through 17 with a diagnosis of mental illness (excluding a single diagnosis of substance abuse, IDD, autism or pervasive development disorder) who exhibit serious emotional, behavioral or mental health disorders and who:
  - (1) Have a serious functional impairment; or
  - (2) Are at risk of disruption of a preferred living or child care environment due to psychiatric symptoms; or
  - (3) Are enrolled in a school system's special education program because of serious emotional disturbance.
- b) Age Limitations:
  - (1) Children under the age of three who have a diagnosed physical or mental health condition are to be served through the Early Childhood Intervention (ECI) program; and
  - (2) Youth 17 years old and younger must be screened for CMH services. Youth 18 years or older must be screened for Adult Mental Health services; and
  - (3) Youth receiving Children's MH Services who are approaching their 18<sup>th</sup> birthday and continue to be in need of services shall either be transferred to Adult MH Services on his/her 18<sup>th</sup> birthday or referred to another community provider, dependent upon the individual's needs. Youth reaching 18 years of age who continue to need services may be transferred to Adult MH Services without meeting the adult priority population criteria and served for up to one additional year.
  - (4) For purposes of this contract definitions of "child" and "youth" are as follows:
    - (a) Child: An individual who is at least three years of age, but younger than 13 years of age.
    - (b) Youth: An individual who is at least 13 years of age, but younger than 18 years of age.

<i>Unique Cat 3 ID: 121989102.3.1</i>	<i>Ref Number from RHP PP: 3.IT-2.4</i>	<i>Behavioral Health/Substance Abuse (BH/SA) Admission Rate</i>	
<i>Performing Provider Name: Border Region Behavioral Health Center</i>			<i>TPI - 121989102</i>
<b>Related Category 1 or 2 Projects:</b>	<i>Unique Category 1 Identifier - 121989102.1.1, 1219891022.1, 121989102.1.2</i>		
<b>Starting Point/Baseline:</b>	<i>To be developed in DY 3</i>		
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>
<b>Process Milestone 1 [NA]</b>  Process Milestone 1 Estimated Incentive Payment: \$0	<b>Process Milestone 2 [P-4]:</b> Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities  Data Source: Facility minutes, documented reports.  Process Milestone 2 Estimated Incentive Payment: \$6,367	<b>Outcome Improvement Target 1 [IT 2.4]: Behavioral Health/Substance Abuse (BH/SA) Admission Rate</b>  Performing provider should report on both categories below: 1. One for BH/SA as the principal diagnosis; 2. A second category in which a significant BH/SA secondary diagnosis is present  Improvement Target: BH/SA admission decrease 10% from DY2 baseline.  Data Source: Admissions data from CARE system, Anasazi Continuity of Care records  Outcome Improvement Target 1 Estimated Incentive Payment: \$6,811	<b>Outcome Improvement Target 2 [IT 2.4]: Behavioral Health/Substance Abuse (BH/SA) Admission Rate</b>  Performing provider should report on both categories below: 1. One for BH/SA as the principal diagnosis; 2. A second category in which a significant BH/SA secondary diagnosis is present  Improvement Target: BH/SA admission decrease 15% from DY4 baseline.  Data Source: Admissions data from CARE system, Anasazi Continuity of Care records  Outcome Improvement Target 2 Estimated Incentive Payment: \$14,806
<b>Year 2 Estimated Outcome Amount: \$0</b>	<b>Year 3 Estimated Outcome Amount: \$6,367</b>	<b>Year 4 Estimated Outcome Amount: \$6,811</b>	<b>Year 5 Estimated Outcome Amount: \$14,806</b>
<b>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5): \$27,984</b>			

## **Project Summary:**

Unique Project Identifier: 121989102.1.2

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

Provider Description: Border Region Behavioral Health Center provides outpatient in four South Texas counties. Three counties - Webb, Jim Hogg & Zapata – are in Region 20 and one county– Starr – is in Region 5.

In Region 20 approximately 2,200 adult and child clients are enrolled at any given time. Region 5 has a combined enrollment of approximately 500.

The overall payer mix is 63% Medicaid, 24% general revenue and 13% other.

Intervention(s): This project concentrates on the procuring licensed personnel to provide services directly to clients and expand services – including the new services proposed under this waiver. Professions needed include psychiatrists, nurses, Licensed Professional Counselors and Care Coordinators. These services may be hired directly or acquired through contract. The expanded staff/consultants will promote access to behavioral health services through the implementation of telemedicine services, integrated primary and behavioral health services, and crisis management and prevention.

Need for the project (include data as appropriate): Lack of licensed professional health workers in South Texas is well documented. This delays service delivery and prohibits expansion. Telemedicine will permit sharing of staff with areas that experience a shortage and expand the types of specialties available, either through staff positions or contract telemedicine specialty providers.

Target population (number of patients the project will serve and how many Medicaid/Indigent will benefit from the project): All of the 850 patients (adult and children) seen annually will benefit from greater access to specialty care if need indicates. Specifically targets clients in crisis or at risk of crisis and clients with co-morbid physical symptoms.

Category 1 or 2 expected patient benefits: Clients will be afforded a wider variety of specialized consultations and wait times for services will decrease. An increase in 10% per year in adult consumers seen 20% per year in children seen is expected for DY3-5.

Expected impact (additional patients served): DY2 - no increase, DY3 - 328, DY4- 377, DY5 - 454

Category 3 outcomes expected patient benefits: Hospital admissions and readmissions will be reduced. Patients will experience greater access to specialty care in their community, thereby reducing inpatient hospitalizations and criminal justice involvement.

## **Identifying Project and Provider Information**

**Project Option:** 1.14.1 Develop Workforce Enhancement Initiatives to Support Access to Behavioral Health Providers in Underserved Markets and Areas

**Unique RHP ID#:** 121989102.1.2

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

## **Project Description**

**Brief Description:** This project is designed to address the lack of licensed Behavioral Health providers and other Behavioral Health workers residing in and serving Region 20 (licensed positions have been historically under filled). New initiatives and changes in the health care law will exacerbate this situation unless new efforts can be initiated to recruit and train behavioral health care and primary care workers. The project will involve hiring a physician, RN, LCN, an intensive case manager, two LPHA (licensed practitioner of the healing arts), one half time child psychiatrist, one half time adult psychiatrist and one family partner position.

The expanded staff/consultants will enable the delivery of telemedicine services, integrated primary and behavioral health services, and crisis management and prevention.

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

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

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

**Goals and Relationship to Regional Goals:** Workforce expansion is in response to community input from providers, local researchers and residents, based on regional meetings, local research results, needs assessments involving resident surveys and focus groups, as well as state and federally-supported health and demographic statistics on the region. It addresses RHP 20 need for projects designed to expand the workforce of qualified primary care and specialty care providers to reduce health care workforce shortages and thus reduce delays in care seeking and reduce inappropriate emergency department utilization, as well as improve patient satisfaction.

Goals of this project are to enhance access and reduce shortages in behavioral health and improve integration of Border Region services into the overall health delivery system; improve consumer choice; increase availability of effective, lower-cost alternatives to inpatient care; and prevent inpatient admission where possible; and, promote recovery from behavioral health disorders.

On a regional basis, Region 20 faces a shortage of licensed health care workers, especially for behavioral health. Border Region must compete with the school system for the limited pool of licensed behavioral health counselors. If a project for integrated primary & behavioral health services is undertaken, Border Region will enter into competition for primary care physicians and RNs with the local hospitals and clinics.

**Challenges/Issues:**

- Competition for licensed professionals from school system
- Difficulty attracting people to live in borderlands
- Lack of patient data on access to care provided by other agencies
- Perception of the border as a dangerous place to live
- Inflated property values
- Limited graduate education programs

This project will meet these challenges in three ways:

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

In addition to expanding behavioral health workers, primary care providers will be provided with training to assist them in addressing the behavioral health needs of individuals beyond the scope of their usual practice.

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

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

**Starting Point/Baseline**

Typically in this Region four Licensed Practitioner of the Healing Arts are available for approximately 1,920 clients receiving service at any given time. No child psychiatrist or LPHA is available for the client needs for Jim Hogg or Zapata County. Traveling physicians provide

authorizations in these counties in the absence of LPHAs. Children and adults are served by the same psychiatrist.

One Licensed Vocational Nurse provides the nursing services for the behavioral health clients in Jim Hogg and Zapata counties. No family partner for children's services is available in these counties.

An increase in 10% per year in adult consumers seen and 20% per year in children seen is expected for DY3-5.

### **Rationale**

Overall, there is a lack of behavioral health staff serving Region 20. Staff shortages cause frequent delays in service delivery and screening for services. LPHAs are needed for authorization, CBT and utilization review.

Project 2.15.1 for integrating primary and behavioral health care will create additional demand for LPHAs, Intensive Case Managers, nursing and medical staff. Additional staff such as Community Health Workers will also be utilized. The part time LPHA on contract is used only for service authorization. Other specialties required for effective treatment, such as a Family Partner for Children's services are not available. No RN is consistently available for Active Community Treatment services.

Waiting lists for services are usually in excess of 150 clients in adult services. While waiting lists for children's service are short (less than 10), there are over 1,000 children waiting to be assessed for eligibility for services.

Quality Improvement processes are included in the project response to program performance, as well as the development and testing of new solutions. Results are shared with programs and findings may be exported to other providers/programs with similar issues.

### **Project Components:**

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

exported to other needs identified in the gap analysis for serving the safety-net population.

### **Milestones & Metrics:**

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

- Process Milestones and Metrics: P-1 (P-1.1), P-2(P-2.1) to define workforce needs and put in place a remediation plan; P-4 (P-4.1) as a CQI tool for evaluating the continued implementation of the plan; P-5 (P-5.1), to measure project implementation in DY; P-9 (p-9.1) to learn from other providers with similar projects and challenges. This will be done in collaboration with RHP 20 anchor and performing providers.
- Improvement Milestones and Metrics: I-11 (I-11.1, I-11.2) to determine the effectiveness of workforce enhancement on consumer satisfaction with the workforce and to determine if enhancement has any effect on bed day utilization.

### **Unique community need identification number the project addresses:**

(CN-1) Capacity - Primary and Specialty Care, addresses the lack of providers and inadequate access to primary or preventive care.

**How the project represents a new initiative or significantly enhances an existing delivery system reform initiative:** This project changes the focus of the current clinic from medication management and case management to a clinic with a greater array of clinical interventions and selection of providers. Telemedicine with appropriate nursing assistance will be available, clinic centered crisis management will help reduce dependence on law enforcement and the hospital and cognitive behavioral therapy can be offered for ACT clients.

### **Related Category 3 Outcome Measure**

OD-2 Potentially Preventable Admissions

IT-2.4 Behavioral Health/Substance Abuse (BH/SA) Admission Rate

With additional behavioral health services, populations in Region 20 should be able to avoid the number of preventable inpatient admissions. 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<sup>45</sup>. Co-occurring mental and physical health issues are common in the general population but are significant for persons with serious mental illness.

An increase in the number of licensed professionals will improve access, making clients' initial access to care more timely. This will decrease waiting list and promote community care before

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

people's needs reach crisis levels, thus avoiding inpatient care. More counseling and behavioral therapies will be available for those with identified needs.

### **Relationship to other Projects**

This project relates to 1.11.2 - Implement technology assisted behavioral health services from psychologists, psychiatrists, substance abuse counselors, peers and other qualified provider, and to 2.15.1 - Design, implement, and evaluate projects that provide integrated primary and behavioral health care services. It is expected that some specialty providers will be available only via telemedicine and trainings may be done with the same technology infrastructure. This will be especially true for providers and clients in the outlying counties of Jim Hogg and Zapata. Project 2.15.1 will rely on personnel hired or contracted and trained through this project almost entirely. Current DSHS state contract does not provide for treatment of primary care needs.

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

N/A

### **Plan for Learning Collaborative**

We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 20, Webb County. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system. The RHP 20 Anchor will sponsor two learning collaboratives per year.

### **Project Valuation**

Psychiatric inpatient costs attributed to Region 20 counties are approximately \$723,654 per year and reflect a combination of State Hospital and private psychiatric care. Approximately 216 admissions come from Webb County annually with an average length of stay of 5.7 days. Inpatient cost is \$595 per day based on Center for Medicare Services research. An additional 137 admissions are made to private psychiatric hospitals due to a shortage of State beds and are paid for by Border Region.

([www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Reports/downloads/cromwell\\_2005\\_3.pdf](http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Reports/downloads/cromwell_2005_3.pdf)).

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

<b>Unique Identifier:</b> 121989102.1.2	<b>RHP PP Reference:</b> 1.14.1	<b>Project Components:</b> 1.14.1(a-c)	<b>Develop Workforce enhancement initiatives to support access to behavioral health providers in underserved markets and areas</b>	
Performing Provider Name: Border Region Behavioral Health Center			TPI: 121989102	
<b>Related Category 3 Outcome Measure(s):</b>	121989102.3.2	IT-2.4	Behavioral Health/Substance Abuse (BH/SA) Admission Rate	
<b>Year 2</b> (10/1/2012 – 9/30/2013)		<b>Year 3</b> (10/1/2013 – 9/30/2014)	<b>Year 4</b> (10/1/2014 – 9/30/2015)	<b>Year 5</b> (10/1/2015 – 9/30/2016)
<p><b>Milestone 1 [P-1]:</b> Conduct Gap Analysis</p> <p><u>Metric 1</u> [P-1.1]: Baseline analysis of behavioral health patient population, which may include elements such as consumer demographics, proximity to sources of specialty care, utilization of Emergency Department, other crisis and inpatient services including state hospital services used by residents of the region, incarceration rates, most common sites of mental health care, most prevalent diagnoses, co-morbidities; existing provider caseload, provider demographics and other factors of regional significance</p> <p><b>Baseline:</b> Demographic data and provider profiles data is available, though not analyzed to date. <b>/Goal</b> Match service needs to available providers to determine needed provider strength. Data Source: Client data system, HHSC website, Patient registry DSHS MBOW, and encounter reporting.</p> <p>Milestone 1 Estimated Incentive Payment: \$430,261</p>	<p><b>Milestone 4 [P-4]:</b> Evaluate and continuously improve strategies</p> <p><u>Metric 1</u> [P-4.1]: Project planning and implementation documentation describes plan, do, study act quality improvement cycles.</p> <p><b>Baseline:</b> This will be the initial PSDA QI cycle based gap analysis/<b>Goal:</b> Produce two examples of rapid-cycle improvement <b>Data Source:</b> Project reports including examples of how real-time data is used for rapid-cycle improvement to guide continuous quality improvement Milestone 4 Estimated Incentive Payment: \$ 448,855</p> <p><b>Milestone 5 [P-5]:</b> Number of behavioral health providers serving medically indigent public health clients</p> <p><u>Metric 1 [P-5.1]</u> Track and report the number of behavioral health providers serving medically indigent public health clients by provider type on at least a quarterly basis.<sup>279</sup></p> <p><b>Baseline:</b> Workforce totals for region</p>	<p><b>Milestone 7 [P-9]:</b> Participate in face-to-face learning at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects.</p> <p><u>Metric 1</u> [P-9.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP.</p> <p>Goal: Promote continuous learning and exchange between providers.</p> <p>Providers participate in at least 3 face-to-face meetings/seminars hosted by RHP</p> <p>Data Source: Documentation of semiannual meetings including agendas, presentation slides and/or meeting notes.</p> <p>Milestone 7 Estimated Incentive Payment: \$ 360,128</p> <p><b>Milestone 8 [P-4]:</b> Evaluate and continuously improve strategies</p> <p><u>Metric 1</u> [P-4.1]: Project planning and implementation documentation describes plan, do, study act quality</p>	<p><b>Milestone 11 [P-9]:</b> Participate in face-to-face learning at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects.</p> <p><u>Metric 1</u> [P-9.1]: Participate in semi-annual face-to-face meetings or seminars organized by the RHP.</p> <p>Goal: Promote continuous learning and exchange between providers.</p> <p>Providers participate in at least 4 face-to-face meetings/seminars hosted by RHP</p> <p>Data Source: Documentation of semiannual meetings including agendas, presentation slides and/or meeting notes.</p> <p>Milestone 11 Estimated Incentive Payment: \$ 347,950</p> <p><b>Milestone 12 [P-4]:</b> Evaluate and continuously improve strategies</p> <p><u>Metric 1</u> [P-4.1]: Project planning and implementation documentation</p>	

<p><b>Milestone 2 [P-2]:</b> Remediation Plan</p> <p><u>Metric 1 [P-2.1]:</u> Remediation plan which addresses elements relating to shortages identified in the Gap analysis.</p> <p>Baseline: Pending gap analysis Goal: Completion/distribution and training on Remediation plan completed. Data Source: Completed Plan on file, training records <del>Data source: Documented Remediation Plan</del></p> <p><b>Milestone 2</b> Estimated Incentive Payment: \$430,261</p> <p><b>Milestone 3 [P-9]:</b> Participate in face-to-face learning at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects.</p> <p><u>Metric 1 [P-9.1]:</u> Participate in semi-annual face-to-face meetings or seminars organized by the RHP.</p> <p><b>Baseline:</b> RHP has organized conference calls and webinars since the beginning of the 1115 Waiver initiative. Goal: Promote continuous learning and exchange between providers. Data Source: Documentation of semiannual meetings including agendas, presentation slides and/or meeting notes.</p> <p>Milestone 3 Estimated Incentive</p>	<p>stated in Region 5 Community Needs document.</p> <p><b>Goal:</b> Measure the increase in number of providers and effectiveness of Remediation Plan implementation. 10 % increase in adult patients served by licensed staff over DY2, 20% increase for children Total number of services delivered is 8% greater than previous DY.</p> <p><b>Data Source:</b> Border Region Human Resources documents and Provider Contracts. Border Region client encounter database.</p> <p>Milestone 5 Estimated Incentive Payment: \$ 448,857</p> <p><b>Milestone 6 [P-9]:</b> Participate in face-to-face learning at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects.</p> <p><u>Metric 1 [P-9.1]:</u> Participate in semi-annual face-to-face meetings or seminars organized by the RHP.</p> <p><b>Baseline:</b> RHP has organized conference calls and webinars since the beginning of the 1115 Waiver initiative. Goal: Promote continuous learning and exchange between providers. Providers participate in at least 2 face-to-face meetings/seminars hosted by RHP.</p> <p>Data Source: Documentation of</p>	<p>improvement cycles Data Source: Project reports including examples of how real-time data is used for rapid-cycle quality improvement Goal: Assess and improve use of quantitative and qualitative data. Four examples of projects demonstrating improvement from rapid-cycle improvements</p> <p>Milestone 8 Estimated Incentive Payment: \$ 360,128</p> <p><b>Milestone 9 [P-5]:</b> Number of behavioral health providers serving medically indigent public health clients.</p> <p><u>Metric 1 [P-5.1]:</u> Track and report the number of behavioral health providers serving medically indigent public health clients by provider type on at least a quarterly basis.</p> <p>Goal: Increase the use of behavioral health providers serving medically indigent clients. Establish a system for tracking delivery of behavioral health services by provider</p> <p>50% (4 full time equivalent) increase number of licensed providers for medically indigent public health clients served over DY2 baseline. 5 % increase in adult patients served by licensed staff over DY3, 15% increase for children.</p>	<p>describes plan, do, study act quality improvement cycles</p> <p>Data Source: Project reports including examples of how real-time data is used for rapid-cycle quality improvement Goal: Establish baseline for first operational years use. Five examples of projects demonstrating improvement from rapid-cycle improvements</p> <p>Milestone 12 Estimated Incentive Payment: \$ 347,950</p> <p><b>Milestone 13 [P-5]:</b> Number of behavioral health providers serving medically indigent public health clients.</p> <p><u>Metric 1 [P-5.1]:</u> Track and report the number of behavioral health providers serving medically indigent public health clients by provider type on at least a quarterly basis.</p> <p>Goal: Use of behavioral health providers serving medically indigent clients increase and Monitor and increase number of behavioral health providers providing services.</p> <p>60% (5 full time equivalent) increase number of licensed providers for medically indigent public health clients served over DY2 baseline.</p>
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<p>Payment (<i>maximum amount</i>): \$430,261</p>	<p>semiannual meetings including agendas, presentation slides and/or meeting notes. Milestone 6 Estimated Incentive Payment: \$448,856</p>	<p>Total number of services delivered is 8% greater than previous DY. Data Source: Client data system and batched and analyzed survey data</p> <p>Milestone 9 Estimated Incentive Payment: \$360,128</p> <p><b>Milestone 10</b> [I-11]: Consumer satisfaction with Care</p> <p><u>Metric 1</u> [I-11.1]: % People reporting satisfaction with care</p> <p>Goal: 85% people reporting satisfaction with care</p> <p>Data source: Completed satisfaction surveys</p> <p><u>Metric 2</u> [I-11.2]: % State Psychiatric Facility Bed Utilization</p> <p>Goal: 10% decrease from DY1 (216 admissions)</p> <p>Data Source: DSHS CARE client data system</p> <p>Milestone 10 Estimated Incentive Payment: \$360,129</p>	<p>5 % increase in adult patients served by licensed staff over DY4, 15% increase for children. Total number of services delivered is 8% greater than previous DY.</p> <p>Data Source: Client data system and batched and analyzed survey data</p> <p>Milestone 13 Estimated Incentive Payment: \$347,950</p> <p><b>Milestone 14</b> [I-11]: Consumer satisfaction with Care</p> <p><u>Metric 1</u> [I-11.1]: % People reporting satisfaction with care</p> <p>Goal: 90% people reporting satisfaction with care. Data Source: Survey documentation and completed satisfaction surveys</p> <p><u>Metric 2</u> [I-11.2]: % State Psychiatric Facility Bed Utilization</p> <p>Goal: 20% decrease from DY1 (216 admissions) Data Source: DSHS CARE client data system</p> <p>Milestone 14 Estimated Incentive Payment: \$347,950</p>
<p><b>Year 2 Estimated Milestone Bundle Amount: \$1,290,783</b></p>	<p><b>Year 3 Estimated Milestone Bundle Amount: \$1,346,567</b></p>	<p><b>Year 4 Estimated Milestone Bundle Amount: \$1,440,513</b></p>	<p><b>Year 5 Estimated Milestone Bundle Amount: \$1,391,800</b></p>
<p><b>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5): \$5,469,663</b></p>			

**Title of Outcome Measure (Improvement Target)**

**Provider Name/TPI:** Border Region Behavioral Health Care 121989102

**Title:** IT-2.4 Behavioral Health/Substance Abuse Admission Rate

**Unique RHP ID#:** 121989102.3.2

**Outcome Measure Description**

OD-2 Potentially Preventable Admissions

IT-2.4 Behavioral Health/Substance Abuse Admission Rate

The Category 3 project template describes various processes milestones and metrics for measuring both the progress in acquiring and implementing the infrastructure plans and their effect on the implementation of the 1.14.1 project. The Quality Assurance activities defined in this Category 3 project address an approach to Quality Assurance which can be applied to each project.

**Process Milestones:**

- DY2  
N/A
- DY3  
P-4 Ongoing Plan-Do-Study-Act sessions in which activities such as data collection are evaluated, and initiatives conceived and reviewed.

**Outcome Improvement Targets for Each Year:**

- DY4:  
IT-2.4 Behavioral Health/Substance Abuse admission rate – One for BH/SA as the principal diagnosis; second in which a significant BH/SA secondary diagnosis is present
- DY5:  
IT-2.4 Behavioral Health/Substance Abuse admission rate – One for BH/SA as the principal diagnosis; second in which a significant BH/SA secondary diagnosis is present

Estimated client impact: DY2&DY3: No impact on Inpatient admissions. DY4 inpatient admissions decrease by 10% from DY12 to 479 per year. DY5 inpatient admission decrease 15% from DY4 to 407 admissions per year.

**Rationale:**

Appropriate staffing is key to the success of any program design. The overarching goal of these waiver proposals is to shift utilization patterns away from expensive and often less effective public services and toward more cost effective community services. Understaffed programs also experience access issues, creating delays in services during which clients may decompensate further. The documented lack of credentialed staff in Region 20 makes workforce expansion a key component of these initiatives.

The three projects requested in Pass 1 of Region 20 are designed to support the goal of preventing hospital admissions. Specifically this refers to State Hospital, private psychiatric hospital and acute medical/surgical hospital admissions.

### **Outcome Measure Valuation**

The population included in this (1.11.2 or 2.15.1) project is the entire adult and child/adolescent client population of Border Region Behavioral Health Center in Region 20. The clinic has an active enrollment of approximately 1500 adult and 600 child/adolescent clients.

The Pass 1 infrastructure projects (1.11.2 and 1.14.1) both support the Program Innovation and Redesign project 2.15.2. The impetus of the infrastructure projects is to make more licensed personnel available in the region. Needed licensed personnel such as LPHAs, nurses and psychiatrists are historically underrepresented in this region. Telecommunication infrastructure will permit contracting services for behavioral health, and in the case of 2.15.1 project, medical services that cannot be hired or contracted locally.

Specific description of Adult population served:

- a) Adults who have severe and persistent mental illnesses such as schizophrenia, major depression, bipolar disorder, or other severely disabling mental disorders which require crisis resolution or ongoing and long-term support and treatment.
- b) Adult MH Target Population - Adults who have a diagnosis of schizophrenia, bipolar disorder, and severe major depression.
- c) Initial Eligibility:
  - (1) An individual age 18 or older that has a diagnosis of:
    - (a) schizophrenia as defined in the following Diagnostic and Statistical Manual, Fourth Edition
    - (b) bi-polar disorder as defined in the f DSM-IV TR
    - (c) major depression as defined in the f DSM-IV TR; with a Global Assessment of Functioning (GAF) of 50 or below at intake.
  - (2) An individual age 18 or older who has a diagnosis other than those listed in I.B.2.c.1. and whose current Global Assessment of Functioning (GAF) is 50 or less and needs on-going MH services; or
  - (3) An individual age 18 or older who was served in children's MH services and meets the children's MH priority population definition prior to turning 18 is considered eligible for one year.
- d) Individuals with only the following diagnoses are excluded from this provision:
  - (1) Substance Abuse as defined in the DSM-IV TR
  - (2) IDD as defined in the DSM-IV TR diagnostic codes.
  - (3) Pervasive Developmental Disorder as defined in the DSM-IV TR diagnostic codes.

Persons with mental conditions referred by primary care or other providers but not meeting the above criteria may be eligible for services funded under transformation waiver 1115 projects.

Specific description of Child/Adolescent population:

- a) Children/youth ages 3 through 17 with a diagnosis of mental illness (excluding a single diagnosis of substance abuse, IDD, autism or pervasive development disorder) who exhibit serious emotional, behavioral or mental health disorders and who:
  - (1) Have a serious functional impairment; or
  - (2) Are at risk of disruption of a preferred living or child care environment due to psychiatric symptoms; or
  - (3) Are enrolled in a school system's special education program because of serious emotional disturbance.
- b) Age Limitations:
  - (1) Children under the age of three who have a diagnosed physical or mental health condition are to be served through the Early Childhood Intervention (ECI) program; and
  - (2) Youth 17 years old and younger must be screened for CMH services. Youth 18 years or older must be screened for Adult Mental Health services; and
  - (3) Youth receiving Children's MH Services who are approaching their 18<sup>th</sup> birthday and continue to be in need of services shall either be transferred to Adult MH Services on his/her 18<sup>th</sup> birthday or referred to another community provider, dependent upon the individual's needs. Youth reaching 18 years of age who continue to need services may be transferred to Adult MH Services without meeting the adult priority population criteria and served for up to one additional year.
  - (4) For purposes of this contract definitions of "child" and "youth" are as follows:
    - (a) Child: An individual who is at least three years of age, but younger than 13 years of age.
    - (b) Youth: An individual who is at least 13 years of age, but younger than 18 years of age.

<i>Unique Cat 3 ID: 121989102.3.2</i>	<i>Ref Number from RHP PP: IT-2.4</i>	<i>Behavioral Health/Substance Abuse Admission Rate</i>	
<i>Performing Provider Name: Border Region Behavioral Health Center</i>			<i>TPI: 121989102</i>
<b>Related Category 1 or 2 Projects::</b>	<i>Unique Cat 1 ID: 121989102.1.2, 121989102.1.1, 121989102.2.1</i>		
<b>Starting Point/Baseline:</b>	<i>To be determined in DY 3</i>		
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>
<b>Process Milestone 1 [NA]:</b>  Process Milestone 1 Estimated Incentive Payment: \$0	<b>Process Milestone 2 [P-4]:</b> Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities  <b>Data Source:</b> Facility minutes, documented reports  Process Milestone 2 Estimated Incentive Payment: \$149,619	<b>Outcome Improvement Target 1 [IT-2.4]:</b> Behavioral Health/Substance Abuse (BH/SA) Admission Rate  Performing provider should report on both categories below: 1. One for BH/SA as the principal diagnosis; 2. A second category in which a significant BH/SA secondary diagnosis is present  <b>Improvement Target:</b> 10% decrease in admission rate from DY2  <b>Data Source:</b> Admissions data from CARE system, Anasazi Continuity of Care records  Outcome Improvement Target 1 Estimated Incentive Payment: \$160,057	<b>Outcome Improvement Target 2 [IT-2.4]:</b> Behavioral Health/Substance Abuse (BH/SA) Admission Rate  Performing provider should report on both categories below: 1. One for BH/SA as the principal diagnosis; 2. A second category in which a significant BH/SA secondary diagnosis is present  <b>Improvement Target:</b> 15% decrease in admission rate from DY4  <b>Data Source:</b> Admissions data from CARE system, Anasazi Continuity of Care records  Outcome Improvement Target 2 Estimated Incentive Payment: \$347,950
<b>Year 2 Estimated Outcome Amount:\$0</b>	<b>Year 3 Estimated Outcome Amount: \$149,619</b>	<b>Year 4 Estimated Outcome Amount \$160,057</b>	<b>Year 5 Estimated Outcome Amount \$347,950</b>
<b>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5): \$657,626</b>			

## **Project Summary:**

Unique Project Identifier: 121989102.1.3 (Pass 2)

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

Provider Description: Border Region Behavioral Health Center provides outpatient in four South Texas counties. Three counties - Webb, Jim Hogg & Zapata – are in Region 20 and one county– Starr – is in Region 5.

In Region 20 approximately 2,200 adult and child clients are enrolled at any given time.

Region 5 has a combined enrollment of approximately 500.

The overall payer mix is 63% Medicaid, 24% general revenue and 13% other.

Intervention(s): This project conducts a gap analysis of crisis services and designs a plan with the aim of implementing less intense alternatives to state hospitalizations or incarceration.

Need for the project (include data as appropriate): Current inpatient admission rates (over 500 per year) exceed budget allocations and the system must be analyzed to determine where changes can be made to prevent admissions. New ideas must be tried and evaluated for their effectiveness in preventing admissions.

Target population (number of patients the project will serve and how many Medicaid/Indigent will benefit from the project): The target population for this project are the patients in crisis, of which about 500 per year are currently being served by inpatient admission. Approximately 50% of these are Medicaid covered and 50% are indigent at time of admission.

Category 1 or 2 expected patient benefits: Patients in crisis receive crisis assessment and initial treatment at Border Region as opposed to the Emergency Department. Patients in crisis are afforded alternatives to inpatient hospitalization for treatment of their crisis episode. Patients will enjoy more days in their community setting, fewer family related expenses and less days lost from work.

Expected impact (total patients per year): DY2 - no impact, DY3- 437, DY4-492, DY5-547

Category 3 outcomes expected patient benefits: Reduced Emergency Department visits for the behavioral health/substance abuse population. Patients will not have to compete with other emergency room visitors to access services for their needs. Access to behavioral health services will be improved.

## **Identifying Project and Provider Information**

**Project Option:** 1.13.1 Develop and implement crisis stabilization services to address the identified gaps in the current community crisis system.

**Unique RHP ID#:** 121989102.1.3 (Pass 2)

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

## **Project Description**

**Brief Description:** Border Region Behavioral Health Center will define and address gap in the current crisis management system. . New intervention methodologies will be implemented as alternatives to ER utilization and state hospital inpatient admission. The gaps analysis will describe the current crisis management interventions and options available and compare them to evidence-based programs which are demonstrating effectiveness nationally.

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

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

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

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

- Minimize involvement of corrections systems in crisis management and prevention
- Reduce Corrections systems involvement by 10% by end of DY4.
- Provide alternatives to inpatient hospitalization at a cost no greater than 80% of hospitalization.
- Provide alternatives to ER utilization
- Decrease possibly preventable admission to State Hospitals
- Minimize use of hospital ER resources
- Develop new intervention systems as alternatives to hospitalization.

Better crisis management will promote the utilization of less expensive community treatment settings and facilitate continuity of care. After discharge from state institutions, many whose first contact with the system was inpatient treatment during crisis do not follow through with outpatient community services. By keeping the crisis management within the community, clients will gain familiarity with the system and be aware service offered.

This project incorporates resources from the other projects to make it effective and has the same over-arching goals of reducing potentially preventable admissions.

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

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

Frequency of crisis calls are increasing.

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

To address these challenges Border Region will:

- Initiate stakeholders meetings as part of the gap analysis to identify strategies productive community partnerships.
- Employ telemedicine technology to reduce the number of hospital admissions which could have been handled by other means
- Expand use of Mobil Crisis Intervention teams
- Partner with Starr Memorial Hospital to perform medical clearance at Border Region, Starr County crisis clinic.
- Increasing crisis frequency is being addressed in project 2.13.1 on crisis prevention.
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**Five-Year Expected Outcome for Provider and Patients:** It is expected that each service provider; criminal justice, education, hospitals and community behavioral health, understands its role in crisis management and implements proper procedures, which all their members will be trained in and apply them.

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

**Starting Point/Baseline:**

Currently, Border Region, Webb County clinic experiences over 500 crisis inpatient admissions per year. Hospital emergency rooms are the point of first contact between persons in crisis and Behavioral Health workers in most cases.

## **Rationale**

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

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

- a) Convene community stakeholders who can support the development of crisis stabilization to conduct gap analysis of the current system for mild exacerbations that could be treated in the community. This will be addressed through milestone P-1: Conduct stakeholders meeting among consumers, family members, law enforcement, medical staff and social workers from emergency departments and psychiatric hospitals, EMS and relevant community behavioral health services.
- b) Analyze current system of crisis stabilization including capacity of each service, utilization patterns, eligibility criteria and discharge criteria. Addressed in Milestone 2: gap analysis will be conducted to determine where needs do not align with assignment of resources, which needs were previously unidentified and suggest which new approaches may be the best suited alternatives to systems currently in place.
- c) Address behavioral health needs of patient currently receiving crisis services in jails, EDs & psychiatric hospitals. Determine types and volumes of services needed to resolve crisis in community setting. This is addressed in Milestone 2: through gap analysis. Data is being analyzed from encounters of the Jail Diversion program, Continuity of Care encounter (follow-along by Border Region while patient is enrolled) as well as functional status before and after inpatient hospitalization.
- d) Explore potential crisis alternative services models and determine acceptable models for implementation. This is addressed in Milestone 3: Develop and implement plans for needed crisis services. Literature review of evidenced-based practices will be discussed in Plan Do Study Act sessions to determine best fit for needs defined in the gap analysis.
- e) Review interventions impact on access to and quality of behavioral health opportunities to scale off or part of the intervention to a broader patient population. Identify key challenges associated with expansion of the interventions including special considerations for safety-net populations. This will be addressed with a combination of Milestone 4: development of an operations manual and QI activities from the corresponding category 3 project and Milestone 3: which will be reviewing procedures for relevance and effectiveness.

**Unique community need identification number the project addresses:**

This project relates to Community Need Number:  
(CN 2) Behavioral Health Services

Existing behavioral health services resources are insufficient to meet the current population needs and the projected population growth

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

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

OD-9 IT 9.2 Reduce Emergency Department visits for target condition (Behavioral Health/Substance Abuse)

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

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

**Relationship to other Projects**

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

- 1.11.2: Implement technology-assisted services. After hours or When licensed personnel are not available or after hours, Border Region will utilize the telemedicine hardware
- 1.14.1: Develop workforce enhancement initiatives. Staff resources, whether FTE or contract, made available through the workforce expansion project will be among the key resources providing the various components of crisis service delivery
- 2.15.1: Integrate primary and behavioral health services. Medical clearance in crisis triage may be performed with resources from the integration of primary/behavioral health project
- 2.13.1: Provide an intervention for a targeted behavioral health service. Persons in crisis evaluated as not needing inpatient care will be served through initiatives developed under this project, which will address crisis prevention and reduction on an outpatient basis.

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

This project is independent of other performing providers in the RHP.

### **Plan for Learning Collaborative**

We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system. The RHP 20 Anchor will sponsor two learning collaboratives per year

### **Project Valuation**

This project is valued based on avoidance of costs commonly associated with of forms of publicly financed interventions comply associated with the management of behavioral crises. These include:

Corrections- Jail Diversion is a key component of our proposed projects. According to the Treatment Advocacy Center, 40% of individuals with serious mental illnesses have been in jail or prison at some time in their lives

Emergency Rooms & Medical Surgical Hospital admission- According to the Hogg Foundation, 18.6% of admissions to medical hospitals are due to mental health conditions. Our data indicate that approximately 1.2 % of TTBH's service population is admitted to medical hospitals, and an estimated 17.4% of those served are kept out of the hospital. Texas Hospital Association sponsors Texas PricePoint as a resource for information on Texas hospitals. Our service population admitted into the hospital visits the emergency room before hospitalization occurs. Therefore, our projected numbers are a reflection of our hospital data with a cost of \$986 per visit

State psychiatric & private hospitals – Borer Region utilization of these resources typically is in excess of \$550 per day according to billing records. Utilization currently is in excess of DSHS allotted state operated bed day allotments and subsequently requires contracting with private hospitals.

Other sources of savings include Law Enforcement & Border Region manpower time and travel incurred with transportation to San Antonio State Hospital, lost time and wages from client's employment, More efficient operations of behavioral health enter due to a decrease in Management by Crisis. Improved overall client satisfaction due to other clients not having to wait while staff and doctors attend to crises.

<b>Unique Identifier:</b> 121989102.1.3 (Pass 2)	<b>RHP PP Reference:</b> 1.13.1	<b>Project Components:</b> 1.13.1(a-e)	<b>Develop and implement crisis stabilization services to address the identified gaps in the current community crisis system.</b>	
Performing Provider Name: Border Region Behavioral Health Center			TPI: 121989102	
<b>Related Category 3 Outcome Measure(s):</b>	121989102.3.4	IT-9.2	ED appropriate utilization (Standalone Measure) Reduce Emergency Department visits for target condition (Behavioral Health/Substance Abuse)	
<b>Year 2</b> (10/1/2012 – 9/30/2013)		<b>Year 3</b> (10/1/2013 – 9/30/2014)	<b>Year 4</b> (10/1/2014 – 9/30/2015)	<b>Year 5</b> (10/1/2015 – 9/30/2016)
<p><b>Milestone 1 [P-1]:</b> Conduct Stake holder meetings among consumers, family members, law enforcement, medical staff and social workers from EDs and psychiatric hospitals, EMS and relevant community behavioral health services</p> <p><u>Metric 1 [P-1.1]:</u> Number of meeting and participants</p> <p>Baseline: 0</p> <p>Goal: Stakeholder community is successfully invested and produces actionable input.</p> <p>Data Source: Documented input from stakeholders.</p> <p><b>Milestone 1</b> Estimated Incentive Payment (<i>maximum amount</i>) \$326,782</p> <p><b>Milestone 2 [P-2]:</b> Conduct mapping and gap analysis of current crisis system.</p> <p><u>Metric 1 [P-2.1]:</u> Produce a written analysis of current crisis system.</p>	<p><b>Milestone 3 [P-3]:</b> Develop implementation plans for needed crisis services</p> <p><u>Metric 1 [P-3.1]:</u> Produce a 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> <p>Data Source: Documented action plan for crisis stabilization alternatives.</p> <p>Baseline: TBA/Goal: Establish baseline for first operational years use.</p> <p>Milestone 3 Estimated Incentive Payment: \$313,433</p> <p><b>Milestone 4 [P-5]:</b> Develop administration of operation protocols and clinical guidelines for crisis services.</p> <p><u>Metric 1 [P-5.1]:</u> Completion of policies and procedures manual.</p>	<p><b>Milestone 6 [I-10]:</b> Criminal Justice Admission/readmissions</p> <p><u>Metric 1 [I-10.1]:</u> % decrease in preventable admissions &amp; readmissions into Criminal Justice system.</p> <p>Goal: Preventable incarcerations decrease 10% from DY3</p> <p>Data Source: Jail Diversion Encounter data, Criminal justice records</p> <p>Milestone 6 Estimated Incentive Payment: \$313,432</p> <p><b>Milestone 7 P-9</b> Participate in face-to-face learning (meetings, seminars), at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects</p> <p><b>Metric 1 P-9.1</b> Participate in semi-annual face-to-face meetings</p>	<p><b>Milestone 8 [I-11]:</b> Costs avoided by using lower cost alternative settings</p> <p><u>Metric 1 [I-11.1]:</u> Costs avoided by comparing utilization of lower costs alternative settings with higher cost settings such as ER, jail, hospitalization</p> <p>Goal: Costs avoided attributable to project are equal or greater than 20% of higher cost settings.</p> <p>Data Source: batched and analyzed survey data</p> <p>Milestone 8 Estimated Incentive Payment: \$ 278,607</p> <p><b>Milestone 9 P-9</b> Participate in face-to-face learning (meetings, seminars), at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects</p> <p><b>Metric 1 P-9.1</b> Participate in semi-annual face-to-face meetings or seminars organized by the RHP.</p>	

<b>Unique Identifier:</b> 121989102.1.3 (Pass 2)	<b>RHP PP Reference:</b> 1.13.1	<b>Project Components:</b> 1.13.1(a-e)	<b>Develop and implement crisis stabilization services to address the identified gaps in the current community crisis system.</b>	
Performing Provider Name: Border Region Behavioral Health Center			TPI: 121989102	
<b>Related Category 3 Outcome Measure(s):</b>	121989102.3.4	IT-9.2	ED appropriate utilization (Standalone Measure) Reduce Emergency Department visits for target condition (Behavioral Health/Substance Abuse)	
<b>Year 2</b> (10/1/2012 – 9/30/2013)	<b>Year 3</b> (10/1/2013 – 9/30/2014)	<b>Year 4</b> (10/1/2014 – 9/30/2015)	<b>Year 5</b> (10/1/2015 – 9/30/2016)	
<p>Baseline: No previous gap analysis.</p> <p>Goal: Establish baseline for first operational years use.</p> <p>Data Source: Gap analysis document</p> <p>Milestone 2 Estimated Incentive Payment: \$326,781</p>	<p>Data Source: Internal policy and procedures documents and operations manual.</p> <p>Baseline: Crisis policy manual exist for current procedures.</p> <p>Goal: Produce a faithful description of operations which can be used to help transport of scale successful programs to other aspects of the Border Regions’ crisis services.</p> <p>Milestone 4 Estimated Incentive Payments: \$313,432</p> <p><b>Milestone 5 [P-4]:</b> Hire and train staff to implement identified crisis stabilization services.</p> <p><u>Metric 1 [P-4.1:</u> Number of staff trained and hired</p> <p>Baseline: All current staff trained in crisis management. Training curricula for current programs in place.</p> <p>Goal: Trained staff are in position</p>	<p>or seminars organized by the RHP.</p> <p><b>Baseline:</b> Collaborative learning not previously practiced. <b>Goal:</b> Applicable Ideas for improvement are incorporated into management and clinical plans.</p> <p><b>Data source:</b> Documentation of face-to-face meetings or seminars organized by the RHP.</p> <p><b>Metric 2 P-9.2</b> Implement “raise the floor” improvement initiatives established at the semi-annual meeting.</p> <p><b>Baseline:</b> “Raise the floor initiatives not previously practiced. <b>Goal:</b> Applicable Ideas for improvement are incorporated into management and clinical plans.</p> <p><b>Data source:</b> Documentation of face-to-face meetings or seminars organized by the RHP.</p>	<p><b>Baseline:</b> Collaborative learning not previously practiced. <b>Goal:</b> Applicable Ideas for improvement are incorporated into management and clinical plans.</p> <p><b>Data source:</b> Documentation of face-to-face meetings or seminars organized by the RHP.</p> <p><b>Milestone 9</b> Estimated Incentive Payment: \$278,607</p>	

<b>Unique Identifier:</b> 121989102.1.3 (Pass 2)	<b>RHP PP Reference:</b> 1.13.1	<b>Project Components:</b> 1.13.1(a-e)	<b>Develop and implement crisis stabilization services to address the identified gaps in the current community crisis system.</b>	
<i>Performing Provider Name:</i> Border Region Behavioral Health Center			<i>TPI:</i> 121989102	
<b>Related Category 3 Outcome Measure(s):</b>	121989102.3.4	IT-9.2	ED appropriate utilization (Standalone Measure) Reduce Emergency Department visits for target condition (Behavioral Health/Substance Abuse)	
<b>Year 2</b> (10/1/2012 – 9/30/2013)	<b>Year 3</b> (10/1/2013 – 9/30/2014)	<b>Year 4</b> (10/1/2014 – 9/30/2015)	<b>Year 5</b> (10/1/2015 – 9/30/2016)	
	to implement crisis stabilization plan.  Data Source: Human resources records of personnel, training curricula  Milestone 5 Estimated Incentive Payment: \$313,433	<b>Milestone 7</b> Estimated Incentive Payment: \$313,433		
<b>Year 2 Estimated Milestone Bundle Amount: : \$653,563</b>	<b>Year 3 Estimated Milestone Bundle Amount: \$626,865</b>	<b>Year 4 Estimated Milestone Bundle Amount: \$626,865</b>	<b>Year 5 Estimated Milestone Bundle Amount: \$557,214</b>	
<b>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD</b> ( <i>add milestone bundle amounts over Years 2-5</i> ): <b>\$2,464,507</b>				

### **Title of Outcome Measure (Improvement Target)**

**Title:** IT-9.2 ED appropriate utilization

**Unique RHP ID#:** 121989102.3.4 (Pass 2)

**Performing Provider Name:** Border Region Behavioral Health Center

**TPI:** 121989102

### **Outcome Measure Description**

The Category 3 project chosen is IT 9.2 Reduce Emergency Department visits for target condition (Behavioral Health/Substance Abuse).

#### **Process Milestones:**

- DY2: P-1 Project Planning. Engage Stakeholders, identify capacity, needed resources, determine timelines and document implementation plans
- DY3: P-4 Plan Do Study Act cycles to improve data collection and intervention activities

#### **Outcome Improvement Target:**

- DY4: IT-9.2 Reduce Emergency Department visits for Behavioral Health / Substance Abuse
- DY5: IT-9.2 Reduce Emergency Department visits for Behavioral Health / Substance Abuse

### **Rationale**

The Emergency Department plays a central role in the current crisis treatment systems. Being the second public resource in the progression of crisis intervention activities; it usually means the police (the first public resource) have already been utilized. The third public resource (community mental health) is then utilized to determine if inpatient services are warranted and should be authorized. As an indicator of the effectiveness of outpatient programs to reduce crisis events, the use of the Emergency room visits and reduction in hospitalization is an important parameter of the effectiveness of outpatient interventions.

This Category 3 quality improvement project will provide additional input to conduct the ongoing evaluation of the gap analysis and result in an improvement plan from the corresponding Category 1 project 1.13.1: Develop and implement crisis stabilization services to address the identified gaps in the current community crisis system.

The process milestones directly service the Region 20 goal of nurturing a culture of ongoing quality improvement and innovation that maximizes the use of technology and best-practices to improve access and timely utilization of appropriate care, including behavioral health services, particularly in our rural communities.

### **Outcome Measure Valuation**

The population included in these projects is the entire adult and child/adolescent population of Border Region Behavioral Health Center clinic in Webb County. The clinic has an active enrollment of approximately 1,500 adult and 600 child/adolescent clients and the county has a population of 235,000. This allows both evaluation of new crisis planning for the enrolled population, plus permits the evaluation of non-enrolled persons as consumers of public resources in a behavioral crisis situation.

The cost for each Border Region intervention rendered at the emergency room represents the use of three public resources: law enforcement, medical (hospital outpatient/inpatient services) and mental health authority (Border Region). The cost attributed to each intervention by these entities can be reasonably determined so any reduction in emergency room use from the determined baseline also represents a savings for these entities. The resulting reduction in inpatient costs due to the reduction of emergency room usage can also be attributed to the interventions represented by these projects.

<i>Unique Cat 3 ID: 121989102.3.4</i>	<i>Ref Number from RHP PP: IT-9.2</i>	<i>Behavioral Health/Substance Abuse Admission Rate</i>	
<i>Performing Provider Name: Border Region Behavioral Health Center</i>		<i>TPI: 121989102</i>	
<b>Related Category 1 or 2 Projects: Starting Point/Baseline:</b>	<i>Unique Cat 1 ID: 121989102.1.3 &amp; 121989102.2.2</i>		
	<i>No GAP analysis of Crisis Services has been implemented. Webb County provides over 2,000 crisis interventions per year.</i>		
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>
<b>Process Milestone 1 [P-1]:</b> Project Planning – engage stakeholders, identify current capacity and needed resources, determine time lines and document implementation plans.  Data Source: Attendance rosters and summaries of meetings.  Process Milestone 1 Estimated Incentive Payment : \$34,398	<b>Process Milestone 2 [P-4]:</b> Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities  Data Source: Facility minutes, documented reports.  Process Milestone 2 Estimated Incentive Payment \$69,652	<b>Outcome Improvement Target 1 IT-9.2</b> Reduce Emergency Department visits for Behavioral Health / Substance Abuse  Improvement Target: 10% decrease in number of ED visits from DY2 baseline  Data Source: Admissions data from CARE system, Anasazi client record system encounter data  Outcome Improvement Target 1 Estimated Incentive Payment: \$69,652	<b>Outcome Improvement Target 2 IT-9.2</b> Reduce Emergency Department visits for Behavioral Health / Substance Abuse  Improvement Target: 30% decrease in admission rate from DY4  Data Source: Admissions data from CARE system, Anasazi client record system Encounter  Outcome Improvement Target 2 Estimated Incentive Payment: \$139,303
<b>Year 2 Estimated Outcome Amount: \$34,398</b>	<b>Year 3 Estimated Outcome Amount: \$69,652</b>	<b>Year 4 Estimated Outcome Amount: \$69,652</b>	<b>Year 5 Estimated Outcome Amount: \$139,303</b>
<b>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5): . \$313,005</b>			

**Project Summary:**

Unique Project Identifier: 137917402.1.1

Provider Name/TPI: City of Laredo Health Department (CLHD) TPI: 137917402

Provider Description: The CLHD along the Texas/Mexico Border serves Laredo/Webb County primarily for disease control, prevention and public health response to the over 35% of the population that is indigent and the 40% uninsured. Laredo is designated a health professions shortage area by Health Resources Services Administration (HRSA) and a Medically Underserved Area (MUA) by the Texas Department of State Health Services (DSHS). Through its four primary divisions the CLHD provides expert public health and prevention services in Environmental Health Services; Disease Control, Preparedness and Epidemiology; Patient Care and Prevention (women’s health, family planning, prenatal care, well child, dental care, chronic disease primary care, pharmacy) and Public Health Promotion.

Intervention(s): Category I – 1.1.2 Expand Existing Primary Care Capacity- will increase and/or enhance preventive primary health care by adding more clinic hours, space, and/or add/train staff to improve access for the uninsured, high risk and indigent patients. The additional primary preventive and early detection clinical care and screening services will improve access for more persons and reduce hospitalizations for preventable and unnecessary hospitalizations.

Need for the project (include data as appropriate): Category I - Access to early primary and preventive care is a problem as Laredo/Webb County and the entire Region 20 due to its HPSA, MUA status and its 40% of the population being uninsured (45% is on Medicaid or Medicare).

Target population: Category I–Patients currently being served by CLHD, all are either, Medicaid eligible, Title V patients or uninsured indigent persons and are being targeted with 150 new patients added for primary preventive care and early detection services each year.

Category 1 expected patient benefits: Baseline: 2,400; 150 new patients in 4 years, specifically:

- Expand clinic hours, space and train/hire additional staff to see more patients (allows for more patient visits: DY2-25; DY3-50; DY5-75; 150 new patients)
- Planning and evaluation for expansion and implementation of additional services
- Early detection in general care and for glucose levels reduces hospital admissions
- Services will address breast, cervical, and colon cancer detection, women’s health, maternal child health services, well child services, HIV/STD and high risk screening services.

Category 3 outcomes expected patient benefits: Category I-OD-2 Potentially Preventable Admissions: IT-2-7 Diabetes Short Term Complication Admission Rate– Enhanced capacity to improve access to preventive primary care will detect diabetes early and along with DSM will reduce diabetes short term complications admissions. As a new effort DSM and mental health will be integrated into preventive primary care (high-risk/vulnerable persons can reduce their risk, and prevent hospitalizations, reduce complications, and preventable hospitalizations.

## **Identifying Project and Provider Information**

**Project Option:** 1.1.2 Expand Existing Primary Care Capacity  
**Unique RHP ID#:** 137917402.1.1

**Performing Provider:** City of Laredo Health Department  
**Performing Provider TPI:** 137917402

## **Project Description**

**Brief Description:** Expand primary care (clinic) capacity services being provided by the City of Laredo Health Department (CLHD) with additional hours (night/weekend services), space and/or staff/staff training. These will serve as an extension and preliminary enlarged network for preventive care, early detection and screening services. These additional, new or decentralized services, in areas of need in the city and county, will improve access and will increase the clinic's ability to see more patients for preventive care. This new network will form the basis for a safety net system of early preventive care services with the regional partners; Laredo Medical Center, Doctors Hospital of Laredo, University of Texas Health Science Center San Antonio, Border Region Behavioral Health and others to assure person's access early detection and preventive care to Medicaid eligible, Title V, high risk and indigent patients. This new infrastructure for preventive, early detection clinical care and screening services is the basis for a potential hospital district. In particular, targeting diabetes prevention and care, hypertension prevention and care, cancer detection (breast, cervical and colon), HIV/STD prevention and care, women's health (prenatal, postpartum and interconception care), and family planning.

**Goal:** Project goals are

- Expand clinic hours, space and train/hire additional staff to see more patients (more clinic capacity will allow us to see more patients: DY3-25; DY4-50; DY5-75; 150 new patients)
- Planning and evaluation for expansion and implementation of additional services
- Reduce hospital admissions due to early detection for general care and for high glucose levels
- Services will address breast, cervical, and colon cancer detection, women's health, maternal child health services, well child services, HIV/STD and high risk screening services.

**Region 20 Goals:** The increase in new preventive health care clinic services to the current services being provided by the City of Laredo Health Department (CLHD) is appropriately matched with the Region 20 goals of prevention and wellness to reduce preventable hospitalizations. These will also serve to further build a hospital and public health network for preventive and early detection and screening services as a basis for a hospital district and safety net system. These expanded capacity and/or decentralized services and in new areas of need in the city and county will improve access and early detection to more high risk and indigent patients and will provide an added infrastructure of care in particular targeting diabetes prevention and care, hypertension prevention and care, cancer detection (breast, cervical and colon), HIV/STD prevention and care, women's health (prenatal, postpartum and interconception

care) and family planning. Finally it relates to the services by mental health to integrate into primary care.

**Challenges/Issues:** The need for adequate resources to care for the 40% of the population that is uninsured and the 45% on Medicaid or Medicare that also cannot access care due to a health professions shortage area and in addition some physicians do not accept patients on Medicaid.

**Five-Year Expected Outcome for Provider and Patients:** Develop a network of providers for extended preventive primary care, early detection and screening services for persons without access to care; Reduce unnecessary hospitalization and non-emergency visits to the hospital (addressing category 3) by providing additional preventive care and wellness services in clinics and Reduce costs to the hospital and promote healthier outcomes of persons without access to preventive care.

### **Starting Point/Baseline**

2,400 clients are currently being served by this intervention, with 100% of the health department providers participating in this intervention that yield over 5,000 encounters. This allows us to provide clinic services to 150new patients over the 4 year period.

### **Rationale**

None of our services being proposed are covered by any USHHS funds or projects. Yet because of the over 35% of the population being indigent and 40% are uninsured (Laredo is also a health professions shortage area); extending preventive care clinical services to more high risk and vulnerable populations is important. Services in preventive care, early detection, chronic disease prevention, women's health, family planning, STD/HIV services, and TB control services will be expanded/extended. This action will prevent persons from using and going to the hospital for preventable acute or complicated care, and improve emergency care services for true medical emergencies and not for preventive outpatient care. This action after an analysis for expansion to determine best practices for expanded times, space and/or for training/adding staff will also be measured by providing care for more patients;DY3-25; DY4-50; DY5-75; 150new patients). This effort also addresses Category 3 readmission and preventable hospitalizations. By, expanding preventive care capacity, adding new service hours to more patients and especially those that are high risk and/or n high risk areas and adding early detection and preventive care services, we can improve wellness and detect issues earlier to more patients. This will reduce acute urgent care issues and reduce the need to go to the hospital for unnecessary visits, reduce persons using the emergency room for preventable outpatient services and reduce non-emergency hospitalizations. For Laredo, where 60% of the population is medically indigent and wait until they need to see the doctor, they use the hospital as their medical home, visit the hospital acutely ill, or have complications needing more costly inpatient interventions.

### **Project Components**

As stated above, this project will address the three required components in Project Option 1.1.2, as detailed in the RHP Planning Protocol.

1.1.2 Expand existing primary care capacity

Required core project components:

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

**Unique Community Need Identification Numbers the Project Addresses:**

**CN.1 Capacity – Primary and Specialty Care** - The demand for primary and specialty care services exceeds that of available medical physicians in these areas and prevents adequate access to care and management or specialized treatment for prevalent health condition and preventative health conditions.

Increase access diabetic health care based on based on insurance coverage, and scarcity of coverage

**CQI:** CLHD will assess achievements and progress through our quality assurance program that includes peer review, medical provider review and assessment of proposed achievements, customer service and patient care response as well to monitor each metrics of all services. In particular we will assess that at least 90% of all performance measures are met.

**How the Project Represents a New Initiative or Significantly Enhances an Existing Delivery System Reform Initiative:** By integrating disease self-management (including mental health and case management) in primary care, preventive care and early detection services and enhancing community disease self-management we can improve health outcomes, further prevent disease, reduce risks and co-morbidities, improve healthier nutrition choices and increase physical activity. These actions along with increased preventive care stated in category I will reduce health care costs especially hospitalizations by improving early detection and preventive care. Moreover this adds value to the already proven disease self-management model as it integrates it into preventive primary care and it also adds mental health and case management to assure continuity and compliance of care and improve wellness and prevention.

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

**OD-2 Potentially Preventable Admissions:**

IT-2-7 Diabetes Short Term Complication Admission Rate reduction- 2.5% less hospitalizations in DY3, 3% reduction in hospitalizations in DY4 and 6% reduction in DY5. Success will be monitored through department data analysis of developed surveys (hospitalizations), patient feedback and overall wellness improvement rates as well through clinic encounters captured data.

**Reasons/Rationale for Selecting the Outcome Measures:** The need to expand access to care is critically needed in Laredo due to having an indigent population of 35%,40% is uninsured, is a designated health professions shortage area by the Health Resources Services Administration and a designated medically underserved area by the Texas Department of State Health Services. The new addition of clinics for preventive care clinical services to Medicaid eligible, Title V, high risk and vulnerable populations (preventive care, early detection, chronic disease prevention,

women's health, family planning, STD/HIV services, and TB control services) will improve wellness and early detection, specifically for the critical lack of health care access in Laredo. One of the specific focuses is chronic disease prevention and risk reduction in particular diabetes. Through more early detection and better access to preventive care services we can detect early diabetes and along with disease self-management reduce diabetes short term complications; as well detect other acute, chronic, and infectious disease in an outpatient early intervention. By further integrating disease self-management and mental health into preventive primary care services for high-risk and vulnerable populations, we can reduce risk, hospitalization for complications, and admissions for preventable diseases, as well readmission for hospitalized patients. Additional accessible primary preventive care and early detection clinics will greatly reduce unnecessary hospitalization and non-emergency visits. A follow-up tracking and educational service after hospital discharge will need to be created to further reduce potentially preventable, regular admissions, and readmission of patients. Through this transforming efforts Laredo can improve health.

### **Relationship to other Projects**

The City of Laredo Health Department is the only entity seeking to add primary care preventive care clinic services. This will enhance preventive care outpatient services rather than seeking hospital care that is not necessary as well reduce preventable hospitalizations. It will also link people to disease self- management services and mental health in both the health department and others in the RHP - ultimately achieving hospital project goals of reducing unnecessary hospitalizations.

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

The overall RHP effort is to enhance prevention and wellness; this project will coordinate and collaborate with the Mental Health Authority project that integrates mental health into primary care as well to refer patients with needed specialty care through telemedicine, both proposed by the MHA. This also relates to the University of Texas Health Science Center San Antonio project that will increase access to care using health navigators. Laredo Health Department, city and county officials through this effort will transform this region into a healthier one through better access to preventive and early detection primary care clinics into a healthier one. The collaborative efforts are not new to this region, but reinforce our actions to further learn from each other, work closer in building a network for primary preventive care, and also consider a hospital district.

Our Category 3 measures will also link the CLHD to the University of Texas Health Science Center San Antonio (UTHSCSA) and Mental Health Authority activities, in particular, to integrate disease self-management and mental health. This will further reduce unnecessary and preventable hospitalization by establishing a network of continuum of care with case management, thereby, further reducing preventable admissions and re-admissions.

### **Plan for Learning Collaborative**

The best practice developed by this region to address primary preventive care and early detection while integrating disease self-management and mental health as well using patient navigators will serve as a footprint for future improvement to health care access while being directly linked to reducing hospitalization and reinforces prevention and wellness as well will integrate social services case management and mental health. This is related to the intent of the regional plan as proposed by Hospital, Mental Health Authority, and the University of Texas Health Science Center San Antonio.

In addition, we plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 20, Webb County. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system. The RHP 20 Anchor will sponsor two learning collaborative per year

### **Project Valuation**

Valuation is based on clinical care needs assessed through our medical encounters, costs for expansion of space and hours, health care community needs assessment, costs of health care for expansion, costs for hiring/training clinicians and staff, care costs for high risk populations, adding services for early detection and preventive care, costs for diagnostic and laboratory services for clinics, costs for integrating psychosocial and mental health case management, consideration for community benefits (improving healthier outcomes and making healthier choices), adding allied health services such as nutrition, as well reducing hospitalizations and hospital care costs for unnecessary/preventable hospitalization . Lastly, the lack of local funding for these services is of primary consideration.

<b>Unique Identifier:</b> 137917402.1.1	<b>RHP PP Reference Number</b> 1.1.2	<b>Project component</b> 1.1.2	<b>Project title: Expand Primary Care Capacity</b>	
Performing Provider Name: City of Laredo Health Department			TPI - 137917402	
<b>Related Category 3 Outcome Measure(s):</b>	137917402.3.1	IT-2-7	Reduce Potentially Preventable Readmissions	
<b>Year 2</b> (10/1/2012 – 9/30/2013)	<b>Year 3</b> (10/1/2013 – 9/30/2014)	<b>Year 4</b> (10/1/2014 – 9/30/2015)	<b>Year 5</b> (10/1/2015 – 9/30/2016)	
<b>Milestone 1 [P-X]</b> Expansion analysis documentation  <b>Metric 1 [P-X.1]</b> Expansion analysis documentation for services/visits over prior periods due to expanded hours, space, training/staffing for patient visits  Baseline/Goal: Conduct need analysis for operations, services, patient visits Data Source: Needs analysis  Milestone 1 Estimated Incentive Payment ( <i>maximum amount</i> ): \$500,000	<b>Milestone 2 [I-12]</b> Increase of primary care clinic patient volume through improved access for patients needing services.  <u>Metric 1 [I-12.1]</u> Documentation of increase in patient volume (visits) demonstrating improvement over prior reporting period (through expanded hours, space, training/adding staff)  Baseline/Goal: Increase patients seen by 25 over baseline (2400)  Data Source: : Primary Care Clinic registry/encounters  Milestone 2 Estimated Incentive Payment: \$500,000	<b>Milestone 3 [I-12]</b> Increase of primary care clinic patient volume through improved access for patients needing services.  <u>Metric 1 [I-12.1]</u> Documentation of increase in patient volume (visits) demonstrating improvement over prior reporting period (through expanded hours, space, training/adding staff)  Baseline/Goal: Increase of 50 patients seen over baseline  Data Source: Primary Care Clinic registry/encounters  Milestone 2 Estimated Incentive Payment: \$500,000	<b>Milestone 4 [I-12]</b> Increase of primary care clinic patient volume through improved access for patients needing services.  <u>Metric 1 [I-12.1]</u> Documentation of increase in patient volume (visits) demonstrating improvement over prior reporting period (through expanded hours, space, training/adding staff)  Baseline/Goal: Increase of 75 patients seen over baseline  Data Source: Primary Care Clinic registry/encounters  Milestone 2 Estimated Incentive Payment: \$500,000	
Year 2 Estimated Milestone Bundle Amount: ( <i>add incentive payments amounts from each milestone</i> ): \$500,000	Year 3 Estimated Milestone Bundle Amount: <b>\$500,000</b>	Year 4 Estimated Milestone Bundle Amount: <b>\$500,000</b>	Year 5 Estimated Milestone Bundle Amount: <b>\$500,000</b>	
<b>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD</b> ( <i>add milestone bundle amounts over Years 2-5</i> ): <b>\$2,000,000</b>				

**Title of Outcome Measure (Improvement Target)**

**Title:** 1.1.2 Expand Existing Primary Care Capacity

**Performing Provider/TPI:** City of Laredo Health Department/137917402

**Unique RHP ID#:** 137917402.1.1

**Outcome Measure Description**

IT-2.7 Diabetes Short Term Complication Admission Rate

Provide additional chronic disease, cancer, women's health, family planning, and HIV/STD Preventive Care and Early Detection Clinics for underserved at-risk individuals. This will reduce diabetes short term complication admission rate by 2.5% in DY3, 3% in DY4 and 6% in DY5. With early detection, screening, and preventive care with integrated disease management we can reduce emergency and complicated hospitalizations, reduce preventable hospitalizations and promote healthier outcomes. In particular additional primary care preventive and early detection services will better manage and detect diabetes which will reduce short term diabetes complications admissions. Additional preventive care clinics will provide better diabetes management and reduce complications by being handled at outpatient care

**Process Milestones**

- DY2: Process Milestone  
P-1 Project Planning - develop improved access preventive care plan with tracking and verification of Diabetes Short Term Complication Admission Rates reduction  
Baseline: Documentation of diabetes short term complication admission rates of CLHD services to be determine in DY4 and 5  
Data Source: Health Clinic patient surveys, encounter data and hospital data
- DY3: Process Milestone:  
P-1 Develop and test (tracking) systems for improved patient access to determine number of persons admitted to hospitals for diabetes short term complications from the CLHD services  
Baseline: Documentation of diabetes short term complication admission rates baseline to be used for DY4 and DY5 improvement  
Data Source: Health Clinic patient surveys, encounter data and hospital data

**Outcome Improvement Targets for Each Year:**

- DY3: Outcome Improvement Target  
IT-2.7 Diabetes Short Term Complication Admission Rate reduction  
Data Source: Health Clinic patient surveys, encounter data and hospital data  
Metric: a. numerator - 2.5% reduction of CLHD non-maternal persons 18 years and older for DSTCA

b. Denominator: CLHD baseline of chronic disease clinic patients during previous year

- DY4: Outcome Improvement Target

IT-2.7 Diabetes Short Term Complication Admission Rate reduction

Data Source: Health Clinic patient surveys, encounter data and hospital data

Metric: a. numerator - 3% reduction of CLHD non-maternal persons 18 years and older for DSTCA

b. Denominator: CLHD baseline of chronic disease clinic patients during previous year

- DY5: Outcome Improvement Target

IT-2.7 Diabetes Short Term Complication Admission Rate reduction

Data Source: Health Clinic patient surveys, encounter data and hospital data

Metric: a. numerator - 6% reduction of CLHD non-maternal persons 18 years and older for DSTCA

b. Denominator: CLHD baseline of chronic disease clinic patients during previous year

## **Rationale**

None of our services being proposed are covered by any USHHS funds or projects. Yet because of the over 35% of the population being indigent and 40% are uninsured (Laredo is also a health professions shortage area); extending preventive care clinical services to high risk and vulnerable populations is important. Services in preventive care, early detection, chronic disease prevention, women's health, family planning, STD/HIV services, and TB control services will be extended. This action will prevent persons from using and going to the hospital for preventable acute or complicated care, and improve emergency care services. In DY2 an analysis will be conducted for the expanded capacity of patient visits and for the development of an assessment and tracking tool for diabetes short term complication admission (DSTCA). In DY3 patient visits will increase by 25 new patients and DSTCA rate reduction of 2.5% of the baseline for previous year. In DY4 increase patient visits by 50 patients and reduce by 3% the number of DSTCA. In DY5 increase patient visits by 75 and reduce by 6% DSTCA. This effort addresses also Category 3 readmission and preventable hospitalizations. By expanding preventive care, adding new clinics in high risk areas, and adding early detection and preventive care services, we can improve wellness and detect issues earlier. This will reduce acute urgent care issues and reduce the need to go to the hospital. This will also reduce unnecessary visits to the emergency room, and reduce non-emergency hospitalizations. For Laredo, where 60% of the population is medically indigent and wait until they need to see the doctor, they use the hospital as their medical home, visit the hospital acutely ill, or have complications needing more costly inpatient interventions.

## **Outcome Measure Valuation**

Valuation is based on clinical care needs, costs for expansion of space and hours, health care community needs assessment, costs of health care for expansion, costs for hiring/training

clinicians and staff, costs for hiring or training clinicians, care costs for high risk populations, adding services for early detection and preventive care, costs for diagnostic and laboratory services for clinics, costs for integrating psychosocial and mental health case management to assure reduction in diabetes complication admissions, costs for surveys and tracking systems to reduce diabetes complications admissions, consideration for community benefits (improving healthier outcomes, providing disease managed and making healthier choices), adding allied health services such as nutrition and accessing better mental health services, as well reducing hospitalizations and hospital care costs. Final factor considered is the lack of local funding for these services.

<i>Unique Cat 3 ID: 137917402.3.1</i>	<i>Ref Number from RHP PP: IT-2-7</i>	<i>Expand Primary Care Capacity</i>	
<i>Performing Provider Name: City of Laredo Health Department</i>			<i>TPI - 137917402</i>
<b>Related Category 1 or 2 Projects:</b>	Unique Category 1 identifier: 1379174021.1.1		
<b>Starting Point/Baseline:</b>	<i>Number of DSTCA</i>		
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>
<b>Process Milestone 1</b> [P-1]: Project Planning - Develop improved access preventive care plan with tracking and verification of Diabetes Short Term Complication Admission (DSTCA) Rates reduction  Data Source: Project Planning document  Process Milestone 1 Estimated <b>Incentive Payment: \$16,567</b>	<b>Process Milestone 2</b> [P-2]: Develop and test (tracking) systems for improved patient access to determine number of persons admitted to hospitals for diabetes short term complications from the CLHD services  Data Source: Project Planning document  Process Milestone 1 Estimated <b>Incentive Payment: \$37,700</b>  Outcome Improvement Target 1 Reduce DSTCA rates  Numerator- 2.5% reduction number of CLHD non-maternal persons 18 years and older for DSTCA Denominator: CLHD baseline of chronic disease clinic patients during previous year  <b>Estimated Incentive Payment: \$37,700</b>	<b>Outcome Improvement Target 1</b> IT-2.1Reduce Diabetes Short Term Complications Hospital Admission  Numerator:3% reduction number of CLHD non-maternal persons 18 years and older for DSTCA  Denominator: CLHD baseline of chronic disease clinic patients during previous year  Data Source: Documentation of CLHD patients with Diabetes and DSTCA rates  <b>Estimated Incentive Payment: \$75,400</b>	<b>Outcome Improvement Target 2</b> IT-2.1Reduce Diabetes Short Term Complications Hospital Admissions  Numerator: 6% reduction number of CLHD non-maternal persons 18 years and older for DSTCA  Denominator: CLHD baseline of chronic disease clinic patients during previous year  Data Source: Documentation of CLHD patients with Diabetes and DSTCA rates  <b>Estimated Incentive Payment: \$156,000</b>
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target): <b>\$16,576</b>	Year 3 Estimated Outcome Amount: <b>\$75,400</b>	Year 4 Estimated Outcome Amount: <b>\$75,400</b>	Year 5 Estimated Outcome Amount: <b>\$156,000</b>
<b>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD</b> (add outcome amounts over DYs 2-5): <b>\$323,376</b>			

## **Project Summary:**

Unique Project Identifier: 085114601.1.1

Provider Name/TPI: University of Texas Health Science Center – San Antonio/085114601

Provider Description: The University of Texas Health Science Center at San Antonio serves San Antonio and the 50,000 square-mile area of South Texas. It extends to campuses in the metropolitan border communities of Laredo and the Rio Grande Valley. More than 3,000 students a year train in an environment that involves more than 100 affiliated hospitals, clinics and health care facilities in South Texas.

Intervention(s): The goal of this proposal is to deliver epilepsy care to the underserved communities of Del Rio, Eagle Pass, and Laredo by providing an outreach clinic for patients with epilepsy. Epilepsy specialist physicians and support staff comprised of a case manager, social worker, and medical assistant will travel to these areas once every other month at the beginning of the project and increase the frequency of the services as needed in response to increasing need.

Need for the project (include data as appropriate): Epilepsy is a chronic medical condition that is best treated in an outpatient clinic setting by neurologists with specialized training in epilepsy. When people with epilepsy do not have access to specialty care, they generally seek care in the Emergency Department (ED). Care in the ED is not sufficient for long-term effective management of seizures. Repeated use of the ED for seizures results in poor medication compliance, repeated expensive diagnostic testing, and poor seizure management. By providing access to neurologists, patients with epilepsy will have improved seizure management which will reduce the need to visit the ED.

Target population (number of patients the project will serve and how many Medicaid/Indigent will benefit from the project): There are an estimated 8,555 patients with epilepsy in this region with estimated 2,567 (30 percent) patients without insurance. Of this amount, there are an estimated 1,027 patients with uncontrolled epilepsy who are uninsured.

Category 1 or 2 expected patient benefits: This project seeks to serve 150 unique patients in DY2 and increase the number of patients served by 30 percent above baseline in DY3, 60 percent above baseline in DY4, and 80 percent above baseline in DY5.

Category 3 outcomes expected patient benefits: IT-9.2 ED appropriate utilization.

The goal of this project is to reduce the ED visit rate for seizures by 50 percent over current rates for patients followed in these clinics by DY5.

## **Identifying Project and Provider Information**

**Project Option:** 1.9.2 Improve Access to Specialty Care (Outreach Epilepsy Clinic – Del Rio, Eagle Pass, Laredo)

**Unique RHP ID#:** 085144601.1.1

**Performing Provider/TPI:** University of Texas Health Science Center at San Antonio/085144601

## **Project Description**

**Brief Description:** The goal of this proposal is to develop a mechanism to deliver epilepsy care to underserved areas in South and West Texas. The main focus of the outreach program will be to provide expanded outpatient care to people with epilepsy, both insured and indigent, who are predominantly Latinos. We are already providing this service to patients in Harlingen, Texas in collaboration with the Epilepsy Foundation Central & South Texas (EFCST) (see baseline data below). We are proposing to expand this care to Del Rio, Eagle Pass, and Laredo which are areas with the greatest need. Our epilepsy specialists and EFCST staff will travel to these remote clinics one day every two months at the beginning of the project, and increase the frequency of services as the project proceeds, and in response to increasing need. The services would continue to be provided jointly with the EFCST. EFCST would also provide subsidies for medical therapies, access to medication assistance programs from Pharma, social services for employment, behavioral health services, disability applications, epilepsy education, and access to support groups. EFCST serves over 23,000 individuals in 79 Texas counties annually. The funding requested will support a nurse case manager, physician services, travel, and other support costs for the nurse case manager and physicians traveling to these underserved areas.

**Goal:** The specific objective is to develop outpatient epilepsy services for the underserved populations of Del Rio, Eagle Pass, and Laredo as an extension of what is already being done in Harlingen (see baseline data below). Epilepsy is a chronic medical condition that is best treated in an outpatient clinic setting by neurologists with specialized training in epilepsy. When people with epilepsy do not have access to specialty care, they generally seek care in the Emergency Department (ED). Care in the ED is not sufficient for long-term, effective management of seizures. By providing access to neurologists, patients with epilepsy will have improved seizure management thereby reducing the need to visit the ED.

In addition, the outreach clinics will provide community access to the services offered by the South Texas Comprehensive Epilepsy Center in San Antonio and the educational and social service resources of the EFCST.

This project seeks to provide 50 visits in each of the outreach clinic locations (150 visits total) in DY2 and increase the visits as follows:

- DY3: 30 percent above baseline (195 visits)
- DY4: 60 percent above baseline (240 visits)
- DY5: 80 percent above baseline (270 visits)

**Scope of the Problem:** There are 6.4 million uninsured people in Texas, with 172,800 diagnosed with epilepsy. The total population for the catchment areas is 427,744. Of this population, there are approximately 8,555 individuals with epilepsy with an estimated 30 percent (2,566) who are indigent.

The uninsured generally seek care through emergency room or primary care settings which are not adequately prepared to diagnose and treat epilepsy. There are direct (medical costs) and indirect (work-related) costs when patients do not receive the specialty care they need. Given the lack of access in these areas to epilepsy specialty care, even for those individuals who have some type of insurance, the opportunity to improve care for epilepsy patients in these areas is even greater. Information attached below provides details about the demographics of epilepsy service needs of the proposed service area.

**Challenges/Issues:** Delivery of any type of specialty care to an underinsured, immigrant population is a large challenge. Health care services and infrastructure are rudimentary in most of our targeted locations. For this proposal to succeed, outreach to local physicians, hospitals, schools, and social service providers, among others, will be crucial. Our project will provide access to patients. But, we must first raise community awareness of the service so patients will be able to benefit from it. Another challenge is the poverty in our targeted service areas. Many patients cannot afford necessary tests and medications to appropriately treat their epilepsy. By partnering with the EFCST, who has resources to help underwrite tests and assist patients in obtaining medications, we will dramatically improve outcomes by helping patients get access to the diagnostic services and treatments they need.

Even with access to medications though, medication compliance is still a big issue. A recent study found that 26% of patients with insurance were non-compliant with their epilepsy medications, leading to an increase in hospitalizations and emergency room visits. For the uninsured, the problem is even worse. Our plan to provide robust educational services – in English and Spanish – will help patients understand what to expect from their medications and why it is important to take them as directed. We anticipate that this will improve compliance, and decrease seizure frequency. As described above, 75% of medically refractory seizure patients may be helped by epilepsy surgery or other non-medical therapies. Currently, most epilepsy patients in these regions have no access to this type of treatment. By partnering with the South Texas Comprehensive Epilepsy Center at University Hospital in San Antonio, with financial help from the EFCST, these potentially life-changing treatments will now be an option for patients. By providing access to outpatient neurology services and educating patients on the importance of their treatment, patients will have increased medication compliance, improved seizure management, and a reduction in visits to the ED for seizures.

Less than 10 percent of patients seen in our Harlingen location have some type of medical insurance (predominantly Medicare) with over 90 percent of the patients being indigent or on Medicaid. We anticipate that the same payer mix will exist in Del Rio, Eagle Pass, and Laredo. Given the lack of neurology, let alone epilepsy specialty care, in the region, we anticipate that the insured and uninsured patients served will continue to be seen by our group in the future rather than make the long trip into San Antonio for care.

**Quality:** To achieve continuous quality improvement we shall assess the projects impact and make adjustments as necessary, share best practice and lessons learned, seize scaling opportunities to expand successful outcomes to broader populations, and rapidly disseminate successful outcomes to other providers across Texas.

**Region 20 Goals:** This project achieves CMS’s Triple aim objectives of assuring patients receive high quality and patient centered care, in the most cost effective way, improves the health care infrastructure to better serve the Medicaid and uninsured residents of the counties we serve, further develops and maintains a coordinated care delivery system, and improves outcomes while containing costs.

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

By year five, the expected outcomes are:

- Clinics occur every other month at each location —Del Rio, Eagle Pass, and Laredo.
- ED visits for patients seen in the clinics are reduced by 50 percent over baseline
- Patients have improved seizure control with medication therapy or epilepsy surgery for patients who do not respond to medication therapy.

**Starting Point/Baseline**

Outreach epilepsy services are currently provided to patients in Harlingen in collaboration with the Epilepsy Foundation Central & South Texas. The clinic, in operation for 10 years, occurs two days every other month, and provided 689 visits to 349 patients in FY11. To date, there have been a total of 92 patients from this out-reach clinic who have had epilepsy surgery at the South Texas Comprehensive Epilepsy Center at University Hospital. The baseline for this proposal is 50 clinic visits per location (150 visits total) in DY2. While current ED utilization rates are unknown for patients with epilepsy in the region, studies have shown that patients with uncontrolled epilepsy visit the ED up to five times more often than patients with controlled epilepsy.<sup>1</sup>

**Rationale**

Epilepsy is a chronic medical condition that is best managed in an outpatient clinic setting by neurologists with specialized training in epilepsy. Given that people living in this area do not have access to specialty care even if they have some type of health insurance, the opportunity to improve care of the patients with epilepsy is great. Many of these people use the emergency department frequently because of this lack of access. The total population for the catchment areas is 427,744. Of this population, there are approximately 8,555 individuals with epilepsy with an estimated 30 percent (2,566) who are indigent.

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<sup>1</sup> 1: Manjunath R, Paradis PE, Parisé H, Lafeuille MH, Bowers B, Duh MS, Lefebvre P, Faught E. Burden of uncontrolled epilepsy in patients requiring an emergency room visit or hospitalization. *Neurology*. 2012 Oct 30;79(18):1908-16. doi: 10.1212/WNL.0b013e318271f77e. Epub 2012 Oct 17. PubMed PMID: 23077014.

The overall expectation is to reduce ED utilization based on access to clinical expertise in epilepsy, and with it more effective medical management, and the availability of diagnostic testing and medical or surgical therapies. Epilepsy surgery and other non-medical treatments may benefit as much as 75 percent of patients with medically refractory epilepsy (patients who are not helped by appropriate antiepileptic therapy). Patients with frequent seizures are unable to drive, have difficulty holding jobs, and are risk for seizure-related sudden death.

**Project Components:** This project will address the following required components of Project Option 1.9.2, as detailed in the RHP Planning Protocol.as follows:

- a) Increase number of specialty clinic locations by adding clinics in Del Rio, Eagle Pass, and Laredo
- b) Implement transparent, standardized referrals across the system by using a standardized referral process and establishing one point of contact
- c) Conduct quality improvement for project using methods such as rapid cycle improvement as part of the South Texas Comprehensive Epilepsy Center quality review program

### **Increase Number of Specialty Clinics Locations**

Epilepsy outreach clinics will be conducted in Del Rio, Eagle Pass, and Laredo.

### **Implement Transparent, Standardized Referrals across the System**

Education and outreach about the services will be provided to community hospitals, local physicians' schools, and social service agencies. Referrals will be accepted from all of the above sources through a centralized call center following a standardized process.

### **Quality Improvements**

These outreach clinics will build upon the experience of the clinics that has been conducted in Harlingen for 10 years. Quality improvements will continue across all clinic locations with lessons learned in one location applied to other locations.

**Unique Community Need Identification Numbers the Project Addresses:** This project addresses community needs:

- (CN.1), Capacity – Primary and Specialty Care, as well as community need
- (CN.3), Chronic Disease and Disease Self-Management Initiatives.

### **How the Project Represents a New Initiative or Significantly Enhances an Existing Delivery System Reform Initiative:**

The establishment of Epilepsy Outpatient Clinics in Del Rio, Eagle Pass, and Laredo is an expansion of current outreach clinic activities in Harlingen.

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

OD-9 Right Care, Right Setting:  
IT-9.2ED Appropriate Utilization

The above outcome measure was selected to measure reduction in visits to the emergency department resulting from improved seizure medication compliance/seizure management.

### **Reasons/Rationale for Selecting the Outcome Measures:**

- **Data supporting why these outcomes are a priority for the RHP -**  
Epilepsy is a chronic medical condition that is best treated in an outpatient clinic setting by neurologists with specialized training in epilepsy (epileptologists). People with epilepsy who do not have access to specialty care generally seek care in an emergency room at an average cost of \$3,000 per visit. Care in the ED is not sufficient for long-term, effective management of seizures. Repeated use of the ED for seizures results in poor medication compliance and seizure management. The use of the ED as a substitute for outpatient clinic care imposes a tremendous burden on the healthcare system both in terms of cost, as expensive diagnostic tests are often repeated, and inappropriate utilization of resources.
- **Validated Evidence Based Rationale describing how the related category 1 or 2 project will help achieve category 3 outcome measures:**

By providing patients with access to epileptologists, patients will have improved seizure management. One consequence of poor seizure control is frequent use of the ED for seizure care. Studies have shown that patients with uncontrolled epilepsy visit the ED up to five times more often than patients with well-controlled epilepsy.<sup>1</sup>

### **Relationship to other Projects**

N/A

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

NA – no similar/related projected.

### **Plan for Learning Collaborative**

The South Texas Comprehensive Epilepsy Center based at University Health System in San Antonio consists of a multidisciplinary group of physicians and staff. This group meets weekly to review cases, exchange ideas, and discuss best practices/approaches to patient management. Services provided under this proposal will be included in these weekly discussions.

In addition, we plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 20, Webb County. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our

Region’s healthcare system. The RHP 20 Anchor will sponsor two learning collaboratives per year.

**Project Valuation**

People with epilepsy who do not have access to specialty care generally seek care in an emergency room, at an average cost of \$3,000 per visit or approximately \$9,939 per year on average. In addition, lost productivity in terms of work-related earnings for people with uncontrolled epilepsy amount to \$8,953 per year per household. With seizure control due to appropriate treatment, approximately 60% of patients could return to work. The cost savings realized by this proposal detailed below is conservative, as it primarily accounts for benefits to those who are uninsured. The table below provides the data used to estimate the conservative value of this proposal in terms of cost savings.

**Cost Savings of This Proposal:**

<b>Number of uninsured with uncontrolled epilepsy to be treated</b>	<b>Direct Cost of uncontrolled epilepsy in uninsured (\$9,939/person/year)</b>	<b>Indirect of uncontrolled epilepsy in uninsured (\$8,953/household/year)</b>	<b>Total Costs of uncontrolled epilepsy in uninsured (potential cost savings)</b>
135	\$1,341,765	\$1,208,655	\$2,550,420

<b>Unique Identifier:</b> 085144601.1.1	<b>RHP PP REFERENCE</b> NUMBER 1.9.2	<b>PROJECT COMPONENT</b> 1.9.2 (A-D)	<b>PROJECT TITLE: IMPROVE ACCESS TO SPECIALTY CARE (EPILEPSY OUTREACH SERVICES – DEL RIO, EAGLE PASS, LAREDO)</b>	
Performing Provider Name: University Of Texas Health Science Center At San Antonio			TPI - 085144601	
<b>Related Category 3 Outcome Measure(s):</b>	085144601.3.1	IT-9.2	ED APPROPRIATE UTILIZATION	
<b>Year 2</b> <b>(10/1/2012 – 9/30/2013)</b>	<b>Year 3</b> <b>(10/1/2013 – 9/30/2014)</b>	<b>Year 4</b> <b>(10/1/2014 – 9/30/2015)</b>	<b>Year 5</b> <b>(10/1/2015 – 9/30/2016)</b>	
<p><b>Milestone 1</b> [P-1]: Conduct specialty gap assessment based on community need</p> <p><u>Metric 1</u> [P-1.1] Documentation of gap assessment</p> <p>Baseline/Goal: Conduct gap assessment Data Source: Needs assessment</p> <p>Milestone 1 Estimated Incentive Payment (<i>maximum amount</i>): \$238,608</p> <p><b>Milestone 2</b> [I-22] Increase the number of specialist providers, clinic hours and/or procedure hours available for the high impact/most impacted medical specialties</p> <p><u>Metric 1</u> [I-22.1] Increase number of specialist providers, clinic hours and/or procedure hours in targeted specialties.</p> <p>Baseline/Goal: Number of specialist providers and qualified support staff over baseline</p> <p>Data Source: HR documents</p>	<p><b>Milestone 4</b> [I-23]: Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services</p> <p><u>Metric 1</u> [I-23.2]. Documentation of increased number of unique patients</p> <p>Goal: Increase visits provided to 30 percent above baseline in year 2 (195 visits)</p> <p>Metric: Clinic Visits</p> <p>Data Source: Epic</p> <p>Milestone 4 Estimated Incentive Payment: \$678,150</p>	<p><b>Milestone 5</b> [I-23]: Increase specialty care clinic volume of visits and evidence of improved access for patients seeking services</p> <p><u>Metric 1</u> [I-23.2]. Documentation of increased number of unique patients</p> <p>Goal: Increase visits provided to 60 percent above baseline in year 2 (240 visits)</p> <p>Metric: Clinic Visits</p> <p>Data Source: Epic</p> <p>Milestone 5 Estimated Incentive Payment: \$678,150</p>	<p><b>Milestone 6</b> [I-23]: Increase specialty care clinic volume of visits and evidence of improved access for patients seeking service</p> <p><u>Metric 1</u> [I-23.2]. Documentation of increased number of unique patients</p> <p>Goal: Increase visits provided to 80 percent above baseline in year 2 (270 visits)</p> <p>Metric: Clinic Visits</p> <p>Data Source: Epic</p> <p>Milestone 6 Estimated Incentive Payment: \$602,800</p>	

<p>Milestone 2 Estimated Incentive Payment (<i>maximum amount</i>): \$238,608</p> <p><b>Milestone 3</b> [P-11]: Launch/expand a specialty care clinic</p> <p><u>Metric 1</u> [P-11.1] Establish/expand specialty care clinics</p> <p>Baseline/Goal: Establish clinic, provide 150 clinic visits</p> <p>Milestone 3 Estimated Incentive Payment (<i>maximum amount</i>): \$238,608</p>			
<p><b>Year 2 Estimated Milestone Bundle Amount: \$715,825</b></p>	<p><b>Year 3 Estimated Milestone Bundle Amount: \$678,150</b></p>	<p><b>Year 4 Estimated Milestone Bundle Amount: \$678,150</b></p>	<p><b>Year 5 Estimated Milestone Bundle Amount: \$602,800</b></p>
<p><b>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD</b> (<i>add milestone bundle amounts over Years 2-5</i>): <b>\$2,674,925</b></p>			

## **Title of Outcome Measure (Improvement Target)**

**Title:** IT-9.2 ED Appropriate Utilization

**Performing Provider/TPI:** University of Texas Health Science Center at San Antonio/085144601

**Unique RHP ID#:** 085144601.3.1

## **Outcome Measure Description**

OD-9 Right Care, Right Setting

IT-9.2 ED Appropriate Utilization (Reduce ED visits related to uncontrolled epilepsy)

### **Process Milestones:**

- DY2  
P-1 Project Planning
- DY3  
P-2 Establish Baseline Rates

### **Outcome Improvement Targets for Each Year:**

- DY4:  
[IT-9.2] ED appropriate utilization  
25 percent reduction in ED visits over baseline
- DY5:  
[IT-9.2] ED appropriate utilization  
50 percent reduction in ED visits over baseline

## **Rationale**

Epilepsy is a chronic medical condition that is best treated in an outpatient clinic setting. Optimal control of seizures is achieved through consistent outpatient management. Poor seizure control results in frequent use of the Emergency Department (ED) for seizure care. Uncontrolled epilepsy in patients requiring ED visits is associated with significantly greater health care resource utilization and increased direct and indirect costs compared to patients with well-controlled epilepsy.

Through the outpatient epilepsy clinics, patients will have the opportunity to manage their epilepsy in a cost-effective manner and reduce the need to visit the ED.

## **Outcome Measure Valuation**

People with epilepsy who do not have access to specialty care generally seek care in an emergency room, at an average cost of \$3,000 per visit. Difficulty in accessing needed medications will lead to noncompliance at a cost of about \$5,000 per person. For those uninsured and without some type of assistance, epilepsy medications can't be accessed through Pharma assistance programs (\$1,338,525 in such assistance was facilitated by the EFCST in FY 2010 alone) and lost productivity in terms of work-related earnings for people with uncontrolled

epilepsy amount to \$8,953 per year per household. With seizure control due to appropriate treatment, approximately 60% of could return to work. The cost savings realized by this proposal detailed below is conservative, as it primarily accounts for benefits to those who are uninsured. As mentioned above, approximately 37% have some type of insurance and will be benefitted as well. The project is valued based upon achieving waiver goals, meeting community needs, scope, and investment.

<i>Unique Cat 3 ID: 085144601.3.1</i>	<i>Ref Number from RHP PP: IT-9.2</i>	<i>ED Appropriate Utilization</i>	
<i>Performing Provider Name: University of Texas Health Science Center at San Antonio</i>			<i>TPI - 085144601</i>
<b>Related Category 1 or 2 Projects::</b>	<i>Unique Category 1 identifier - 085144601.1.1</i>		
<b>Starting Point/Baseline:</b>	<i>To be developed in DY3</i>		
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>
<b>Process Milestone 1</b> [P-1] Project planning-Develop plan for identifying and capturing encounter information in order to develop ED baseline in DY 3  Data Source: Project planning document  Process Milestone 1 Estimated Incentive Payment ( <i>maximum amount</i> ): \$37,675	<b>Process Milestone 2</b> [P-2] Establish baseline rates for ED visits  Data Source: Patient encounter information  Outcome Improvement Target 1 Estimated Incentive Payment: \$75,350	<b>Outcome Improvement Target 1</b> [IT-9.2] ED appropriate utilization  Improvement Target: Reduce ED visits for epilepsy/seizure by 25% over baseline  Data Source: Patient Survey/ED records  Outcome Improvement Target 1 Estimated Incentive Payment: \$75,350	<b>Outcome Improvement Target 2</b> [IT-9.2] ED appropriate utilization  Improvement Target: Reduce ED visits for epilepsy/seizure by 50 % over baseline  Data Source: Patient Survey/ED records  Outcome Improvement Target 2 Estimated Incentive Payment: \$150,700
<b>Year 2 Estimated Outcome Amount: : \$37,675</b>	<b>Year 3 Estimated Outcome Amount: \$75,350</b>	<b>Year 4 Estimated Outcome Amount: \$75,350</b>	<b>Year 5 Estimated Outcome Amount: \$150,700</b>
<b>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5): \$339,075</b>			

## **Project Summary:**

Unique Project Identifier: 121990904.1.1 (**Pass 2**)

Provider Name/TPI: Camino Real Community Services/121990904

Provider Description: Camino Real Community Services is a Local Mental Health Authority that provides outpatient mental health services to child, adolescent, and adult patients with severe and persistent mental illness. The provider is located in a 10,000 square mile rural service area with a total population of approximately 206,777. In 2012, the Center provided services to 3,538 adults and children that met criteria for services. The Mental Health Operating budget is approximately 6.9 million dollars. The programs work closely with schools, health centers, hospitals, law enforcement, judiciary and local elected officials to coordinate the provision of services.

Intervention(s): The project is to establish Crisis Stabilization Services in the service area. More specifically, it is the Center's intent to provide a minimum of a 10 bed Crisis Residential Facility.

Need for the project (include data as appropriate): Camino Real Community Services' area is challenged by its extremely rural nature where there is limited access to community based options that provide readily accessible crisis intervention services. The designation as a historically health care professional shortage area and mental health professional shortage area reflects the great challenge this area has with accessibility to needed services. There are no local psychiatric hospitals or crisis stabilization facilities in the service area. The center provided 262 crisis assessments (December 2011 – August 2012) to individuals. Of the 262 patients seen in crisis approximately 59 patients were sent to inpatient psychiatric hospitals during this time frame.

Target population (number of patients the project will serve and how many Medicaid/Indigent will benefit from the project): The target population is individuals of all ages experiencing a psychiatric crisis and requiring crisis stabilization services. In Maverick County 25% of the population is living below poverty, 35 % are without medical insurance and 55% are Medicaid eligible. It is anticipated that once a crisis facility is fully operational, it will serve 100 persons per 12 month period. This assumes an average stay of 30 days per patient. Based on historical hospital admissions of 100 patients, it is projected 60% will be Medicaid and 40% indigent. There are no federal initiatives addressed/ expanded with these funds.

Category 1 or 2 expected patient benefits: The project intends to benefit patients by providing crisis stabilization services including psychiatric intervention, 24 hour active treatment by mental health professionals and rehabilitation and education services that enhance patient skills. It is the performing provider's expectation that this model will improve access to the appropriate level of care for patients. The other benefits include decreasing travel for patients needing crisis stabilization services.

Category 3 outcomes expected patient benefits: OD-9, IT9.4 Decrease Behavioral Health or Substance Abuse admissions and readmissions to institutional facilities including local emergency departments and psychiatric facilities. Patients will benefit from immediate access to crisis service options in lieu of ED usage for related behavioral health or substance abuse issues.

## **Identifying Project and Provider Information**

**Project Option: 1.13.1 Development** of behavioral health crisis stabilization as alternatives to hospitalization. Develop and implement crisis stabilization services to address the identified gaps in the current community crisis system

**Unique RHP ID#:** 121990904.1.1 (Pass 2)

**Performing Provider/TPI:** Camino Real Community Services/121990904

## **Project Description**

The project proposed by Camino Real is to develop local crisis stabilization services for persons in psychiatric crisis. This program will be designed and staffed to provide acute psychiatric intervention comparable to that received at remote psychiatric inpatient hospitals. This community based alternative will have a dramatic impact on frequency, duration and cost associated with usage of local hospital Emergency Rooms.

Local crisis stabilization services will assure that the right care is being provided in the right setting (OD-9). There should be a corresponding decrease of mental health admissions and re-admissions of persons needing crisis stabilization services to institutional facilities.

The target goal is to decrease use of higher cost services in Emergency Rooms and/or Inpatient Facilities. Additional goals would be to decrease travel for patients needing crisis stabilization services. Inherent to the program design will be the provision of responsive psychiatric intervention, active treatment by mental health professionals and rehabilitation and education services that enhance consumer skills as they return to their homes.

By the end of the 5 year period and the establishment of crisis stabilization services, consumers in need, will be able to receive these services in their community. On average, drive times to services will be non-existent or would be no more than one hour. Response times to consumers will be significantly reduced ending long wait times in emergency rooms and/or long transport times to State Hospitals and other facilities. The efficacy of treatment will be significantly improved and overall costs to the total care system (not just hospitals) would be significantly reduced.

When a consumer lacks appropriate behavioral health crisis resolution mechanisms, first responders are often limited in their options to resolve the situation. Sometimes the choice comes down to the ER, jail, or an inpatient hospital bed. Unfortunately, a worst case scenario occurs when even these undesirable options fail, and the consumer is left to the care of family/friends until transportation and availability of an in-patient placement can be arranged. It leaves the person in crisis and the family at great risk and feeling frustrated with the system they turn to for help.

Crisis stabilization services can be developed that create alternatives to these less desirable settings. Building on existing systems, communities can develop crisis alternatives such as sobering units, crisis residential settings and crisis respite programs with varying degrees of clinical services based on the needs of clients. While hospitalization provides a high degree of

safety for the person in crisis, it is very expensive and is often more than what is needed to address the crisis. Community-based crisis alternatives can effectively reduce expensive and undesirable outcomes, such as preventable inpatient stays. For example, state psychiatric hospital recidivism trended downward coincident with implementation of crisis outpatient services in some Texas communities. The percent of persons readmitted to a Texas state psychiatric hospital within 30 days decreased from 8.0% in SFY2008 (before implementation of alternatives) to 6.9% in SFY2011.<sup>1</sup>

The Camino Real Community Services area is vastly rural and has been designated as a Medically Underserved Area, Health Professional Shortage Area and Mental Health Shortage Area by the US Department of Health and Human Services Health Resources and Services Administration division. There are many challenges that accompany these designations. For instance, in the 10,000 square miles that comprises the Camino Real service area, none of the local hospitals have a psychiatric unit to address the needs of the community. The lack of resources in the local community requires extensive travel into San Antonio for access to a private or public psychiatric facility in order to stabilize the person in crisis. Typically, local law enforcement provides transportation to these distant locations. The cost to the community is not only in the man hours and mileage costs associated with the transport, but the risk to the community when the peace officer is diverted from the responsibility of protecting the community to provide the needed transportation. The emotional cost to the person in crisis and their family/friends who wait for hours for logistics to be worked out in order to finally get to the help they need is immeasurable.

The project responds to needs as compiled in the RHP 20 Needs Assessment particularly **CN 2: Behavioral Health Services** – Existing behavioral health services resources are insufficient to meet the current population needs and the projected population growth.

### **Starting Point/Baseline**

No local 24 hour crisis stabilization services are available to community members who are in psychiatric crisis; persons either stay in hospital emergency rooms or are transported long distances to more restrictive inpatient service environments. In DY2 & DY3, assessment of needs, plan development and hiring of staff will occur. In DY4 and DY5 the project will provide services to 100 consumers each year.

The Category 3 outcome measure baseline will be determined in years DY4 and DY 5 when program is implemented.

### **Rationale**

Camino Real has selected Project **Option #1.13.1**, Development of Behavioral Health Crisis Stabilization Services as alternative to hospitalization, with all the required core components.

These are as follows:

- a) Camino Real will convene community stakeholders who can support the development of crisis stabilization services to conduct a gap analysis of the current community crisis system and develop a specific action plan that identifies specific crisis stabilization services to address identified gaps.
- b) Camino Real will collect the result of the gap analysis and 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) Camino Real will assess the behavioral health needs of patients currently receiving crisis services in the jails, EDs, or psychiatric hospitals to 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.
- d) Camino Real will engage stakeholders to explore potential crisis alternative service models and determine acceptable and feasible models for implementation.
- e) Camino Real will 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

This selection is based on the fact that there are no local crisis stabilization services to persons in psychiatric crisis in the Camino Real service area. The population has a significant need as evidenced by the number of calls made to the local crisis hotline and the requests made for crisis assessment at local hospitals. It is responsive to Community Need #2 (CN2).

In 2008, Mental Health or Substance Abuse disorders were the principal reason for 1.8 million inpatient community hospital stays, accounting for 4.5 percent of stays in the U.S. This is according to Brief #117 (Agency for Healthcare Research and Quality, June 2011). It was also noted the MH and SA conditions most frequently treated in community hospitals were mood disorders (depression and bipolar disorder), schizophrenia and other psychotic disorders, alcohol-related disorders and drug-related disorders. These MHSA hospital stays cost \$9.7 billion (\$7.7 billion for MH; \$2.1 billion for SA) accounting for 2.7 percent of all inpatient community hospital costs. Nationwide, the MH average length of stay was 8.0 days and the SA average length of stay was 4.8 days with an average cost \$5100. In another publication (Kaiser Family Foundation, 2010) the prevalence of many serious health conditions such as cognitive or mental impairments, depression, and diabetes is significantly higher for dual eligible individuals. They are also some of the sickest and poorest individuals covered by either Medicare or Medicaid. Approximately 31% of the individuals served by the Performing Provider are dual eligible (Medicaid & Medicare).

This is a new initiative for the Performing Provider since there are no local crisis stabilization services available to persons in psychiatric crisis as an alternative in the local communities. Based on data reviewed from the provider's local database the local population has a significant need as evidenced by the number of calls made to the provider's crisis hotline and requests for crisis assessments by local hospitals. This results in a significant financial impact on local resources including law enforcement, judicial system and hospital emergency rooms. In addition, availability of inpatient psychiatric hospital beds in public and private facilities has been significantly reduced due to the demands of the forensic population. In Fiscal Year 2012 the center crisis hotline received 3016 calls with over 1000 of these requiring crisis assessments that resulted in 28% needing stabilization at higher cost inpatient facilities. The community needs cost effective local option for residents in crisis. In Texas the average cost of an Emergency Room visit is approximately \$996 and an average stay at a state funded mental health facility is \$400/day according to the 2011 report by Health Management Associate on "The Impact of Proposed Budget Cuts to Community Based Mental Health Services". Furthermore the report supports the model of community based services as a better option for treating persons with mental illness in a more cost-effective local environment. In the Texas Fact Sheet-2011 Psychiatric Hospitals there were a total of 5391 psychiatric beds in the state with 49.3% of the beds being public beds, 14.4% were nonprofit beds, and 36.3% were for-profit beds. Two hundred and twelve counties in Texas do not have a psychiatric hospital and most hospitals are located in metropolitan areas. The Performing Providers Service area reported earlier has no psychiatric hospital available; therefore, individuals in crisis do not have access to a local option with regards to alternative crisis stabilization services.

#### **Citations:**

Dual Eligibles: Medicaid Enrollment and Spending for Medicare Beneficiaries in 2007.

<http://www.kff.org> (December 2010)

Directory of Active Hospitals, 2011, Health Facility Licensing and Compliance Division, Texas Department of State Health Services; Hospital Tracking Database, Hospital Survey Unit, Center for Health Statistics, Texas Department of State Health Services.

Stranges, E. (Thomson Reuters), Levit, K. (Thomson Reuters), Stocks, C. (Agency for Healthcare Research and Quality) and Santora, P. (Substance Abuse and Mental Health Services Administration). *State Variation in Inpatient Hospitalizations for Mental Health and Substance Abuse Conditions, 2002-2008*.

HCUP Statistical Brief #117. June 2011. Agency for Healthcare Research and Quality, Rockville, MD. <http://www.hcup-us.ahrq.gov/reports/statbriefs/sb117.pdf>

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

The Category 3 Outcome measure selected for the Camino Real Community Services Development of Behavioral Health Crisis Stabilization Services as alternatives to Hospitalization Project is OD-9, Right Care Right Setting. The improvement Target is IT-9.4 "Decrease Mental Health Admissions and Re-Admissions of persons needing crisis stabilization services to institutional facilities".

The reason for selecting this measure is that it captures the impact of having a local, cost effective alternative to higher costs systems such as jail, emergency room, or inpatient

hospitalization when addressing crisis situations that can be quickly resolved. The project will track the number of admissions to the crisis facility and compare to historical data kept by the Center regarding the number of admissions to public and private in-patient psychiatric institutions to calculate cost avoidance. As the community becomes familiar with the crisis stabilization unit and diverts persons in psychiatric crisis from the jails and Emergency Room, crisis stabilization admission data will be tracked and calculation of cost avoidance to the ER and jails will be maintained to substantiate the cost effectiveness of this alternative.

Health Management Associates, in their March 2011 *Impact of Proposed Budget Cuts to Community-Based Mental Health Services* presented to the Texas Conference of Urban Counties, reported the average per day cost of community based services is \$12 for adults and \$13 for children, as compared to \$401 for a State Hospital bed, \$137 for a jail bed for an inmate with mental illness, and \$986 for an emergency room visit. Camino Real anticipates that development of a crisis stabilization unit in the local community will also reduce costs to other stakeholders involved in the crisis response system which includes the local sheriff's department and the judicial system.

### **Relationship to other Projects**

Camino Real is proposing one project in Region 20 with the unique RHP # of (121990904)2.1. It is category 2.15 Integrate Primary and Behavioral Health Care Services with an accompanying Category 3, OD 6 Improvement Target of (IT-6.1) Patient Satisfaction.

It relates to other projects in the region by addressing the need for increasing access to comprehensive integrated primary care and behavioral health care services. Better health care outcomes for individuals with co-morbid chronic illness and mental illness, will translate into decreased health care costs by reducing use of high cost institutional care systems.

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

By establishing crisis stabilization services as a local option, Camino Real Community Services supports the effort to have better outcomes for persons with mental illness in the service area in line with RHP Regional Goals:

- Triple Aim: assuring patients' receive high quality and patient centered care, in the most cost effective ways.
- Improve the health care infrastructure to better serve the Medicaid and uninsured residents of our counties.
- Further develop and maintain a coordinated care delivery system
- Improve outcomes while containing cost growth

### **Plan for Learning Collaborative**

We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 20. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system.

## **Project Valuation**

Project valuation takes into consideration:

- 1) Costs for both State operated Psychiatric Hospitals
- 2) Cost of private Psychiatric Hospitals
- 3) Local Emergency Room and Hospital costs
- 4) Cost of local Judicial systems
- 5) Cost of local City and County law enforcement systems both in their intervention activity as well as the provision of transportation for consumers needing treatment.

Significant value will be given to a program that can provide services much more responsive to consumer needs with significantly reduced time frames and efficient use of limited resources!

<b>UNIQUE IDENTIFIER:</b> 121990904.1.1	<b>RHP PP Reference Number:</b> 1.13.1	<b>PROJECT COMPONENT</b> 1.13.1.(A-E)	<b>Project Title:</b> 1.13 Development of Behavioral Health Crisis Stabilization Services as alternatives to hospitalization		
Performing Provider Name: Camino Real Community Services			TPI: 121990904		
<b>Related Category 3 Outcome Measure(s):</b> OD-9 Right Care, Right Setting	121990904.3.2	3.IT-9.4	Other Outcome Improvement Target: Decrease mental health admissions and readmissions of persons needing crisis stabilization services to institutional facilities.		
Year 2 (10/1/2012 – 9/30/2013)		Year 3 (10/1/2013 – 9/30/2014)		Year 4 (10/1/2014 – 9/30/2015)	
<p><b>Milestone 1</b> [P-2]: Conduct mapping and gap analysis of current crisis system</p> <p><u>Metric 1</u> [P-2.1]: Produce a written analysis of community needs for crisis services.</p> <p>Baseline/Goal: Produce a comprehensive report documenting all points above. Data Source: Results of Mapping and Gap analysis</p> <p>Milestone 1 Estimated Incentive Payment (<i>maximum amount</i>): <b>\$818,276</b></p> <p><b>Milestone 2</b> [P-3]: Develop implementation plans for needed crisis services.</p> <p><u>Metric 1</u> [P-3.1]: Produce data-driven written action plan for development of specific crisis stabilization alternatives that are needed in each community, based on gap analysis and assessment of needs.</p> <p>Baseline/Goal: At the beginning of DY 2, Crisis Stabilization Services did not exist; therefore,</p>		<p><b>Milestone 3</b> [P-4]: Hire and train staff to implement identified crisis stabilization services</p> <p><u>Metric 1</u> [P-4.1]: Number of staff hired and trained.</p> <p>Baseline/Goal: Hire a minimum of 6 staff for project.</p> <p>Data Source: a. Staff rosters and training records b. Data Source: Training curricula</p> <p>Milestone 3 Estimated Incentive Payment: <b>\$862,223</b></p> <p><b>Milestone 4</b>[P-9]: Participate in face-to-face meetings or seminars organized by the RHP to promote collaborative learning around shared or similar projects</p> <p>Metric: [P-9.1]: Participate in semi-annual face to face meetings or seminars organized by the RHP</p> <p>Data Source: Documentation of semiannual meetings including meeting agenda's, slides from presentations, and/or meeting notes.</p>		<p><b>Milestone 5</b> [I-12]: Utilization of appropriate crisis alternatives</p> <p><u>Metric 1</u> [I-12.1]: Metric: 10% increase in utilization of appropriate crisis alternatives over DY3</p> <p>Baseline/Goal: Provide Crisis Stabilization Services</p> <p>Data Source: c. Claims, encounter, and clinical record data. d. Rationale: see project goals.</p> <p>Milestone 5 Estimated Incentive Payment: <b>\$1,751,012</b></p>	<p><b>Milestone 6</b> [I-12]: Utilization of appropriate crisis alternatives</p> <p><u>Metric 1</u> [I-12.1]: Metric: 20% increase in utilization of appropriate crisis alternatives over DY4.</p> <p>Baseline/Goal: Provide Crisis Stabilization Services</p> <p>Data Source: c. Claims, encounter, and clinical record data. d. Rationale: see project goals.</p> <p>Milestone 5 Estimated Incentive Payment: <b>\$1,797,537</b></p>

<b>UNIQUE IDENTIFIER:</b> 121990904.1.1	<b>RHP PP Reference Number:</b> 1.13.1	<b>PROJECT COMPONENT</b> 1.13.1.(A-E)	<i>Project Title:</i> 1.13 Development of Behavioral Health Crisis Stabilization Services as alternatives to hospitalization	
<i>Performing Provider Name:</i> Camino Real Community Services			<i>TPI:</i> 121990904	
<b>Related Category 3 Outcome Measure(s):</b> OD-9 Right Care, Right Setting	121990904.3.2	3.IT-9.4	<i>Other Outcome Improvement Target:</i> Decrease mental health admissions and readmissions of persons needing crisis stabilization services to institutional facilities.	
<b>Year 2 (10/1/2012 – 9/30/2013)</b> <b>Year 3 (10/1/2013 – 9/30/2014)</b> <b>Year 4 (10/1/2014 – 9/30/2015)</b> <b>Year 5 (10/1/2015 – 9/30/2016)</b>				
baseline for all is 0.  Data Source: a. Written Plan  Milestone 2 Estimated Incentive Payment: \$818,277	Milestone 4 Estimated Incentive Payment: <b>\$862,224</b>			
<b>Year 2 Estimated Milestone Bundle Amount:: \$1,636,553</b>	<b>Year 3 Estimated Milestone Bundle Amount: \$1,724,447</b>		<b>Year 4 Estimated Milestone Bundle Amount: \$1,751,012</b>	<b>Year 5 Estimated Milestone Bundle Amount: \$1,797,537</b>
<b>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over DYs 2-5): \$6,909,549</b>				

## **Title of Outcome Measure (Improvement Target)**

**Title:** IT-9.4 Other Outcome Improvement Target: must be evidence based, appropriate for proposed project, and meet the definition of an outcome measure.

**Performing Provider name/TPI:** Camino Real Community Services/121990904

**Unique RHP ID#:** 121990904.3.2 (Pass 2)

## **Outcome Measure Description**

OD-9 Right Care, Right Setting

IT-9.4 Decrease mental health admissions and readmissions of persons needing crisis stabilization services to institutional facilities.

## **Process Milestones:**

Camino Real Community Services has selected the following process and improvement measures for Category 3:

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

P-7 (Other activities) Implementation plans: i.e. Facility acquisition, architect drawings, building financing, contractor retention, operational budget including staffing requirements, policy procedure development, etc.

## **Outcome Improvement Targets for Each Year:**

Decrease in mental health admissions and readmissions of persons needing crisis stabilization services to institutional facilities (hospital emergency rooms, State Hospitals, jails, private psychiatric facilities).

## **Rationale**

The process milestones and outcome improvement targets selected are those most directly respond to the Transformation Waiver goals and objectives. These milestones and outcome improvement targets directly relate to the provision of community based crisis stabilization services and are milestones and outcomes that are measurable. The outcome improvement targets will be determined in DY 2 for implementation in DY3.

## **Outcome Measure Valuation**

Project valuation takes into consideration:

- 1) Costs for both state operated Psychiatric Hospitals.
- 2) Costs of private Psychiatric Hospitals.
- 3) Local Emergency Room and Hospital costs.
- 4) Cost of local judicial systems.
- 5) Cost of local City and County law enforcement systems both in their intervention activity as well as the provision of transportation for consumers needing treatment.

Significant value will be given to a program that can provide services much more responsive to consumer needs with significantly reduced time frames and efficient use of limited resources!

<i>Unique Cat 3 ID: 121990904.3.2</i>	<i>Ref Number from RHP PP: 3.IT-9.4</i>	<i>Other Outcome Improvement Target: Decrease mental health admissions and readmissions of persons needing crisis stabilization services to institutional facilities.</i>	
<i>Performing Provider Name: Camino Real Community Services</i>			<i>TPI: 121990904</i>
<b>Related Category 1 or 2 Projects::</b>	<i>1.13 Development of Behavioral Health Crisis Stabilization Services as alternative to hospitalization.</i>		
<b>Starting Point/Baseline:</b>	<i>Since this service does not exist in the community, baseline will be established Year 4</i>		
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>
<p><b>Process Milestone 1 [P-1]:</b> Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans.</p> <p>Data Source: Project Plan</p> <p>Process Milestone 1 Estimated Incentive Payment (<i>maximum amount</i>): \$0</p>	<p><b>Process Milestone [P-7]:</b> (Other activities) Implementation plans: i.e. Facility acquisition, architect drawings, building financing, contractor retention, operational budget including staffing requirements, policy procedure development, etc.</p> <p>Data Source: Project Plan</p> <p>Process Milestone 3 Estimated Incentive Payment: \$191,605</p>	<p><b>Outcome Improvement Target 1 [IT-9.4]:</b> Decrease in mental health admissions and readmissions of persons needing crisis stabilization services to institutional facilities (hospital emergency rooms, State Hospitals, jails, private psychiatric facilities).</p> <p>Data Source: Project Data: Profile consumers/history of frequent users of institutional facilities. Those meeting profile or having history would be counted.</p> <p>Outcome Improvement Target 1 Estimated Incentive Payment: \$309,002</p>	<p><b>Outcome Improvement Target 2 [IT-9.4]:</b> Decrease in mental health admissions and readmissions of persons needing crisis stabilization services to institutional facilities (hospital emergency rooms, State Hospitals, jails, private psychiatric facilities).</p> <p>Data Source: Project Data: Profile consumers/history of frequent users of institutional facilities. Those meeting profile or having history would be counted.</p> <p>Outcome Improvement Target 2 Estimated Incentive Payment: \$449,384</p>
<b>Year 2 Estimated Outcome Amount: \$0</b>	<b>Year 3 Estimated Outcome Amount: \$191,605</b>	<b>Year 4 Estimated Outcome Amount: \$309,002</b>	<b>Year 5 Estimated Outcome Amount: \$449,384</b>
<b>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (<i>add outcome amounts over DYs 2-5</i>): \$949,991</b>			

## **Project Summary:**

Unique RHP ID#: 137908303.1.1 (Pass 2)

Provider Name/TPI: Maverick County Hospital District/137908303

Provider Description: Maverick County Hospital District (MCHD) is a designated subdivision of the State of Texas, whose core mission is to provide healthcare to the indigent population of Maverick County. MCHD owned and operated a hospital until the year 2000, when the hospital was sold to Universal Health Systems, d/b/a Fort Duncan Regional Medical Center (FDRMC). MCHD signed an affiliation agreement with FDRMC for continued services to needy population of Maverick County. At present MCHD offers the following community healthcare programs to the benefit of the uninsured and underinsured population: 1) Primary Care Voucher program, 2) Specialty Care at MCHD-Physicians Specialty Group, and 3) Self-Management Diabetes Education, all owned and managed by MCHD. MCHD administer other community services funded by state and federal grants. MCHD is the only provider of specialty services to the indigent population. Maverick County is located in the northwestern section of the Rio Grande region of Southwest Texas. The total population of Maverick is 53,500; this population is characterized by high poverty, low education, and high unemployment.

Interventions: The project will expand existent oncology/hematology services with special provisions to the indigent and Medicaid population.

Need for the project: MCHD services' face real challenges by the demographics of the area. Oncology services have been identified as one of the most impacted specialty services with many gaps in care, coordination and funding. Before the initiation of oncology services our indigent population was unable to receive treatment due to unavailability of funding outside Maverick county, and/or inability to travel to major urban areas. The closest cities are at two to three hours' drive. Ability to work payment arrangements with providers of oncology services for our indigent population is practically non-existent.

Target population: The target population is individuals of all ages diagnosed with any type of cancer requiring treatment for their illness. It is anticipated that approximately 70% of the population served by the expansion of the oncology services will be Medicaid or indigent population.

Category 1 or 2 expected patient benefits: The project will be very beneficial for patients, who will receive chemotherapy services at their place of residence. It is expected the expansion of space and physicians' hours will improve access, coordinate care, facilitate with the added benefit of decreasing travel time and transportation arrangements.

Category 3 outcomes expected patient benefits: Our goal is to have an increase in the patient volume receiving chemotherapy treatment at their place of residence, with a measurable patient satisfaction by DY5.

## **Identifying Project and Provider Information**

**Project Option:** 1.9.2 Expand Specialty Care Capacity-Oncology/Hematology Services

**Unique RHP ID#:** 137908303.1.1 (Pass 2)

**Performing Provider/TPI:** Maverick County Hospital District/137908303

## **Project Description**

### **Brief Description:**

The goal of this project is to expand oncology services to improve access to needed services. This project aligns with the regional goal of expanding specialty care capacity by increasing service availability to our indigent and Medicaid population. Maverick County Hospital District (MCHD) owns and operates a specialty clinic. Oncology consultations and chemotherapy services are offered to patients on a weekly basis. MCHD contracted services from a medical oncologist from Laredo. The volume of patients in need of those services as well the space used to administer chemotherapy exceeds the capacity the District has available at this time. This project will expand oncology/hematology services to provide patient consultations and chemotherapy therapy services to our community with special provisions to our indigent population.

### **Goals:**

1. To develop a data-driven process to assess current capacity and productivity to include an analysis of referral patterns, utilization patterns and availability of current medical providers, and other providers within the regional healthcare partnership.
2. To increase access by expanding clinic space and office hours.
3. To implement electronic referral-processes to improve provider communication, eliminate duplication, save time and resources and increase efficiency.
4. To improve patient satisfaction by allowing patients to receive oncology services at their place of residence in an efficient and timely manner.

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

One of the most important goals of Region 20 has been identified as “Expanding the Specialty Care Capacity.” This project fits within the Region 20 goals by: 1) allowing better access to oncology services to our underserved population; 2) better coordination of care; 3) reducing waiting time; and 4) allowing patients to receive treatment at their place of residence.

### **Challenges/Issues:**

The main challenge in expanding the oncology services to be able to serve an increased number of patients in Maverick and surrounding counties will be to be able to provide services at a lower cost. This project will provide oncology services for an increased uninsured and underinsured population and will operate basically at the cost of rendering those services. To address the availability of physicians, MCHD has contracts in place with oncology physicians in Laredo, Texas to supplement on-site provision of services. Other major challenge is the cost of the oncology drugs that will be offered to uninsured patients. This challenge will be address through

the inclusion of these individuals in our Medical Financial Assistant Program when raising our percentage of poverty level requirement.

This project meets our regional goals in expanding specialty care capacity, transforming healthcare delivery to a patient-centered model, increasing regional cooperation to reduce costs, lowering duplication of services, and increasing the overall patient experience.

**Starting Point/Baseline:**

The baseline will be established in DY2. There is currently no data or infrastructure in place to measure the impact of comprehensive oncology/hematology services in Maverick County.

Oncology services are offered once a week for fifteen (15) patients at a designated day.

Expanding the physician hours and offering chemotherapy services on site will allow increasing the patient load to 20-25 patients per day. The expansion of the chemotherapy suite will host 15 patients receiving chemotherapy at the same time.

**Five-Year Expected Outcomes:**

Demonstration year two (DY2) will be dedicated to the need assessment/gap analysis. Once this is accomplished, we will be able to plan the expansion of physicians' consultation hours and available space for the provision of chemotherapy services. DY3 will focus on the planning and implementation of the expansion of oncology services. Measurable outcomes are expected for DY4 and DY5. Expected outcomes will be measured based on the increase of the population served over the baseline and patient satisfaction regarding the increased access to services as well as the quality of services provided.

**Rationale**

Oncology services have been identified as one of the most impacted specialty services with gaps in care and coordination. Patients diagnosed with illnesses requiring oncology/hematology treatments have to travel to urban sites to receive this treatment, often depending on a friend or relative to provide transportation. Our indigent population was not receiving treatment due to the unavailability of services as well as the cost. MCHD started the Oncology/Hematology Clinic at the end of 2009. Services are provided by a medical oncologist physician who commutes from Laredo, Texas once a week. With the implementation of this project and its expected impact, MCHD sees the opportunity to scale the project to a broader patient population by 1) increasing consultation and treatment hours; and 2) space availability expansion to be able to increase the volume of patients receiving chemotherapy services at a given time.

Patients enrolled in the Medical Financial Assistance Program will be able to receive chemotherapy services through the program. A sliding scale fee schedule will be established for qualified patients. Payment plans will be available as well. Medicaid patients will benefit from the expansion of the service by not incurring the cost of traveling and/or making multiple trips to different locations in order to receive treatment. The Medicaid program will benefit from a better coordinated referral system that will improve the quality of care and avoid unnecessary duplication of services.

## **Projects Components:**

Core project components:

- a) Increase Service availability with extended hours: Physicians' hours will be extended to be able to consult and give chemotherapy services two to three days per week.
- b) Increase number of clinic locations: We plan to expand the chemotherapy suite space to be able to administer chemotherapy to fifteen patients at a time.
- c) Standardized referrals across the system through our electronic health record capacity.
- d) Conduct quality improvement for project using methods such as rapid cycle improvement: Activities may include, but are not limited to, identifying project impacts, opportunities to scale all or part of the project to a broader patient population, and identifying key challenges associated with expansion of project, including special considerations for safety-net populations. We will monitor very closely the volume of indigent and Medicaid population served by the project.

## **Related Community Need**

- a) **CN 1: The expansion of the oncology clinic is aligned with community need CN1: Capacity- Primary and Specialty care.**  
The demand of specialty care services exceeds the capacity in these areas. It is our expectation that this project will address the access to specialized treatment.

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

### **OD-6 Patient Satisfaction**

#### **IT-6.1 Percent Improvement over baseline of patient satisfaction scores.**

The Category 3 Outcome Measure selected for MCHD project "Expanding Specialty Care Capacity-Oncology/Hematology Services" is: **OD-6 Patient Satisfaction**. We plan to use CG-CAHPS survey to establish and evaluate if patients are getting timely care, appointments, how well their doctors communicate and the patient's involvement in shared decision making. Patient feedback is critical to the success of the project. The surveys are designed to produce comparable data that will be used to measure improvements over the established baseline.

## **Relationship to other projects**

MCHD is presenting one project in Region 20 with the unique RHP# 137908303.1.9, category 1.9.2, with Quality Improvement I-22.1-6.1 Patient Satisfaction. It relates to other projects in the region by increasing access to comprehensive medical services, by improving the patient experience, reducing wait time, establishing a standardized referral system and promoting better communication from physician-to-physician and physician-to-patient.

### **Plan for learning collaborative**

We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 20, Webb County. Our participation with other Performing Providers in the region will facilitate sharing of ideas and solutions to promote improvement in our region's healthcare system.

### **Project Valuation**

The valuation of this project is mainly based on the cost of hiring physicians. Chemotherapy drugs are reimbursed by third party payers and our MCHD-Medical Financial Assistance Program. However, we must consider the community benefits such as improved efficiency, saving from transportation costs and the benefits of receiving chemotherapy treatments at a patient's place of residence. Furthermore, it will reduce overall costs to the Medicaid program by providing chemotherapy services in the outpatient setting and being able to provide care to the indigent population outside the ED.

<b>UNIQUE IDENTIFIER:</b> 137908303.1.1	<b>RHP PP Reference Number:</b> 1.9.2	<b>PROJECT COMPONENT (A-D)</b>	<b>Project Title: Expand Specialty Care Capacity: Oncology/Hematology Clinic</b>	
Performing Provider Name: Maverick County Hospital District			TPI: 137908303	
<b>Related Category 3 Outcome Measure(s):</b>	137908303.1.9	IT-6.1	Patient Satisfaction-OD-6 IT 6.1	
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>	
<p><b>Milestone 1 [P-1]:</b> Conduct needs assessment to determine areas where oncology services have the potential to benefit a significant number of underserved populations.</p> <p><u>Metric 1 [P-1.1]:</u> Documentation of gap assessment. Numbers of patients who might benefit from expansion of services.</p> <p>Baseline/Goal: Conduct gap assessment. Baseline is zero. Data Source: Need assessment. EHR data.</p> <p><b>Milestone 1 Estimated Incentive Payment : \$57,750</b></p>	<p><b>Milestone 2 [I-22]:</b> Increase the number of specialist providers, clinic hours for oncology services. <u>Metric 1 [I-22.1]:</u> Increase number of specialists, clinic hours and chemotherapy treatment hours. Goal: Improved access for targeted populations. Increase number of specialty providers</p> <p>Data Source: EHR documentation of expanded oncology services.</p> <p><b>Milestone 2 Estimated Incentive Payment: \$66,983</b></p>	<p><b>Milestone 3 [I-23]:</b> Increase specialty care clinic volume of visits and evidence of improved access to uninsured and underinsured populations.</p> <p><u>Metric 1 [I-23.2]:</u> Documentation of increased number of unique patients.</p> <p>Goal: Increased patient served over prior reporting period by 20 patients.</p> <p>Data Source: EHR data</p> <p><b>Milestone 3 Estimated Incentive Payment: \$48,019</b></p>	<p><b>Milestone 4[I-23]:</b> Increase specialty care clinic volume of visits and evidence of improved access to uninsured and underinsured populations.</p> <p><u>Metric 1 [I-23.2]:</u> Documentation of increased number of unique patients.</p> <p>Goal: Increased patient served over prior reporting period by 25 patients.</p> <p>Data Source: EHR data</p> <p><b>Milestone 4 Estimated Incentive Payment: \$80,817</b></p>	
<b>Year 2 Estimated Milestone Bundle Amount: : \$57,750</b>	<b>Year 3 Estimated Milestone Bundle Amount: \$66,983</b>	<b>Year 4 Estimated Milestone Bundle Amount: \$48,019</b>	<b>Year 5 Estimated Milestone Bundle Amount: \$80,817</b>	
<b>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over DYs 2-5): \$ 253,569</b>				

## **Title of Outcome Measure (Improvement Target)**

**Title:** IT-6.1 Patient Satisfaction

**Performing Provider name/TPI:** Maverick County Hospital District/137908303  
**Unique RHP ID#:**137908303.1 (Pass 2)

## **Outcome Measure Description**

OD-6 Patient Satisfaction

IT-6.1 Percent Improvement over baseline of patient satisfaction scores.

### **Process Milestones:**

- DY2:
  - P- 1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P- 2 Establish baseline rates
- DY3:
  - P- 3 Develop and test data systems
  - P- 4 Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities

The focus for Year 2 and Year 3 will be project planning, start-up, developing and documenting implementation plans as well as establishing baselines. The identification of existing clinics and other community-based settings where the co-location of services can be supported and the engagement of the appropriate stakeholders are also critical to the success of this project.

### **Outcome Improvement Targets for Each Year:**

- DY4:

Improvement targets include an improvement over the baseline of patient satisfaction for patients in getting timely care, appointments, and information.
- DY5:

Improvement targets include an improvement over the baseline of patient satisfaction for the patient's rating of the doctor's access to a specialist.

## **Rationale**

The process milestones for this project include project planning which will involve the engagement of stakeholders, identifying the current capacity of oncology/chemotherapy health specialists and identifying where additional resources are required. Project planning will also include establishing timelines and documenting implementation plans, as well as establishing the baseline rates. In addition, the identification, development and testing of data systems will provide the basis for patient surveys that will include patient satisfaction for getting timely care, appointments, and information about the patient's rating of the doctor's access to a specialist. Obtaining patient feedback on our ability to provide timely care, appointments and information is critical to the success of this project. Patients having access and receiving the appropriate

specialty care in one integrated setting provides the opportunity for comprehensive care as well as patient satisfaction. We expect the number of individuals receiving and reporting satisfaction in Years 4 and 5 in medical and chemotherapy services at the established locations will show improvement over the baseline and provide us with meaningful and objective information that will be used to determine opportunities for improvement.

### **Outcome Measure Valuation**

The integration project is valued on a cost avoidance basis. This project is of unique value for Maverick and surrounding counties. Our uninsured and underinsured population will benefit tremendously by being able to access a more cost effective, comprehensive specialty care in the local community. Addressing the need of treatment at their place of residence will greatly decrease utilization of higher cost service environments or not receiving care at all.

<i>Unique Cat 3 ID: 137908303.3.1</i>	<i>Ref Number from RHP PP: IT-6.1</i>	<i>Percent improvement over baseline of patient satisfaction scores</i>	
<i>Performing Provider Name: Maverick County Hospital District</i>			<i>TPI: 137908303</i>
<b>Related Category 1 or 2 Projects:</b>	<i>Unique Category 1 identifier: 137908303.1.9</i>		
<b>Starting Point/Baseline:</b>	<i>Baseline to be determined in DY2</i>		
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>
<p><b>Process Milestone 1 [P-1]:</b> Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</p> <p>Data Source: Information from discussions/interviews with community health care providers and city and county governments, charities, faith based organizations and other community based helping organizations</p> <p>Process Milestone 1 Estimated Incentive Payment (<i>maximum amount</i>): \$0</p> <p><b>Process Milestone 2 [P-2]:</b> Establish baseline rates</p> <p>Data Source: Claims and encounter data, electronic medical records</p> <p>Process Milestone 2 Estimated Incentive Payment: \$0</p>	<p><b>Process Milestone 3 [P-3]:</b> Establish plan to develop and test data systems</p> <p>Data Source: Information from discussions/interviews to understand current systems and then establish most effective systems for the programs</p> <p>Process Milestone 3 Estimated Incentive Payment: : <b>\$3,725</b></p> <p><b>Process Milestone4 [P-4]:</b> Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities</p> <p>Data Source: Claims and encounters data, medical records</p> <p>Process Milestone 4 Estimated Incentive Payment: <b>\$3,725</b></p>	<p><b>Outcome Improvement Target 1</b></p> <p>Metric 1 [IT-6.1]: Patients are getting timely care, appointments, and information including 5% improvement over baseline</p> <p>Data Source: Patient survey</p> <p>Metric 2 [IT-6.1]: Patient’s rating of doctor access to specialist</p> <p>Data Source: Patient survey</p> <p><b>Outcome Improvement Target 1</b></p> <p>Estimated Incentive Payment: <b>\$5,350</b></p>	<p><b>Outcome Improvement Target 2</b></p> <p>Metric 1 [IT-6.1]: Improvement Target: Patients are getting timely care, appointments, and information including 10% improvement over baseline</p> <p>Data Source: Patient survey</p> <p>Metric 2 [IT-6.1]: Patient’s rating of doctor access to specialist</p> <p>Data Source: Patient Survey</p> <p><b>Outcome Improvement Target 2</b></p> <p>Estimated Incentive Payment: <b>\$20,200</b></p>
<b>Year 2 Estimated Outcome Amount:: \$0</b>	<b>Year 3 Estimated Outcome Amount: \$7,450</b>	<b>Year 4 Estimated Outcome Amount: \$5,350</b>	<b>Year 5 Estimated Outcome Amount: \$20,200</b>
<b>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5):\$33,000</b>			

***D. Category 2: Program Innovation and Redesign***

**Project Summary:**

Unique Project Identifier: 121989102.2.1

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

Provider Description: Border Region Behavioral Health Center provides outpatient in four South Texas counties. Three counties - Webb, Jim Hogg & Zapata – are in Region 20 and one – Starr – is in Region 5.

In Region 20 approximately 2200 adult and child clients are enrolled at any given time. Region 5 combined enrolled in approximately 500.

The overall payer mix is 63% Medicaid, 24% general revenue and, 13% other.

Intervention(s): This project initiates integrated primary and behavioral health services. Behavioral health clients identified as co-morbid physical disorder of diabetes, hypertension, obesity or COPD may qualify for the patient panel in this program.

Need for the project (include data as appropriate): This project initiates integrated primary and behavioral health services. Behavioral health clients identified as co-morbid physical disorder of diabetes, hypertension, obesity or COPD may qualify for the patient panel in this program.

Target population (number of patients the project will serve and how many Medicaid/Indigent will benefit from the project): A patient panel consisting of clients with behavioral health issues with co-morbid physical disorders. Initially to consist of 20 Medicaid clients.

Category 1 or 2 expected patient benefits: Clients will be afforded a wider variety of specialized consultations and wait times for services will decrease.

Category 3 outcomes expected patient benefits: Reduce possibly preventable admission to acute medical surgical hospitals. Patients will experience greater coordination of care for all services.

## **Identifying Project and Provider Information**

**Project Option:** 2.15.1 Design, implement, and evaluate projects that provide integrated primary and behavioral health care services.

**Unique RHP ID#:** 121989102.2.1

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

## **Project Description**

**Brief Description:** Develop and implement an integrated Behavioral Health and Primary Care pilot, targeting at-risk populations with co-morbid diseases of mental illness and chronic disease who currently go untreated, or under treated, and who routinely access more intensive and costly services such as emergency departments or jails.

This project proposes offering a Behavioral Health and Primary Care Integrated treatment model that will introduce/integrate primary care into the behavioral health services already provided within the Border Region service area. The integrated care program/model will offer the following services:

1. behavioral health services
2. primary care services
3. health behavior education and training programs
4. Case management services to help patients navigate the services provided in the community.
5. Health screening will be made available to clients interested in integrated care.

Border Region will implement the IMPACT Model of collaborative care.

**Goals and Relationship to Regional Goals:** The Region 20 plan cites the inadequate integration of care for individuals with co-occurring medical and mental illness or multiple chronic conditions as one of its community needs, and state as one of its goals: *“Transform health care delivery to a patient-centered, coordinated and integrated delivery model that improves patient satisfaction and health outcomes, reduces unnecessary emergency department use and duplicative services, and expands on the accomplishments of our existing health care system.”*

The project will further address these goals:

- Identify a panel of behavioral health clients with co-morbid physical health conditions and provide patient centered treatment and symptoms management under centralized coordination.
- Continue management of patient even when some symptoms are in remission.
- Improve communication between providers and enhance coordination of care.
- Reduce cost and inconvenience of transportation making trips to multiple providers due to colocation.

**Challenges/Issues:** The main challenge for the Border Region is finding and employing primary care providers which include addressing various issues such as:

- Costs
- Cultural barriers
- Lack of health literacy
- Perception of the border as a dangerous place to live
- Inflated property values
- Limited graduate education programs
- Lack of pre-existing data sharing structures and stakeholder networks.

These barriers will be addressed by providing competitive salaries. In addition, Border will advertise nationally. Border will hire through federal programs that provide debt relief to physicians for practicing in underserved areas.

**Five-Year Expected Outcome for Provider and Patients:** We expect to see the following outcomes from implementing this project:

- Increase in access to primary care
- Increase in access to behavioral health care services
- Reduction in inpatient psychiatric hospitalizations
- Increase in patient satisfaction
- Reduction in Emergency Department visits
- Chance to develop and change health behaviors
- Reduction in preventable behavioral health and chronic disease hospitalizations

The project will begin serving clients in DY3, achieving a pool of 50 integrated care clients by the end of that year. 100 will be served by the end of DY4 and 150 by the end of DY5

### **Starting Point/Baseline**

No integrated primary care and behavioral health services are currently available in Region 20.

### **Rationale**

Research has shown that patient centered medical homes that use the IMPACT model of collaborative care have had improved outcomes in physical health, which has benefited various populations and resulted in lower costs of care over the long term<sup>46</sup>. Druss and colleagues conducted a randomized trial of patients within the Veterans Administration system in 2001. In the study, individuals living with serious mental illnesses were to receive primary care in an integrated behavioral health-primary care patient focused model of care. The study showed that individuals were significantly more likely to have made a primary care visit, had a greater mean number of primary care visits, were more likely to have received 15 of 17 preventive measures, and had significantly greater improvement in their health.<sup>47</sup>

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<sup>46</sup> <http://www.impact-uw.org/about/research.html>

<sup>47</sup> Druss, B et al. Integrated medical care for patients with serious psychiatric illness. Archives of General Psychiatry, Vol 58, September 2001

**Project Components:** This project will address all required components in Project Option 2.15.1, as detailed in the RHP Planning Protocol and will include the following:

- a) The Border Region Behavioral Health Center clinic in Region 20 will be the project location site. Border Region is centrally located in the city of Laredo and will be accessible.
- b) Scheduling and client information will reside with the Border Region client information system. It is expected that primary care services will be co-located with the behavioral health care services and provider agreements will not be necessary as it is coordinated the management of Border Region.
- c) Under process standard P3 (milestone 1, DY2), processes and protocols for communication, data sharing and referral and successful follow through will be measured. The number and types of referrals will be measured. Primary and behavioral health providers will both use the Border Region client data system, thus allowing for data sharing and referral tracking.
- d) Specialty providers will be recruited as per Project 1.14.1 and/or contract providers will provide telemedicine services available under project 1.11.2
- e) Provider training will be initiated as per development of protocols and processes for milestone 1, DY2. Milestones 3, 6, 9 & 13 provide for idea testing to assist providers in developing regular and productive case meeting and review shared treatment planning protocols.
- f) Electronic medical records are already in use and data reporting systems are in place and used daily.
- g) Legal agreements for collaborative practices will be explored as a function of DY2 metric for milestone 2. But the project is being planned to operate under Border Region management so collaboration between disparate legal entities may not an issue.
- h) Utilities and building services already exist for selected site. Should new sites become available presenting possibilities for service improvement, this will be addressed under Milestone 2 in DY2 pertaining to identifying sites in the community for clinic co-location.
- i) Data systems and reporting mechanisms are in place. New reporting codes will be developed to isolate data pertinent to this project. This will be address with Milestone P-9 – review project data weekly and respond with new ideas for practices, tools and solutions.
- j) Quality improvement will be addressed under milestones 3&4 (DY2), 6&7 (DY3), 9 (DY 4) and 13&15 (DY 5).

**Milestones & Metrics:** The following milestones and metrics have been chosen for the Border Integrated Primary and Behavioral Health Care project based on the core components and the needs of the target population:

- **Process Milestones and Metrics:** P-2 (P-2.1) to evaluate the best location for the project, ; P-3 (P-3.1) for policy and procedure development related to information sharing and referral handling; P-5 (P-5.2) for tracking the number of non-behavioral providers located in the behavioral health clinic in DY3, P-6 (P-6.1, P-6.2) to track the progress of collaborative co-location from Level 4 colocation to Level 5 in DYs 4&5; P-7 (P-7.1) as a CQI practice in DYs 4&5; P-9 (P-9.1) for weekly project review and idea testing and P-10 (P-10-1) for semi-annual face-to-face learning collaborative with the RHP and other

providers. This will be done in collaboration with RHP 20 anchor and performing providers.

- **Improvement Milestones and Metrics:** I-10 (I-10.1) to track No-Shows as an indicator of integrated clinic patient acceptance.

**Unique Community Need Identification Numbers the Project Addresses:** The following community identification numbers address the inadequate integration of care for individuals with co-occurring medical and mental illness or multiple chronic conditions:

(CN.2) Behavioral Health Services

(CN.3) Chronic Disease and Disease Self-Management Initiatives

**How the Project Represents a New Initiative or Significantly Enhances an Existing Delivery System Reform Initiative:** Border Region in Webb, Jim Hogg and Zapata counties has traditionally served only behavioral health needs with no communication or coordination with providers of physical health. This project represents a new initiative and may also be the first experience of regular physical health maintenance for some behavioral health clients. This will also afford Border Region greater access to the physician community as it positions itself uniquely in the medical provider community.

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

#### **OD-2 Potentially Preventable Admissions:**

IT-2.4 Behavioral Health/Substance Abuse Admission Rate

**Reasons/Rationale for Selecting the Outcome Measures:** This domain was chosen because research has shown that those patients affected by mental illness and suffering from chronic disease are dying 25 years earlier than the rest of the population<sup>48</sup>. Co-occurring mental and physical health issues are common in the general population, but are significant for persons with serious mental illness.

National statistics demonstrate on average more than 68% of adults with a mental disorder had at least one medical condition, and 29% of those with a medical disorder also had a mental health condition. People with schizophrenia and bipolar disorder are up to three times more likely to have three or more chronic conditions compared to people without these disorders. Treating patients in an integrated behavioral health primary care model will reduce preventable inpatient admissions.

### **Relationship to other Projects**

This project relates to project 1.11.2 in that teleconferencing will permit access to specialty providers on contract and enable participation by qualified panel members in outlying counties. With Project 1.14.1, it will be necessary to recruit, train, and retain additional licensed service providers needed to treat clients involved in this project. Projects 1.14.1 will provide recruitment

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<sup>48</sup> Freeman, E, Yoe, J. The Poor health status of consumers of mental healthcare: Behavioral disorders and chronic disease, Presentation to NASMHPD Medical Directors Work Group, May 2006.

and training efforts to provide licensed and other primary care workers. Project 1.11.2 will expand telemedicine services to permit inclusion of geographically distant clients and expand the number and type of specialty services that may be offered under this integrated care effort.

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

The Camino Real Center serves one county in Region 20 and is also requesting approval for an integration project of their own. That project and this one proposed by Border region are not designed to function together, and will operate independently. As the projects proceed, opportunities for information sharing and other collaboration may be explored

### **Plan for Learning Collaborative**

We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 20, Webb County. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system. The RHP 20 Anchor will sponsor two learning collaboratives per year.

### **Project Valuation**

The project will reduce unnecessary emergency room utilization and inpatient admissions. By creating co-located primary care and behavioral health, patients will experience more years of productive life.

Psychiatric inpatient costs attributed to Region 20 are approximately \$3,088,052.63 per year, and reflect a combination of State Hospital and private psychiatric care. Approximately 508 admissions come from Region 20 annually with an average length of stay of 5.7 days. Inpatient cost is \$595 per day based on Center for Medicare Services research ([www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Reports/downloads/cromwell\\_2005\\_3.pdf](http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Reports/downloads/cromwell_2005_3.pdf)).

Patient records of approximately 20,000 residents of Webb, Zapata and Jim Hogg counties reveal the presence of an Axis III diagnosis in approximately 4,500 clients, although this number is probably low as this information cannot be obtained for all clients. Of these 4,500, 1,277 are for a diagnosis related to diabetes, and 863 for a diagnosis related to hypertension. 569 relate to obesity. Of these 4,500 clients, 77 had two or more co-morbid diseases. At any given time, approximately 2,000 adult and child cases are active, affording a possible client panel.

<b>Unique Identifier:</b> 121989102.2.1	<b>RHP PP Reference Number</b> 2.15.1	<b>Project Component</b> 2.15.1 (A-J)	<b>Project Title: Integrate Primary and Behavioral Health Care Services</b>	
Performing Provider Name: Border Region Behavioral Health Center			TPI - 121989102	
<b>Related Category 3 Outcome Measure(s):</b>	121989102.3.1	IT-2.4	Behavioral Health/Substance Abuse Admission Rate	
<b>Year 2</b> (10/1/2012 – 9/30/2013)		<b>Year 3</b> (10/1/2013 – 9/30/2014)	<b>Year 4</b> (10/1/2014 – 9/30/2015)	<b>Year 5</b> (10/1/2015 – 9/30/2016)
<p><b>Milestone 1 [P-3]:</b> Develop and implement a set of standards to be used for integrated services to ensure effective information sharing, proper handling of referrals of behavioral health clients to physical health providers and vice versa.</p> <p><u>Metric 1 [P 3.1]:</u> Number and types of referrals that are made between providers at the location</p> <p>Baseline: No integrated services or standards exist.</p> <p>Goal: Incorporate industry standards as per chosen integration model. No clients served in this project in DY2.</p> <p>Data Sources: Surveys of providers to determine the degree and quality Of information sharing</p> <p>Process Milestone 1 Estimated Incentive Payment (<i>maximum amount</i>): \$350,159</p> <p><b>Milestone 2 [P-2]:</b> Identify existing clinics or other community-based settings where integration could be</p>	<p><b>Milestone 5 [P-5]:</b> Develop integrated sites reflected in the number of locations and providers participating in the integration project.</p> <p><u>Metric 1 [P-5.2]:</u> Number of primary care health providers newly located in behavioral health clinics.</p> <p>Data Source: Human Resources records of employees or contract management records. Baseline: Only Behavioral health workers at locations. Goal: Begin project operations in DY3</p> <p>Program provides service to 50 clients Program has 4 participating providers</p> <p>Milestone 5 Estimated Incentive Payment: \$487,056</p> <p><b>Milestone 6 [P-9]:</b> Review project data and respond to it every week with tests of new ideas, practices, tools or solutions.</p> <p><u>Metric 1 [P-9.1]:</u> Number of new ideas, practices, tools, or solutions tested by each provider.</p>	<p><b>Milestone 8 [P-6]:</b> Develop integrated behavioral health and primary care services within co- located sites.</p> <p><u>Metric 1 [P-6.1]:</u> Number of providers achieving Level 4 of interaction (close collaboration in a partially integrated system).</p> <p>Data Source: Project data Goal: Complete first full year of service to clients of integrated clinic. Program provides service to 100 clients. Program has 6 participating providers</p> <p>Milestone 8 Estimated Incentive Payment: \$390,777.50</p> <p><b>Milestone 9 [P-7]:</b> Evaluate and continuously improve integration of primary and behavioral health services.</p> <p><u>Metric 1 [P-7.1].</u> Project planning and implementation documentation demonstrates plan, do, study, act quality improvement cycles.</p>	<p>Milestone 12 [P-6]: Develop integrated behavioral health and primary care services within co- located sites.</p> <p><u>Metric 1 [P-6.2]</u> Number of providers achieving Level 5 of interaction (close collaboration in a fully integrated system)</p> <p>Data Source: Project data Goal: Service delivery indicates full integration Program provides service to 150 clients Program has 7 participating providers</p> <p>Milestone 12 Estimated Incentive Payment: \$302,051</p> <p>Milestone 13 [P- 7]: Evaluate and continuously improve integration of primary and behavioral health services.</p> <p><u>Metric 1 [P 7.1]:</u> Project planning and implementation documentation demonstrates plan, do, study, act quality improvement cycles.</p>	

<b>Unique Identifier:</b> 121989102.2.1	<b>RHP PP Reference Number</b> 2.15.1	<b>Project Component</b> 2.15.1 (A-J)	<b>Project Title: Integrate Primary and Behavioral Health Care Services</b>	
Performing Provider Name: Border Region Behavioral Health Center			TPI - 121989102	
<b>Related Category 3 Outcome Measure(s):</b>	121989102.3.1	IT-2.4	Behavioral Health/Substance Abuse Admission Rate	
<b>Year 2 (10/1/2012 – 9/30/2013)</b>		<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>
<p>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.</p> <p><u>Metric 1</u> [P-2.1]: Discussions/Interviews with community healthcare providers (physical and behavioral), city and county governments, charities, faith-based organizations and other community based organizations.</p> <p><b>Baseline:</b> No spaces identified and clinic may be relocating to more accessible section of city. <b>Goal:</b> Selected located provides for physical co-location of primary and behavioral health care providers. Data Source: Information from participating persons</p> <p>Milestone 2 Estimated Incentive Payment: \$350,159</p> <p><b>Milestone 3</b> [P-9]: Review project data and respond to it every week with tests of new ideas, practices,</p>		<p>Baseline: Idea testing not instituted, data review done monthly, usually related to productivity. Goal: Institute system of regular evaluation of service by providers Providers produce 10 new ideas, practices, tools or solutions. Data Source: Brief description of the idea, practice, tool, or solution tested by each provider each week. Could be summarized at quarterly</p> <p>Milestone 6 Estimated Incentive Payment: \$ 487,056 <b>Milestone 7</b> [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. <u>Metric 1</u> [P-10-1]: Participate in semi-annual face-to-face meeting or seminars organized by the RHP. Baseline: Region 5 RHP hosting meetings, webinars since Waiver project introduction. Goal: Share and learn from other providers. Data Source: Documentation of semi-annual meetings including agendas, presentation slides,</p>	<p>Goal: Assure system is achieving integration, and moving toward positive outcomes. Data Source: Client Data system, Documented PDSA sessions. Milestone 9 Estimated Incentive Payment: \$390,777.50</p> <p><b>Milestone 10</b> [I-10]: No-Show Appointments <u>Metric 1</u> [I-10.1]: % decrease the “no shows” for behavioral and physical health appointments. Goal: Number of No Shows decreases 10% from DY3 Data Source: Project Data; Clinic Registry Data; Claims and Encounter Data</p> <p>Milestone 10 Estimated Incentive Payment \$390,777.50</p> <p><b>Milestone 11</b> [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. <u>Metric 1</u> [P-10-1]: Participate in semi-annual face-to-face meeting or</p>	<p>Goal: Assure system is achieving integration, and moving toward positive outcomes Data Source: Client Data system, Documented PDSA sessions.</p> <p>Milestone 13 Estimated Incentive Payment: \$302,051 Milestone 14 [I-10]: No-Show Appointments</p> <p><u>Metric 1</u> [I-10.1]: % decrease the “no shows” for behavioral and physical health appointments. Goal: Number of No Shows decreased 15% from DY4 Data Source: Project Data; Clinic Registry Data; Claims and Encounter Data</p> <p>Milestone 14 Estimated Incentive Payment: \$302,050</p> <p>Milestone 15 [P-10]: Participate in face-to-face learning at least twice per year with other providers and the RHP to promote collaborative learning around shared or similar projects.</p> <p>Metric 1 [P-10-1]: Participate in semi-</p>

<b>Unique Identifier:</b> 121989102.2.1	<b>RHP PP Reference</b> Number 2.15.1	<b>Project Component</b> 2.15.1 (A-J)	<b>Project Title: Integrate Primary and Behavioral Health Care Services</b>	
<i>Performing Provider Name: Border Region Behavioral Health Center</i>			<i>TPI - 121989102</i>	
<b>Related Category 3</b> <b>Outcome Measure(s):</b>	121989102.3.1	IT-2.4	Behavioral Health/Substance Abuse Admission Rate	
<b>Year 2 (10/1/2012 – 9/30/2013)</b>				
<b>Year 3 (10/1/2013 – 9/30/2014)</b>				
<b>Year 4 (10/1/2014 – 9/30/2015)</b>				
<b>Year 5 (10/1/2015 – 9/30/2016)</b>				
<p>tools, or solutions. This data should be collected with simple, interim measurement systems, and should be based on self-reported data and sampling that is sufficient for the purposes of improvement.</p> <p><u>Metric 1</u> [P 9.1]: Number of new ideas, practices, tools, or solutions tested by each provider.</p> <p>Baseline: Idea testing not instituted, data review done monthly, usually related to productivity.</p> <p>Goal: Provider produces at least 5 new ideas, practices, tools or solutions.</p> <p>Data Source: Brief description of the idea, practice, tool, or solution tested by each provider each week. Could be summarized at quarterly intervals.</p> <p>Milestone 3 Estimated Incentive \$ 350,159</p> <p><b>Milestone 4</b> [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.</p>	<p>and/or meeting notes.</p> <p>Milestone 7 Estimated Incentive Payment: \$ 487,055</p>	<p>seminars organized by the RHP.</p> <p>Goal: Share and learn from other providers. Providers participate in at least 2 face-to-face meetings</p> <p>Data Source: Documentation of semi-annual meetings including agendas, presentation slides, and/or meeting notes.</p> <p>Milestone 11 Estimated Incentive Payment: \$ 390,777.50</p>	<p>annual face-to-face meeting or seminars organized by the RHP.</p> <p>Goal: Share and learn from other providers. Providers participate in at least 4 face-to-face meetings</p> <p>Data Source: Documentation of semi-annual meetings including agendas, presentation slides, and/or meeting notes.</p> <p>Milestone 15 Estimated Incentive Payment: \$302,050</p> <p><b>Milestone 16</b> [I-10]: No-Show Appointments</p> <p><u>Metric 1</u> [I-10.1]: % decrease the “no shows” for behavioral and physical health appointments.</p> <p>Goal: Number of No Shows decreases 10% from DY3</p> <p>Data Source: Project Data; Clinic Registry Data; Claims and Encounter Data</p> <p>Milestone 10 Estimated Incentive Payment \$302,050</p>	

<b>Unique Identifier:</b> 121989102.2.1	<b>RHP PP Reference Number</b> 2.15.1	<b>Project Component</b> 2.15.1 (A-J)	<b>Project Title: Integrate Primary and Behavioral Health Care Services</b>	
<i>Performing Provider Name: Border Region Behavioral Health Center</i>			<i>TPI - 121989102</i>	
<b>Related Category 3 Outcome Measure(s):</b>	121989102.3.1	IT-2.4	Behavioral Health/Substance Abuse Admission Rate	
<b>Year 2</b> <b>(10/1/2012 – 9/30/2013)</b>	<b>Year 3</b> <b>(10/1/2013 – 9/30/2014)</b>	<b>Year 4</b> <b>(10/1/2014 – 9/30/2015)</b>	<b>Year 5</b> <b>(10/1/2015 – 9/30/2016)</b>	
<p><u>Metric 1</u> [P-10-1]: Participate in semi-annual face-to-face meeting or seminars organized by the RHP.</p> <p>Baseline: Region 5 RHP hosting meetings, webinars since Waiver project introduction. Goal: Share and learn from other providers. Data Source: Documentation of semi-annual meetings including agendas, presentation slides, and/or meeting notes.</p> <p>Milestone 4 Estimated Incentive Payment: \$ 350,159</p>				
<b>Year 2 Estimated Milestone Bundle Amount: : \$1,400,636</b>	<b>Year 3 Estimated Milestone Bundle Amount: \$1,461,167</b>	<b>Year 4 Estimated Milestone Bundle Amount: \$1,563,110</b>	<b>Year 5 Estimated Milestone Bundle Amount: \$1,510,252</b>	
<b>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5): \$5,935,165</b>				

## **Title of Outcome Measure (Improvement Target)**

**Title:** 2.15 Integrate Primary and Behavioral Health Care Services

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

**Unique RHP ID#:** 121989102.3.3

## **Outcome Measure Description**

The Category 3 project template describes various processes milestones and metrics for measuring both the progress in acquiring and implementing the infrastructure plans and their effect on the implementation of 2.15.1.

The Quality Assurance activities defined in this Category 3 project address an approach to Quality Assurance, which can be applied to each project. Included are:

- Ongoing Plan-Do-Study-Act sessions in which activities such as data collection are evaluated, baselines established and initiatives conceived and reviewed.

Combined with process milestones and metrics from QA project and its related project 1.14.1, it is expected an accurate assessment of integrated health care's role and ability to reduce preventable admissions may be established.

### **Process Milestones:**

- DY2  
N/A
- 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-2.4 Behavioral Health/Substance Abuse (BH/SA) Admission Rate (Standalone Measure)
- DY5:  
IT-2.4 Behavioral Health/Substance Abuse (BH/SA) Admission Rate (Standalone Measure)

Estimated client impact: DY2&DY3: No impact on Inpatient admissions. DY4 inpatient admissions decrease by 10% from DY12 to 479 per year. DY5 inpatient admission decrease 15% from DY4 to 407 admissions per year.

## **Rationale**

The three projects requested in Pass 1 (1.11.2, 1.14.1 & 2.151.1) of Region 20 are designed to support the goal of preventing hospital admissions. Specifically, this refers to State Hospital, private psychiatric hospital and acute medical/surgical hospital admissions.

## **Outcome Measure Valuation**

The population\_included in this project will be the patient panel selected to receive integrated primary and behavioral health services through the Region 20 clinic of Border Region Behavioral Health Center. As a subset of the numerator for the improvement target (the number of admissions from the entire adult and child/adolescent client), specific data reporting will highlight these individuals.

The Pass 1 infrastructure projects 1.11.2 and 1.14.1 both support the Program Innovation and Redesign project 2.15.2. The impetus of the infrastructure projects is to make more licensed personnel available in the region. Needed licensed personnel such as LPHAs, nurses, and psychiatrists are historically underrepresented in this region. Telecommunication infrastructure will permit contracting services for behavioral health, and in the case of 2.15.1, medical services that cannot be hired or contracted locally.

The specific description of the Adult population served is as follows:

Adults who have severe and persistent mental illnesses such as schizophrenia, major depression, bipolar disorder, or other severely disabling mental disorders which require crisis resolution or ongoing and long-term support and treatment.

Adult MH Target Population - Adults who have a diagnosis of schizophrenia, bipolar disorder, and severe major depression.

### Initial Eligibility:

An individual age 18 or older that has a diagnosis of:

schizophrenia as defined in the following Diagnostic and Statistical Manual, Fourth Edition - Text Revision (DSM-IV TR) diagnostic codes.

bi-polar disorder as defined in the DSM-IV TR diagnostic codes

major depression as defined in the DSM-IV TR diagnostic codes, with a Global Assessment of Functioning (GAF) of 50 or below at intake.

An individual age 18 or older who has a diagnosis other than those listed in I.B.2.c.1. and whose current Global Assessment of Functioning (GAF) is 50 or less and needs on-going MH services;  
or

An individual age 18 or older who was served in children's MH services and meets the children's MH priority population definition prior to turning 18 is considered eligible for one year.

Individuals with only the following diagnoses are excluded from this provision:

Substance Abuse as defined in the DSM-IV TR diagnostic.

IDD as defined in the DSM-IV TR diagnostic codes.

Pervasive Developmental Disorder as defined in the following DSM-IV TR diagnostic codes.

Persons with mental conditions referred by primary care or other providers, but not meeting the above criteria, may be eligible for services funded under transformation waiver 1115 projects.

Specific description of Child/Adolescent population:

Children/youth ages 3 through 17 with a diagnosis of mental illness (excluding a single diagnosis of substance abuse, IDD, autism or pervasive development disorder) who exhibit serious emotional, behavioral or mental health disorders and who:

Have a serious functional impairment; or are at risk of disruption of a preferred living or child care environment due to psychiatric symptoms; or are enrolled in a school system's special education program because of serious emotional disturbance.

Age Limitations:

Children under the age of three who have a diagnosed physical or mental health condition are to be served through the Early Childhood Intervention (ECI) program; and

Youth 17 years old and younger must be screened for CMH services. Youth 18 years or older must be screened for Adult Mental Health services; and

Youth receiving Children's MH Services who are approaching their 18<sup>th</sup> birthday and continue to be in need of services shall either be transferred to Adult MH Services on his/her 18<sup>th</sup> birthday or referred to another community provider, dependent upon the individual's needs. Youth reaching 18 years of age who continue to need services may be transferred to Adult MH Services without meeting the adult priority population criteria and served for up to one additional year.

For purposes of this contract definitions of "child" and "youth" are as follows:

Child: An individual who is at least three years of age, but younger than 13 years of age.

Youth: An individual who is at least 13 years of age, but younger than 18 years of age.

<i>Unique Cat 3 ID: 121989102.3.3</i>	<i>Ref Number from RHP PP: IT-2-4</i>	<i>Behavioral Health/Substance Abuse (BH/SA) Admission Rate</i>	
<i>Performing Provider Name: Border Region Behavioral Health Center</i>			<i>TPI - 121989102</i>
<b>Related Category 1 or 2 Projects::</b>	<i>Unique Category 1 identifier - 121989102.2.1</i>		
<b>Starting Point/Baseline:</b>	<i>To be determined in DY 3 for DY2</i>		
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>
<b>Process Milestone 1 [NA]</b>  Process Milestone 1 Estimated Incentive Payment: \$0	<b>Process Milestone 2 [P-4]:</b> Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities  Data Source: Facility minutes, documented reports.  Process Milestone 2 Estimated Incentive Payment: \$162,352	<b>Outcome Improvement Target 1 [IT 2.4]: Behavioral Health/Substance Abuse (BH/SA) Admission Rate</b>  Performing provider should report on both categories below: 1. One for BH/SA as the principal diagnosis; 2. A second category in which a significant BH/SA secondary diagnosis is present  Improvement Target: Admission rate decrease 10% from DY2 baseline  Data Source: Admissions data from CARE system, Anasazi Continuity of Care records  Outcome Improvement Target 1 Estimated Incentive Payment: \$173,679	<b>Outcome Improvement Target 2 [IT 2.4]: Behavioral Health/Substance Abuse (BH/SA) Admission Rate</b>  Performing provider should report on both categories below: 1. One for BH/SA as the principal diagnosis; 2. A second category in which a significant BH/SA secondary diagnosis is present  Improvement Target: Admission rate decrease 15% from DY4 baseline  Data Source: Admissions data from CARE system, Anasazi Continuity of Care records  Outcome Improvement Target 2 Estimated Incentive Payment: \$377,563
<b>Year 2 Estimated Outcome Amount: \$0</b>	<b>Year 3 Estimated Outcome Amount: \$162,352</b>	<b>Year 4 Estimated Outcome Amount: \$173,679</b>	<b>Year 5 Estimated Outcome Amount: \$377,563</b>
<b>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5): \$713,594</b>			

## **Project Summary:**

Unique Project Identifier: 121989102.2.2 (Pass 2)

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

Provider Description: Border Region Behavioral Health Center provides outpatient in four South Texas counties. Three counties - Webb, Jim Hogg & Zapata – are in Region 20 and one – Starr – is in Region 5.

In Region 20 approximately 2200 adult and child clients are enrolled at any given time. Region 5 adult and child combined enrolled in approximately 500 at any given time. The overall payer mix is 63% Medicaid, 24% general revenue and, 13% other.

Intervention(s): This project designs crisis prevention for outpatient services such as to address factors affecting inpatient admission rates such chronic homeless services, physical illness, lack of monitoring of medication compliance and decrease in functional status.

Need for the project (include data as appropriate): To the degree possible, people should be treated in the community, on an outpatient basis. Current Region 20 inpatient admission rates (over 400 per year) exceed budget allocations and the system must be analyzed to determine where changes can be made to prevent admissions. New ideas must be tried and evaluated for their effectiveness in preventing admissions.

Target population (number of patients the project will serve and how many Medicaid/Indigent will benefit from the project): Potentially available to any client of Border Region as many people with behavioral health issues may experience need for crisis services. Populations especially at risk will be identified as part of the project. Estimated Medicaid mix is 50% and 50% indigent.

Category 1 or 2 expected patient benefits: Crisis episodes will be prevented or identified and addressed prior to escalating to the need for inpatient services. . 3180 crisis services were delivered in the base-line year. It is expected that through the identification of clients prone to crisis and subsequent involvement in crisis prevention, this number may be decreased.

Expected client impact from this program is: DY2 -820 clients, DY3 – 957 clients, DY4 – 1094 clients, DY5- 1368 clients.

Category 3 outcomes expected patient benefits: Reduced Emergency Department visits for the behavioral health/substance abuse population. Patients won't have to compete of other emergency room visitors for access to services for their needs, access to behavioral health services will be improved.

## **Identifying Project and Provider Information**

**Project Option:** 2.13.1 Design, implement and evaluate research-supported and evidence-based intervention tailored towards individuals in the target population.

**Unique RHP Project Identification Number:** 121989102.2.2 (Pass 2)

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

## **Project Description**

Border Region Behavioral Health Center will provide an intervention for a target behavioral health population to prevent unnecessary use of services in a specified setting. Efforts in this project will target preventing crises through design of outpatient protocols intended to prevent crisis in current clientele as well as improve accessibility to community services for non-clients at risk of requiring inpatient treatment and the criminal justice and hospital resources that entails. Although new programs may be designed, emphasis will also be placed upon protocols within and between current programs. Medication compliance will be measured in individuals with Schizophrenia.

Providing 3100 crisis services per year in Region, Border Region needs to implement programs not just to respond to crisis, but to prevent them. Through analysis of existing data and gap analysis, trends will be identified and interventions planned through Plan-Do-Study-Act quality improvement cycles.

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

- Define, describe populations with high use of services in ER, criminal justice and state hospital settings
- Design an intervention to target population for the purpose of preventing unnecessary use of services.
- Ongoing Evaluation and process redesign as indicated by real-time data

This project incorporates resources from the Pass 1 projects (telemedicine, expanded workforce and integrated primary/behavioral healthcare) to make it effective and will also serve the Pass 1 s over-arching goals of reducing potentially preventable readmissions as well as the Pass 2 goals of reducing ED utilization. These resources, identified as needed in current Border Region strategic planning, will figure prominently as the gap analysis is addressed. The expanded workforce, telemedicine and primary care will be tools for the program designers as they addressed in-crisis management and crisis prevention.

### **Challenges:**

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

Utilization of high-cost and/or low efficacy but easy access (criminal justice, ED) sources is increasing.

Lack of staff experienced in the design of programs tailored toward specific target groups.

To address these challenges Border Region will:

- Initiate stakeholders meetings as part of the gap analysis to identify strategies productive community partnerships.
- Employ telemedicine technology to reduce the number of hospital admissions which could have been handled by other means
- Expand use of Mobil Crisis Intervention teams
- Expert consultants will be contracted to train staff and provide periodic feedback on implementation of new programs

### **5 Year Expected Outcome:**

Populations of high utilizers are defined and receiving appropriate interventions.

Use of ER/criminal justice and state hospitals for persons with behavioral health issues is reduced.

Frequency of crisis interventions is reduced

Systems which can be tested for reliability are introduced.

Expected client impact from this program is: DY2 -820 clients, DY3 – 957 clients, DY4 – 1094 clients, DY5- 1368 clients.

## **Starting Point/Baseline**

Users of ER, criminal justice and State Hospital is defined solely as being “in crisis” which implies they are a danger to themselves and others. Inpatient admissions for 2012 are expected to be greater than 500. No attempt is made at defining connecting causative factors between admitted individuals or even defining correlative behaviors/histories. There is no predictive work to draw upon to determine who may be at risk. Currently, Webb County experiences about 500 inpatient admissions per year (adult and child) with the attendant drawing upon criminal justice and hospital resources. Over one thousand crisis encounters were delivered in the time covered by DSRIP year 1.

Admission, LOS records are available for inpatient stays. All outpatient encounters including jail diversion are captured along with outpatient psychiatric medication histories. Supported Housing and Supported Employment programs are also already in place and have been for over 20 years.

## **Rationale**

Current crisis management systems are insufficient to meet the burgeoning numbers of persons presenting themselves for crisis. Admissions and associated costs of inpatient admissions are unsustainable levels. New approaches are needed to assure that more people in crisis can remain in the community.

## **Project Components:**

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

- a) Assess size; characteristics and needs of target population(s) for chronic physical health conditions, chronic or intermittent homelessness, and cognitive issues resulting from severe mental illness and/or forensic involvement. Process measure P-1.1
- b) Review literature/experience with population similar to target population to determine community-based intervention that are effective in averting negative outcomes such as repeated or extended psychiatric hospitalization, decreased mental and physical functioning status, nursing facility admission, forensic encounters and in promoting correspondingly positive health and social outcomes / quality of life. Process measure P.2.1
- c) Develop project evaluation plan using qualitative and quantitative metrics to determine outcomes. Process measure P-2.1
- d) Design models which include an appropriate range of community-based services and residential supports. Process measure P-3.1
- e) Assess the impact of intervention based on standardized quantitative measures and qualitative analysis relevant to the target population. Data sources to include: standardized assessment of functional, mental and health status; medical, prescription drug and claims/encounter records; participant surveys; provider surveys. Identify “lessons learned,” opportunities to scale all or part of the intervention(s) to a broader patient population and identify key challenges associated with expansion of the

intervention, including special consideration for safety-net populations. Proves measure P-4.1

**Unique community need identification number the project addresses:**

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

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

Traditionally reduction in the use of ER, criminal justice and State hospital use has centered around the diverting the individual at the time of crisis. This project will expand that scope to define better at-risk populations and design new programs tailored to the needs of these individuals.

Border Region has historically operated under contract with the State of Texas and has delivered program as dictated by contract terms. Funding for development of programs or initiatives not contract specified has never been available. This project represents an opportunity for Border Region to expand services in ways targeted to specific demographic, cultural and clinical parameters identified for our area. It will also afford opportunity and motivation for staff to learn from contractors and research not previously available.

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

OD- 9 Right Care, Right Setting

IT-9.2 2 Reduce Emergency Department visits for target condition (Behavioral Health/Substance Abuse)

The local Emergency Room is the first point of contact for crisis management. This typically involves law enforcement and hospital resources. As the goal of this project is crisis prevention, a practical outcome of a successful program would be less reliance on ER resources.

**Relationship to other Projects**

This project can be considered an extension of project 1.13 which deals with gaps analysis and redesign of the current crisis system. This project will utilize data generated from project 1.13 and may serve many of the same people, but will design a service system that goes beyond the handling of people in crisis and attempts a broader range of interventions. The execution of this project will be amplified by resources made available in the other projects: Expanded telemedicine system (1.11.2), Enhance workforce (1.14.1) and primary care and behavioral health integration (2.15.2).

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

This project operates independently of other Performing providers in the RHP.

### **Plan for Learning Collaborative**

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

### **Project Valuation:**

Project valuation is based on determining reduced costs in the ER costs, psychiatric inpatient days, criminal justice expenses (court, sheriff and police), lost school attendance, reduced transportation costs (at least half of inpatient admissions must be treated in San Antonio or facilities at least 150 miles from service area), lost time and wages from client's employment, More efficient operations of behavioral health enter due to a decrease in "management by crisis". Improved overall client satisfaction due to other clients not having to wait while staff and doctors attend to crises.

<b>UNIQUE IDENTIFIER:</b> 121989102.2.2 (Pass 2)	<b>RHP PREFERENCE NUMBER:</b> 2.13.1	<b>PROJECT COMPONENTS:</b> 2.13.1 [A-H]	Design, implement and evaluate research-supported and evidence-based intervention tailored towards individuals in the target population.	
Performing Provider Name: Border Region Behavioral Health Center			TPI - 121989102	
<b>Related Category 3 Outcome Measure(s):</b> 121989102.3.5	OD-9	IT 9.2	<b>Reduce Emergency Department visits for target condition (Behavioral Health/Substance Abuse)</b>	
<b>Year 2</b> (10/1/2012 – 9/30/2013)	<b>Year 3</b> (10/1/2013 – 9/30/2014)	<b>Year 4</b> (10/1/2014 – 9/30/2015)	<b>Year 5</b> (10/1/2015 – 9/30/2016)	
<p><b>Milestone 1 [P-1]:</b> Conduct needs assessment of complex behavioral health populations who are frequent users of community public health resources.</p> <p><u>Metric 1</u> [P-1.1]: Numbers of individuals, demographics, location, diagnoses, housing status, natural supports, functional and cognitive issues, medical utilization, ED utilization</p> <p>Data Source: Project documentation</p> <p>Baseline: Over 3000 crisis per year. Data sources exist and are being analyzed.</p> <p>Goal: Patterns of frequent use are identified according to parameters specified.</p> <p>Milestone 1 Estimated Incentive Payment (<i>maximum amount</i>): \$980,344</p>	<p><b>Milestone 2 [P-2]:</b> Design community-based specialized interventions for target populations.</p> <p><u>Metric 1</u> [P-2.1]: Project plans which are based on evidence/experience and which address the project goals</p> <p>Data Source: Project documentation Baseline: Needs assessment has been completed.</p> <p>Goal: Project plans completed are completed and relate to needs identified in Milestone #1. Staff are trained and competent, project implementation begins.</p> <p>Milestone 2 Estimated Incentive Payment: \$470,150</p> <p><b>Milestone 3 [P-3]</b> Enroll and serve individuals with targeted complex needs such as chronic physical health conditions, chronic intermittent homelessness, cognitive issues resulting from severe mental illness, forensic involvement, resulting in</p>	<p><b>Milestone 4 [P-4]:</b> Evaluate and continuously improve interventions.</p> <p><u>Metric 1</u> [P-4.1] Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles</p> <p>Data Source: Project documentation</p> <p>Baseline: Project plans completed, service began <b>Goal:</b> Improvement cycles yield actionable steps with evidence of implementation</p> <p>Milestone 4 Estimated Incentive Payment: \$313,433</p> <p><b>Milestone 5 [I-3]:</b> Adherence to Anti-psychotics for individuals with Schizophrenia</p> <p><u>Metric 1</u> [I-3.1] % of individuals with Schizophrenia receiving the specialized interventions who are prescribed an anti-psychotic Rx that had a Proportion of Days Covered (PDC) for antipsychotic medications greater &gt;= 0.8 during the</p>	<p><b>Milestone 7 [P-4]</b> Evaluate and continuously improve interventions.</p> <p><u>Metric 1</u> [P-4.1] Project planning and implementation documentation demonstrates plan, do, study act quality improvement cycles</p> <p>Data Source: Project documentation</p> <p><b>Baseline:</b> Project plans completed, service began/<b>Goal:</b> Improvement cycles yield actionable steps with evidence of implementation</p> <p>Milestone 7 Estimated Incentive Payment: \$ 278,607</p> <p><b>Milestone 8 [I-3]</b> Adherence to Anti-psychotics for individuals with Schizophrenia</p> <p><u>Metric 1</u> [I-3.1] % of individuals with Schizophrenia receiving the specialized interventions who are prescribed an anti-psychotic Rx that had a proportion of Days Covered (PDC) for antipsychotic medications greater &gt;= 0.8 during the</p>	

<b>UNIQUE IDENTIFIER:</b> 121989102.2.2 (Pass 2)	<b>RHP PREFERENCE NUMBER:</b> 2.13.1	<b>PROJECT COMPONENTS:</b> 2.13.1 [A-H]	Design, implement and evaluate research-supported and evidence-based intervention tailored towards individuals in the target population.	
Performing Provider Name: Border Region Behavioral Health Center			TPI - 121989102	
<b>Related Category 3 Outcome Measure(s):</b> 121989102.3.5	OD-9	IT 9.2	<b>Reduce Emergency Department visits for target condition (Behavioral Health/Substance Abuse)</b>	
<b>Year 2</b> (10/1/2012 – 9/30/2013)	<b>Year 3</b> (10/1/2013 – 9/30/2014)	<b>Year 4</b> (10/1/2014 – 9/30/2015)	<b>Year 5</b> (10/1/2015 – 9/30/2016)	
	<p>extended or repeated stays at inpatient psychiatric facilities.</p> <p><b>Metric 1 [P-3.1]:</b> Number of targeted individuals enrolled/served in the project</p> <p>Data Source: Project documentation/ HR training roster documentation</p> <p>Baseline: 3180 clients served in crisis in baseline year</p> <p>Goal: Number of crisis in year does not increase over baseline</p> <p>Milestone 3 Estimated Incentive Payment: \$470,149</p>	<p>measurement period.</p> <p><b>Data Source:</b> Medication records in client medical record</p> <p><b>Baseline:</b> % of individuals with Schizophrenia on record/</p> <p><b>Goal:</b> Medication Possession Ratios are reported for target population. % of clients &gt;0.8 at least 70%</p> <p>Milestone 5 Estimated Incentive Payment: \$313,433</p> <p><b>Milestone 6 [I-5] Functional Status</b></p> <p><b>Metric 1 [I-5.1]</b> % of individuals receiving specialized intervention who demonstrate improved functional status on standardized instruments</p> <p><b>Data Source:</b> Client functional assessment tool</p> <p><b>Baseline:</b> 27% in FY 12 show improvement/<b>Goal:</b> 35% over FY12</p>	<p>measurement period.</p> <p><b>Data Source:</b> Medication records in client medical record</p> <p><b>Baseline:</b> % of individuals with Schizophrenia on record/<b>Goal:</b> Medication Possession Ratios are reported for target population. % of clients &gt;0.8 at least 75%</p> <p>Milestone 8 Estimated Incentive Payment: \$ 278,607</p> <p><b>Milestone 9 [I-5] Functional Status</b></p> <p><b>Metric 1 [I-5.1] TBD</b> % of individuals receiving specialized intervention who demonstrate improved functional status on standardized instruments</p> <p><b>Data Source:</b> Client functional assessment tool</p> <p><b>Baseline:</b> DY4 results/<b>Goal:</b> 20% over DY4</p> <p>Milestone 9 Estimated Incentive Payment: \$ 278,607</p>	

<b>UNIQUE IDENTIFIER:</b> 121989102.2.2 (Pass 2)	<b>RHP PREFERENCE NUMBER:</b> 2.13.1	<b>PROJECT COMPONENTS:</b> 2.13.1 [A-H]	Design, implement and evaluate research-supported and evidence-based intervention tailored towards individuals in the target population.	
<i>Performing Provider Name: Border Region Behavioral Health Center</i>			TPI - 121989102	
<b>Related Category 3 Outcome Measure(s):</b> 121989102.3.5	OD-9	IT 9.2	<b>Reduce Emergency Department visits for target condition (Behavioral Health/Substance Abuse)</b>	
<b>Year 2</b> (10/1/2012 – 9/30/2013)	<b>Year 3</b> (10/1/2013 – 9/30/2014)	<b>Year 4</b> (10/1/2014 – 9/30/2015)	<b>Year 5</b> (10/1/2015 – 9/30/2016)	
		Milestone 6 Estimated Incentive Payment: \$ 313,433		
<b>Year 2 Estimated Milestone Bundle Amount: \$ 980,344</b>	<b>Year 3 Estimated Milestone Bundle Amount: \$ 940,299</b>	<b>Year 4 Estimated Milestone Bundle Amount: \$ 940,299</b>	<b>Year 5 Estimated Milestone Bundle Amount: \$ 835,821</b>	
<b>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5): \$ 3,696,763</b>				

## **Title of Outcome Measure (Improvement Target)**

**Title:** IT 9.2 ED appropriate utilization

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

**Unique RHP ID#:** 121989102.3.5 (Pass 2)

## **Outcome Measure Description:**

The Category 3 project chosen is IT 9.2 Reduce Emergency Department visits for target condition (Behavioral Health/Substance Abuse)

### **Process Milestones:**

- DY2: P-1 Project Planning. Engage Stakeholders, identify capacity, needed resources, establish timelines and document plan implementation
- DY3: P-4 Plan, Do, Study Act cycles to improve data collection, implementation

### **Outcome Improvement Target:**

- DY4: IT-9.2 Reduce Emergency Department visits for Behavioral Health / Substance Abuse
- DY5: IT-9.2 Reduce Emergency Department visits for Behavioral Health / Substance Abuse

## **Rationale**

The Emergency Department plays a central role in the current crisis treatment systems. Being the second public resource in the progression of crisis intervention activities; it usually means the police (the first public resource) have already been utilized. The third public resource (community mental health) is then utilized to determine if inpatient services are warranted and should be authorized. As an indicator of the effectiveness of outpatient programs to reduce crisis events, the use of the Emergency room visits and reduction in hospitalization is an important parameter of the effectiveness of outpatient interventions.

This Category 3 quality improvement project will provide additional input to conduct the ongoing evaluation of the gap analysis and result in an improvement plan from the corresponding Category 1 project 1.13.1: Develop and implement crisis stabilization services to address the identified gaps in the current community crisis system.

The process milestones directly service the Region 20 goal of nurturing a culture of ongoing quality improvement and innovation that maximizes the use of technology and best-practices to improve access and timely utilization of appropriate care, including behavioral health services, particularly in our rural communities.

## **Outcome Measure Valuation**

The population included in these projects is the entire adult and child/adolescent population of Border Region Behavioral Health Center clinic in Webb County. The clinic has an active enrollment of approximately 1,500 adult and 600 child/adolescent clients and the county has a population of 235,000. This allows both evaluation of new crisis planning on the enrolled

population, plus permits the evaluation of non-enrolled persons as consumers of public resources in a behavioral crisis situation.

As each Border Region intervention at the emergency represents three public resources (police, hospital and Border Region) and costs per intervention can be reasonably determined for each, then any reduction in ER use from baseline represents a combined savings for these three resources. Any inpatient costs reductions following reduction Emergency Department use also represents a value attributed the interventions of these projects.

<i>Unique Cat 3 ID: 121989102.3.5 (Pass 2)</i>	<i>Ref Number from RHP PP: IT 9.2</i>	<i>PROJECT TITLE: ED appropriate utilization</i>	
<i>Border Region Behavioral Health Center</i>			121989102.3.5
<b>Related Category 1 or 2 Projects:</b>	121989102.2.2 & 121989102.1.3		
<b>Starting Point/Baseline:</b>	No GAP analysis of Crisis Services has been implemented. Webb County provides over 3100 crisis interventions per year.		
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>
<b>Process Milestone 1 [P-1]:</b> Project Planning – engage stakeholders, identify current capacity and needed resources, determine time lines and document implementation plans.  Data Source: Attendance Rosters and meeting summary documents.  Process Milestone 1 Estimated Incentive Payment \$51,597	<b>Process Milestone 2 [P-4]:</b> Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities  Data Source: Facility minutes, documented reports.  Process Milestone 2 Estimated Incentive Payment \$104,478	<b>Outcome Improvement Target 1 [IT 9.2]</b> Reduce Emergency Department visits for Behavioral Health / Substance Abuse.  Improvement Target: 10% decrease in number of ED visits from DY2 baseline  Data Source: Admissions data from CARE system, Anasazi client record system encounter data  Outcome Improvement Target 1 Estimated Incentive Payment: \$104,478	<b>Outcome Improvement Target 2 [IT 9.2]</b> Reduce Emergency Department visits for Behavioral Health / Substance Abuse  Improvement Target: 30% decrease in number of ED visits from DY4  Data Source: Admissions data from CARE system, Anasazi client record system Encounter  Outcome Improvement Target 2 Estimated Incentive Payment: \$208,955
<b>Year 2 Estimated Milestone Bundle Amount: \$51,597</b>	<b>Year 3 Estimated Milestone Bundle Amount: \$ 104,478</b>	<b>Year 4 Estimated Milestone Bundle Amount: \$ 104,478</b>	<b>Year 5 Estimated Milestone Bundle Amount: \$ 208,955</b>
<b>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5): \$469,508</b>			

## **Project Summary:**

Unique Project Identifier: 121990904.2.1 (Region 20 Pass 1)

Provider Name/TPI: Camino Real Community Services/121990904

Provider Description: Camino Real Community Services is a Local Mental Health Authority that provides outpatient mental health services to child, adolescent, and adult patients with severe and persistent mental illness. The provider is located in a 10,000 square mile rural service area with a total population of approximately 206,777. In 2012, the Center provided services to 3,538 adults and children that met the criteria for services. The Mental Health Operating budget is approximately 6.9 million dollars. The programs work closely with schools, health centers, hospitals, law enforcement, judiciary/local officials to coordinate the provision of services.

Intervention(s): Project will integrate psychiatric and primary health care services

Need for the project: There are no integrated physical and behavioral health care models that currently exist in the targeted area that address services for the serious and persistent mental illness (SPMI) population and those requiring primary medical care services, so providing this integrated physical and behavioral health care services model will assist with this gap.

Target population The target population is patients in Maverick County who receive psychiatric services who also have chronic health conditions. Maverick County designated as medically underserved and as healthcare professional shortage area. There is a high incidence of obesity, diabetes, and chronic health conditions that are exacerbated by the mental illness conditions that challenge compliance with prescribed interventions. Texas Department of State Health Services, 2009 Health Facts Profile for Maverick County reports 29.8% of the population living below Poverty and 35% is without Health Insurance. Maverick County has also been designated as a health professional shortage area and mental health professional shortage area by the Health Resources and Services Administration. Maverick County has 25% of the population living below poverty and 35 % are without medical insurance. The Medicaid % is 55. The project will serve the indigent and Medicaid population. There are no federal initiatives that will be expanded with this project.

Category 1 or 2 expected patient benefits: In DY4 & DY5, the project seeks to serve 100-150 patients in an integrated setting demonstrating improved outcomes in managing behavioral and chronic medical conditions.

Category 3 outcomes expected patient benefits: IT-6-1 Patient Satisfaction: Our goal is to improve patients getting timely care, appointments and information that result in better health outcomes for the patient.

## **Identifying Project and Provider Information**

**Project Option:** 2-15-1 Design, implement, and evaluate projects that provide integrated primary and behavioral health care services

**Unique RHP ID#:** 121990904.2.1

**Performing Provider/TPI:** Camino Real Community Services/121990904

### **Project Description**

**Brief Description:** The goal for this project is to co-locate primary care and behavioral health care services in order to improve integration of care and improve access to needed services. The importance of simultaneously addressing the physical health needs and the behavioral health needs of individuals has become recognized over the past three decades. This project aligns with the Regional goal of improving health care by integrating critical psychiatric and primary care services. The project seeks to serve 100-150 patients in an integrated setting demonstrating improved outcomes in managing behavioral and chronic medical conditions.

In selecting project option 2.15.1, Design, implement, and evaluate projects that provide integrated primary and behavioral health care services, Camino Real seeks to improve overall health outcomes for its targeted population and will implement the following required core components:

- a) Identify sites for integrated care projects, which would have the potential to benefit a significant number of patients in the community. Camino Real will identify provider sites that provide the greatest proximity and accessibility to target population thru survey of the community.
- b) Develop provider agreements whereby co-scheduling and information sharing between physical health and behavioral health providers could be facilitated. This will be accomplished by meeting with primary medical providers and determining capacity and willingness to establish an integrated model to serve target population to include information sharing and scheduling processes.
- c) Establish protocols and processes for communication, data-sharing, and referral between behavioral and physical health providers. Camino Real will work with primary care providers to establish processes and protocols to accomplish integration with all aspects of care. Information technology components will identify potential for exchange of patient care data.
- d) Recruit a number of specialty providers to provide services. Camino Real will establish employment or contractual relationships with primary care providers to serve target population in specified location.
- e) Train physical and behavioral health providers in protocols, effective communication and team approach by building a shared culture of treatment to include specific protocols and methods of information sharing. Camino Real will conduct the following:
  - 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. Camino Real will work with its primary care provider partners in acquiring data reporting, communication and collection tools that can be shared.

- g) Explore the need for and develop any necessary legal agreements that may be needed in a collaborative practice. Camino Real will seek legal consultation to address the development of necessary agreements.
- h) Arrange for utilities and building services for these settings. Camino Real will negotiate with its provider partners to develop colocation logistics (building services/utilities/etc).
- 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. Camino Real will work with its provider partners to identify software that can readily track data elements required and report utilization and health outcomes.
- j) Conduct quality improvement for project using methods such as rapid cycle improvement. As a part of the negotiation with primary care providers, methods for identifying lessons learned and project impact will be agreed upon and data tools developed to obtain the information. Camino Real will seek to expand project to broader patient base.

The first year of the project will focus on assessment of the need/gap analysis, which will lead to planning and implementation of the services in the 2<sup>nd</sup> and 3<sup>rd</sup> years. The outcome improvement target expected for the 4<sup>th</sup> year includes an improvement over the baseline of patient satisfaction for patients getting timely care, appointments, information and integrated services. The outcome improvement target expected for the 5<sup>th</sup> year includes an improvement over the baseline of patient satisfaction as stated above and improvement for the patient's rating of the doctor's access to a specialist. There are no integrated medical and behavioral health care models that currently exist in the targeted area that address services for the serious and persistent mental illness (SPMI) populations and those requiring primary medical care services, so providing this integrated physical and behavioral health care services model will assist with this gap in services.

### **Starting Point/Baseline**

Currently, the baseline is zero as integrated Behavioral Health and Primary Care sites do not exist in Maverick County. The baseline will be established in DY 2.

### **Rationale**

By selecting project option 2.15.1 and addressing all core components, Camino Real Community Services seeks to improve overall wellness for persons with mental illness by mutually integrating primary care and behavioral health care access for those individuals requiring this level of care. National statistics indicate persons with mental illness die an average of 25 years earlier than the general population due to poor or inadequate access to primary health care. The counties identified for this project are designated as medically underserved and as healthcare professional shortage areas. There is a high incidence of obesity, diabetes, and chronic health conditions that are exacerbated by the mental illness conditions that challenge compliance with prescribed interventions. Texas Department of State Health Services, 2009 Health Facts Profile for Maverick County reports 29.8% of the population living below Poverty and 35% is without Health Insurance. Maverick County has also been designated as a health professional shortage area and mental health professional shortage area by the Health Resources and Services Administration.

According to a recent study released by the Robert Wood Johnson Foundation, only 33% of patients with behavioral health conditions (24% of the adult population) receive adequate treatment. Patients with behavioral health issues experience higher risk of mortality and poor health outcomes, largely due

to a lack of preventive health services and poorly controlled co-morbid medical disease. Risk increases with the severity of the behavioral health diagnoses. Behavioral health conditions, also account for increased health care expenditures such as higher rates of potentially preventable inpatient admissions. Texas Medicaid data on potentially preventable inpatient readmissions demonstrates that behavioral health conditions are a significant driver of inpatient costs.

Currently Behavioral and Primary Care providers operate in silos in Maverick County. This new initiative will facilitate the integration of behavioral health and physical health care services, and opportunities to address both conditions during a single visit are vastly increased. Co-location, when coupled with protocols, training, technology and team building has the potential to improve communications between providers and enhance coordination of care. Additionally, access to care is enhanced because individuals do not have to incur the cost or inconvenience of arranging transportation or making multiple trips to different locations to address physical and behavioral health care needs.

### **Related Community Need**

The integration of behavioral health and physical health care services addresses Community need (CN2) in Region 20.

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

The Category 3 Outcome Measure selected for the Camino Real Community Services Integrating Primary and Behavioral Health Care Services Project is OD-6 Patient Satisfaction. We intend to use the CG-CAHPS or other standardized survey to measure improvement over the baseline of patient satisfaction scores in the following two areas. Patient surveys will include patient satisfaction for getting timely care, appointments, and information, and patient satisfaction for the patient's rating of the doctor's access to a specialist. Obtaining patient feedback on our ability to provide timely care, appointments and information is critical to the success of this project. Patients having access and receiving the appropriate behavioral and primary health care in one integrated setting provides the opportunity for overall patient health and wellness as well as patient satisfaction. We expect the number of individuals receiving and reporting satisfaction in Years 4 and 5, with both physical and behavioral health care at the established locations will show improvement over the baseline and provide us with meaningful and objective information that will be used to determine opportunities for improvement. People living with serious mental illnesses are dying on average 25 years earlier than the rest of the population, in large part due to unmanaged physical health conditions. Many people with We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 20, Webb County. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system. Both physical and behavioral health illnesses can benefit from immediate attention to both conditions as well as prevention efforts, screening tests, routine check-ups, and treatment through an integrated approach.

Assessing patient satisfaction with access to the appropriate care including both primary care and behavioral health care specialists will assist in measuring the success of integrating primary and behavioral health care services.

### **Relationship to other Projects**

Camino Real is proposing one project in Region 20 with the unique RHP # of (121990904)2.1. It is Category 2.15.1 Integrate Primary and Behavioral Health Care Services with Quality Improvement 3.IT-6.1 Patient Satisfaction.

It relates to other projects in the region by addressing the need for increasing access to comprehensive integrated primary care and behavioral health care services. Better health care outcomes for individuals with co-morbid chronic illness and mental illness, will translate into decrease health care costs by reducing use of high cost institutional care systems.

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

The project selected by Camino Real is related to Category 2 project by Border Region (2.1) that seeks to integrate primary and behavioral health services for persons with co-morbid conditions.

### **Plan for Learning Collaborative**

We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 20. 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 integration project is valued on a cost avoidance basis. It is well documented that persons with co-morbid chronic illnesses and behavioral problems greatly increase the cost of health care. In its presentation at the 2012 National Conference for Community Behavioral Health Services, the Substance Abuse and Mental Health Services Administration (SAMHSA) reported that the average monthly expenditure for a person with a chronic disease and depression is \$560 more than for a person without depression. It was also reported that an HMO claims analysis found that general medical costs were 40 % higher for people treated with bipolar disorder than those without it. Co-morbid anxiety is \$710 more than for those without mental illness. In addition, Health Management Associates in their March 2011 *Impact of Proposed Budget Cuts to Community-Based Mental Health Services* presented to the Texas Conference of Urban Counties, reported the average per day cost of community based services is \$12 for adults and \$13 for children, as compared to \$401 for a State Hospital bed, \$137 for a jail bed for an inmate with mental illness, and \$986 for an emergency room visit.

The March 2007 Medical Expenditure Panel Survey, Statistical Brief #166 reports the average expenditure for an office-based physician visit was \$155 while the median visit expenditure was \$72. Among the specialty types examined, average expenses per visit were lowest for primary care providers, pediatricians and psychiatrists. Addressing physical health and behavioral health conditions in an integrated community setting will greatly decrease utilization of higher cost service environments. Provision of comprehensive psychiatric and primary care services in the local community is not only cost effective but more user friendly and convenient for the person with co-morbid conditions.

<b>UNIQUE IDENTIFIER:</b> 121990904.2.1	<b>RHP PP Reference Number:</b> 2.15.1	<b>PROJECT COMPONENT</b> 2.15.1(A-J)	<b>Project Title: Integrate Primary and Behavioral Health Care Services</b>	
Performing Provider Name: Camino Real Community Services			TPI: 121990904	
<b>Related Category 3 Outcome Measure(s):</b>	121990904.3.1	IT-6.1	Patient Satisfaction	
<b>Year 2</b> (10/1/2012 – 9/30/2013)	<b>Year 3</b> (10/1/2013 – 9/30/2014)	<b>Year 4</b> (10/1/2014 – 9/30/2015)	<b>Year 5</b> (10/1/2015 – 9/30/2016)	
<p><b>Milestone 1 [P-1]:</b> Conduct needs assessment to determine areas of the state where the co-location of services has the potential to benefit a significant number of people who have physical/behavioral health needs.</p> <p><b>Metric 1 [P-1.1]:</b> Numbers of patients in various areas who might benefit from integrated services. Demographics, location, &amp; diagnoses</p> <p>Baseline/Goal: Baseline is zero Data Source: Inpatient, discharge and ED records; survey of primary care providers; survey of behavioral health providers; state demographic information relating to treated health conditions; Medicaid claims data</p> <p>Milestone 1 Estimated Incentive Payment (<i>maximum amount</i>): <b>\$189,894</b></p> <p><b>Milestone 2 [P- 2]:</b> Identify existing clinics or other community-based settings where the co-location of services could be supported. It is expected that physical health practitioners will share space in existing behavioral health settings,</p>	<p><b>Milestone 4 [P-6]:</b> Develop integrated behavioral health and primary care services within co-located sites. <b>Metric 1 [P-6.1]:</b> Number of providers achieving Level 4 of interaction (close collaboration in a partially integrated system).</p> <p>Goal: 1 primary care and 1 mental health care provider will provide integrated care to 5% of individuals that meet established criteria</p> <p>Data Source: Project data</p> <p>Milestone 4 Estimated Incentive Payment: <b>\$594,302</b></p>	<p><b>Improvement Milestone 5 [I-8]:</b> Integrated Services</p> <p><b>Metric 1 [I-8.1]</b> 10% of Individuals receiving both physical and behavioral health care at the established locations.</p> <p>Goal: Provide integrated care to 10% of individuals that meet established criteria</p> <p>Data Source: Project data; claims and encounter data; medical records</p> <p>Milestone 5 Estimated Incentive Payment: <b>\$300,223</b></p> <p><b>Improvement Milestone 6 [I-9]:</b> Coordination of Care <b>Metric 1 [I-9.1]:</b> 10% of Individuals with a treatment plan developed and implemented with primary care and behavioral health expertise</p> <p>Goal: Provide integrated care to 10% of individuals that meet established criteria</p> <p>Data Source: Project data; claims and encounter data; medical records</p>	<p><b>Improvement Milestone 7 [I-9]:</b> Coordination of Care <b>Metric 1 [I-9.1]:</b> 20% of Individuals with a treatment plan developed and implemented with primary care and behavioral health expertise</p> <p>Goal: Provide integrated care to 20% of individuals that meet established criteria</p> <p>Data Source: Project data; claims and encounter data; medical records</p> <p>Milestone 7 Estimated Incentive Payment: <b>\$307,133</b></p> <p><b>Improvement Milestone 8 [I-8]:</b> Integrated Services <b>Metric 1 [I-8.1]:</b> 20% of Individuals receiving both physical and behavioral health care at the established locations.</p> <p>Goal: Provide integrated care to 20% of individuals that meet established criteria</p> <p>Data Source: Project data; claims and encounter data; medical records</p>	

<b>UNIQUE IDENTIFIER:</b> 121990904.2.1	<b>RHP PP Reference Number:</b> 2.15.1	<b>PROJECT COMPONENT</b> 2.15.1(A-J)	<b>Project Title: Integrate Primary and Behavioral Health Care Services</b>	
Performing Provider Name: Camino Real Community Services			TPI: 121990904	
<b>Related Category 3 Outcome Measure(s):</b>	121990904.3.1	IT-6.1	Patient Satisfaction	
<b>Year 2</b> <b>(10/1/2012 – 9/30/2013)</b>	<b>Year 3</b> <b>(10/1/2013 – 9/30/2014)</b>	<b>Year 4</b> <b>(10/1/2014 – 9/30/2015)</b>	<b>Year 5</b> <b>(10/1/2015 – 9/30/2016)</b>	
<p>but it may also be possible to include both in new settings and for physicians to share their office space with behavioral health practitioners.</p> <p><u>Metric 1</u> [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</p> <p>Baseline/Goal: Baseline is zero</p> <p>Data Source: Information from persons interviewed.</p> <p>Milestone 2 Estimated Incentive Payment (<i>maximum amount</i>): <b>\$189,894</b></p> <p><b>Milestone 3</b> [P-4]: Assess ease of access to potential locations for project implementation</p> <p><u>Metric 1</u> [P-4.1]: Access to major roadways, bus routes, or proximity to a large number of individuals who may benefit from services</p> <p>Baseline/Goal: Baseline is zero</p>		Milestone 6 Estimated Incentive Payment: <b>\$300,222</b>	Milestone 8 Estimated Incentive Payment: <b>\$307,133</b>	

<b>UNIQUE IDENTIFIER:</b> 121990904.2.1	<b>RHP PP Reference Number:</b> 2.15.1	<b>PROJECT COMPONENT</b> 2.15.1(A-J)	<b>Project Title: Integrate Primary and Behavioral Health Care Services</b>	
Performing Provider Name: Camino Real Community Services			TPI: 121990904	
<b>Related Category 3 Outcome Measure(s):</b>	121990904.3.1	IT-6.1	Patient Satisfaction	
<b>Year 2</b> <b>(10/1/2012 – 9/30/2013)</b>	<b>Year 3</b> <b>(10/1/2013 – 9/30/2014)</b>	<b>Year 4</b> <b>(10/1/2014 – 9/30/2015)</b>	<b>Year 5</b> <b>(10/1/2015 – 9/30/2016)</b>	
and will be defined in DY2 Data Source: City/County data, maps, demographic data relating to prevalence of health conditions.  Milestone 3 Estimated Incentive Payment ( <i>maximum amount</i> ): <b>\$189,894</b>				
<b>Year 2 Estimated Milestone Bundle Amount: : \$569,682</b>	<b>Year 3 Estimated Milestone Bundle Amount: \$594,302</b>	<b>Year 4 Estimated Milestone Bundle Amount: \$600,445</b>	<b>Year 5 Estimated Milestone Bundle Amount: \$614,266</b>	
<b>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over DYs 2-5): \$2,378,695</b>				

## **Title of Outcome Measure (Improvement Target)**

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

**Performing Provider name/TPI:** Camino Real Community Services/121990904

**Unique RHP ID#:** 121990904.3.1

## **Outcome Measure Description:**

OD-6 Patient Satisfaction

IT-6.1 Percent improvement over baseline of patient satisfaction scores

## **Process Milestones:**

- DY2:
  - P- 1 Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
  - P- 2 Establish baseline rates
- DY3:
  - P- 3 Develop and test data systems
  - P- 4 Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities

Year 2 and Year 3's focus is project planning, start-up, developing and documenting implementation plans as well as establishing baselines. Identifying existing clinics and other community-based settings where the co-location of services can be supported and engaging the right stakeholders is also critical to the success of this project.

## **Outcome Improvement Targets for Each Year:**

- DY4:
  - Includes an improvement over the baseline of patient satisfaction for patients getting timely care, appointments, and information.
- DY5:
  - Includes an improvement over the baseline of patient satisfaction for the patient's rating of the doctor's access to a specialist.

## **Rationale**

The process milestones for this project include project planning which will involve engagement of stakeholders, identifying current capacity of primary and behavioral health specialists and identifying where additional resources are required, establishing timelines and documenting implementation plans, as well as establishing baseline rates. In addition, identifying, developing and testing data systems will provide the basis for Patient surveys will include patient satisfaction for getting timely care, appointments, and information, and patient satisfaction for the patient's rating of the doctor's access to a specialist. Obtaining patient feedback on our ability to provide timely care, appointments and information is critical to the success of this project. Patients having access and receiving the appropriate behavioral and primary health care in one integrated setting provides the opportunity for overall patient health and wellness as well as patient satisfaction. We expect the number of individuals receiving and reporting satisfaction in Years 4 and 5, with both physical and behavioral health care at

the established locations will show improvement over the baseline and provide us with meaningful and objective information that will be used to determine opportunities for improvement.

### **Outcome Measure Valuation**

The integration project is valued on a cost avoidance basis. It is well documented that persons with co-morbid chronic illnesses and behavioral problems greatly increase the cost of health care. In its presentation at the 2012 National Conference for Community Behavioral Health Services, the Substance Abuse and Mental Health Services Administration (SAMHSA) reported that the average monthly expenditure for a person with a chronic disease and depression is \$560 more than for a person without depression. It was also reported that an HMO claims analysis found that general medical costs were 40 % higher for people treated with bipolar disorder than those without it. Co-morbid anxiety is \$710 more than for those without mental illness. In addition, Health Management Associates in their March 2011 *Impact of Proposed Budget Cuts to Community-Based Mental Health Services* presented to the Texas Conference of Urban Counties, reported the average per day cost of community based services is \$12 for adults and \$13 for children, as compared to \$401 for a State Hospital bed, \$137 for a jail bed for an inmate with mental illness, and \$986 for an emergency room visit.

The March 2007 Medical Expenditure Panel Survey, Statistical Brief #166 reports the average expenditure for an office-based physician visit was \$155 while the median visit expenditure was \$72. Among the specialty types examined, average expenses per visit were lowest for primary care providers, pediatricians and psychiatrists.

Addressing physical health and behavioral health conditions in an integrated community setting will greatly decrease utilization of higher cost service environments. Provision of comprehensive psychiatric and primary care services in the local community is not only cost effective but more user friendly and convenient for the person with co-morbid conditions.

<i>Unique Cat 3 ID: 121990904.3.1</i>	<i>Ref Number from RHP PP: IT-6.1</i>	<i>Percent improvement over baseline of patient satisfaction scores</i>	
<i>Performing Provider Name: Camino Real Community Services</i>		<i>TPI: 121990904</i>	
<b>Related Category 1 or 2 Projects:</b>	<i>Unique Category 2 identifier: 121990904.2.1</i>		
<b>Starting Point/Baseline:</b>	<i>Baseline is Zero as integrated Behavioral Health and Primary Care do not currently exist in project area</i>		
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>
<p><b>Process Milestone 1 [P-1]:</b> Project planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans</p> <p>Data Source: Information from discussions/interviews with community health care providers (physical and behavioral) and city and county governments, charities, faith based organizations and other community based helping organizations</p> <p>Process Milestone 1 Estimated Incentive Payment (<i>maximum amount</i>): \$0</p> <p><b>Process Milestone 2 [P-2]:</b> Establish baseline rates</p> <p>Data Source: Claims and encounter data, medical records</p> <p>Process Milestone 2 Estimated Incentive Payment: \$0</p>	<p><b>Process Milestone 3 [P-3]:</b> Establish plan to develop and test data systems</p> <p>Data Source: Information from discussions/interviews to understand current systems and then establish most effective systems for the programs</p> <p>Process Milestone 3 Estimated Incentive Payment: \$33,017</p> <p><b>Process Milestone 4 [P-4]:</b> Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities</p> <p>Data Source: Claims and encounters data, medical records</p> <p>Process Milestone 4 Estimated Incentive Payment: \$33,017</p>	<p><b>Outcome Improvement Target 1 [IT-6.1]:</b> Patients are getting timely care, appointments, and information including 5% improvement over future determined DY3 baseline</p> <p>Data Source: Patient survey</p> <p>Outcome Improvement Target 1 Estimated Incentive Payment: \$52,980</p> <p><b>Outcome Improvement Target 2 [IT-6.1]:</b> Patient’s rating of doctor access to specialist</p> <p>Data Source: Patient Survey</p> <p>Outcome Improvement Target 2 Estimated Incentive Payment: \$52,981</p>	<p><b>Outcome Improvement Target 3 [IT-6.1]:</b> Improvement Target: Patients are getting timely care, appointments, and information including 10% improvement over DY3 established baseline</p> <p>Data Source: Patient survey</p> <p>Outcome Improvement Target 3 Estimated Incentive Payment: \$76,783</p> <p><b>Outcome Improvement Target 4 [IT-6.1]:</b> Patient’s rating of doctor access to specialist</p> <p>Data Source: Patient Survey</p> <p>Outcome Improvement Target 4 Estimated Incentive Payment: \$76,783</p>
<b>Year 2 Estimated Outcome Amount: \$0</b>	<b>Year 3 Estimated Outcome Amount: \$66,034</b>	<b>Year 4 Estimated Outcome Amount: \$105,961</b>	<b>Year 5 Estimated Outcome Amount: \$153,567</b>
<b>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD</b> ( <i>add outcome amounts over DYs 2-5</i> ): <b>\$325,562</b>			

## **Project Summary:**

Unique Project Identifier: 137917402.2.1

Provider Name/TPI: City of Laredo Health Department (CLHD) TPI: 137917402

Provider Description: The CLHD provides disease control, prevention and public health response to the over 35% of the population that is indigent and the 40% uninsured. As a Health Resources Services Administration (HRSA) health professions shortage area and a Texas Department of State Health Services (DSHS) Medically Underserved Area (MUA) we target prevention and early detection as a priority. A dedicated effort to Patient Care and Prevention and Public Health Promotion is our chronic disease prevention especially disease self-management-Healthy Living/Viviendo Mejor (HLVM), early detection/Buena Vida.

Intervention: Category II-2.2 Expand Chronic Care Management Models-Increase Disease Self-Management (DSM) interventions in primary care to address diabetes and obesity using the CLHD model HLVM (diabetes and hypertension self-management and education; hypertension and diabetes screening; physical activity, learning healthier food choices, cooking healthier; psychosocial case management, peer education in the clinical setting). As a new effort DSM HLVM will be integrated into primary care services.

Need for the project: Category II–Laredo has 36% of the population overweight, 16% of the school age population has abnormal glucose levels, 40% of women develop gestational diabetes and eclampsia (region has a higher than state diabetes mortality& 54% of deaths in women is due to heart disease). Increasing community DSM (HLVM) and integrating DSM into primary care will reduce risks and improve healthier outcomes of persons living with diabetes and its co-morbidities (heart, cardiovascular, renal and vision disease).

Target population: This intervention will expand DSM to high risk persons and family members of persons with the disease while adding DSM into the primary care clinics where all persons are Medicaid eligible, Title V patients or uninsured indigent persons.

Category 2 expected patient benefits: Baseline 500- DY2,3 serve 25 new patients, in DY 4-40 and DY5-50; specifically:

- Will increase diabetes community DSM
- Will integrate DSM into primary care
- Will reduce hospitalization admission of newly diagnosed diabetics due to short term complications
- Will reduce a hospitalization admission due high blood pressure higher than 140/80

Category 3 outcomes expected patient benefits:OD-1Primary Care & Chronic Disease Management: IT-1.11 Diabetes Care: BP control (<140/80mmHg): Diabetes DSM and mental health preventive primary care integration services to high risk and vulnerable persons we can reduce risks, hospitalization for complications of diabetes and will reduce admissions for preventable diseases as well readmission for hospitalized patients. As a progress measure we will reduce and control the BP of diabetics and subsequent kidney and cardiovascular complications.

## **Identifying Project and Provider Information**

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

**Unique RHP ID#:** 137917402.2.1

**Performing Provider/TPI:** City of Laredo Health Department/137917402

## **Project Description**

**Brief Description:** This project will increase evidenced based disease self-management (DSM) interventions already being provided by the City of Laredo Health Department (CLHD) community diabetes prevention services (Healthy Living/Viviendo Mejor-HLVM). As a new addition it will integrate DSM into primary care services stated in Category I. This will help maximize care and prevention and reduce preventable hospitalizations as well reduce diabetes complications. The focus will continue and increase targeting persons at risk and persons with the disease to better manage their disease but will also add this in the primary care setting. All who are at risk or are diagnosed with a chronic disease will have to participate in the DSM HLVM activities. In particular, the DSM activities will include: diabetes self-management and education; hypertension self-management and education; and, hypertension and diabetes screening; HLVM services (physical activity, learning healthier food choices, cooking healthier); psycho social case management support systems; mental health care; and, peer education in the clinical setting. These efforts will enhance chronic and acute disease self-management, thereby, reducing the risk of individuals developing more serious disease, co-morbidities, and additional complications. Additionally, efforts will also increase early detection and cancer screening in underserved areas of the city and county, as well as link individuals to disease self-management services. By increasing chronic disease prevention activities, disease self-management, mental health and case management initiatives into the clinical care model, individuals will be able to understand their health conditions, the need for annual check-ups, and how to manage their disease which will improve healthier outcomes and reduce risk factors.

Critically important is to designate adequate resources to address the diabetes and obesity problem of the 36% of the population that is overweight, 16% of the school age population that has abnormal glucose levels, 45% of women with gestational diabetes (and a rising eclampsia problem). In addition Laredo has a higher than state diabetes mortality and an increase in women's death due to heart disease. Furthermore, because of the 40% uninsured and an additional 45% that is on Medicaid or Medicare that cannot access care due to a health professions shortage area, or to address lack of care due to physicians that do not accept patients on Medicaid, DSM at the community level but especially integrated into primary preventive care is essential and critically important. Adequate resources for mental health and social services case management. Promote healthier behavior and early entry into preventive care, decrease visits to the hospital and hospitalizations for complex pathology and complications of chronic disease (diabetes, cardiovascular disease and cancer). Reduce nonemergency care. Reduce costs to the hospital and promote healthier outcomes of persons without access to preventive care.

**Goals and Relationship to Region 20 Goals:** This project adds chronic disease prevention activities at the community level and adds DSM, mental health and case management into the clinical care model which is transforming our community into a healthier one. It aligns with the RHP transformation goals to improve current disease risks and management and develop a healthier community. Persons at risk and persons with disease will better understand their health, need for annual check-ups, how to manage their disease, improve healthier outcomes and reduce risk factors. DSM already in provided through the HLVM CLHD activities will increase but as a new effort will be fully integrated into primary care services stated in Category I. This will maximize care and prevention, in particular the DSM activities to be implemented and integrated are: diabetes self-management and education, hypertension self-management and education, hypertension and diabetes screening, increase healthy living/Viviendo Mejor services (physical activity, learning healthier food choices, cooking healthier), increase psycho social case management support systems, mental health care and peer education in the clinical setting. These efforts will enhance chronic and acute disease self-management (and reduce risks of person who can develop more serious disease, co-morbidities and additional complications); increase early detection and cancer screening in underserved areas of the city and county and as well link persons to disease self-management services. All of these activities are being proposed by the RHP to transform the region into a healthier one in large part of better management of one's disease and reducing risk factors. As a network of preventive health care services this is precisely what the RHP is planning.

**Project Goals are:**

- Increase diabetes disease self-management by 25 in DY2 and DY3, 40 in DY4 and 50 in DY5 (total 140)
- Integrate disease self-management into primary care services
- Train and/or add new providers and staff on the chronic disease model
- Reduce hospitalization admission of newly diagnosed diabetics due to short term complications
- Reduce a hospitalization admission due high blood pressure higher than 140/80
- Reduce risk of diabetes through early detection and disease self-management (DSM)

**Region 20 Goals:** This aligns with the RHP to increase regional diabetes disease self-management activities (cooking healthier, providing peer support and education, increase physical activity) and reduce the region's hospital visits for diabetes complications (kidney, cardiovascular and nervous system).

**Challenges/Issues:** Adequate resources to meet the need of 36% of the population that is overweight, 16% of the school age population that has abnormal glucose levels, increase in gestational diabetes and eclampsia, a higher than state diabetes mortality and an increase in women's death due to heart disease. In addition because of the 40% uninsured and an additional 45% that is on Medicaid or Medicare that cannot access care due to a health professions shortage area, or to address lack of care due to physicians that do not accept patients on Medicaid, chronic disease self-management especially integrated into primary preventive care is essential and critically important. Adequate resources for mental health and social services case management.

**Five-Year Expected Outcome for Provider and Patients:** Promote healthier behavior and early entry into preventive care, and decrease visits to the hospital and hospitalizations for complex pathology and complications of chronic disease (diabetes, cardiovascular disease and cancer). Reduce nonemergency care. Reduce costs to the hospital and promote healthier outcomes of persons without access to preventive care.

### **Starting Point/Baseline**

500 at risk patients, few providers are trained at this time

### **Rationale**

Because of the 35% indigent population, 40% uninsured and being a health professions shortage area; it is imperative that the RHP include integrating disease self-management, health education, case management and mental health into preventive primary care services to high-risk and vulnerable populations is important. Through this early effort to reduce risk and assist persons understand their disease we can transform our community into a healthier one. We can also further reduce chronic diseases, acute care, improve healthier choices, and reduce chronic and acute disease complications and co-morbidity acute illness. This preventive action can further prevent individuals from using and going to the hospital for preventable chronic and acute disease complications, co-morbidities, and acute infections, thus reducing hospitalizations and hospital and health care costs. By increasing disease self-management (including mental health and case management) in primary care, preventive care and early detection services, we can improve health outcomes, further prevent disease, reduce risks and co-morbidities, improve healthier nutrition choices, and increase physical activity. These actions, along with increased preventive care stated in Category I, will reduce healthcare costs, especially hospitalizations by improving early detection and preventive care. Moreover, this adds value to the already proven disease self-management model as it is integrated into preventive primary care. It also adds mental health and case management to assure continuity and compliance of care and improve wellness and prevention. The following has been stated in our needs assessment and through health department data: one in three adults has abnormal glucose levels (health department data); 16% of primary school age children have abnormal glucose levels (Bienestar school health data); diabetes mortality is higher than the state level; and, 50% of Title V maternity patients at the health department have gestational diabetes and/or hypertension. Through our chronic disease clinic of 700 patients, 505 have diabetes and/or hypertension.

**Project Components:** To address health disparities, obesity and diabetes we are integrating disease self-management (DSM) into primary care and at community level to better understand and manage disease/diabetes and care, as well how it impacts the human body functions, Healthy living nutritional education and cooking, Healthy living physically activity, Metabolic control education, Mental health/psychosocial support for diabetes control, and to understand the importance annual medical exams improves.

**Continuous Quality Improvements:** The CLHD will assess achievements and progress through our quality assurance program that includes peer review, medical provider review, assessment of proposed achievements, customer service and patient care response as well to monitor each

metrics of all services. In particular we will assess that at least 90% of all performance measures are met.

**Unique Community Need Identification Numbers the Project Addresses:**

CN.2 Improve quality of diabetes health care based on most recent community needs assessment and the public health data from the Department of State Health Services and the City of Laredo Health Department.

**How the Project Represents a New Initiative or Significantly Enhances an Existing Delivery System Reform Initiative:** By further increasing disease self-management (including mental health and case management) in primary care, preventive care and early detection services, as well as enhancing community disease self-management, we can improve health outcomes, further prevent disease, reduce risks and co-morbidities, improve healthier nutrition choices and increase physical activity. Classes will be given in health to understand disease and diabetes management and care, human body function, healthy living nutritional education and cooking, healthy living physical activity, and metabolic control. Also, mental health/psychosocial support for diabetes control will be offered. These actions along with increased preventive care stated in Category I will reduce health care costs especially hospitalizations by improving early detection and preventive care. Moreover this adds value to the already proven disease self-management model as it integrates it into preventive primary care and it also adds mental health and case management to assure continuity and compliance of care and improve wellness and prevention.

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

OD-1 Primary Care and Chronic Disease Management:  
IT-1.11 Diabetes Care: BP control (<140/80mmHg)

**Reasons/Rationale for Selecting the Outcome Measures:** Because of the indigent population, (40% uninsured and being a health professions shortage area); extending preventive care clinical and integrating disease self-management, health education, case management and mental health into preventive primary care services to high risk and vulnerable populations we will reduce risk, hospitalization for complications and admissions for preventable diseases as well readmission for hospitalized patients. Specifically, this measure will address control of BP of diabetics. The integration of community disease self-management can reduce chronic disease risks, improve healthier choices, and reduce chronic and acute disease complications and co-morbidity. This prevents persons from using and going to the hospital for preventable chronic and acute disease complications, co-morbidities, and thus reduces hospitalizations, hospital and health care costs. This will reduce unnecessary hospitalization and non-emergency visits by as persons recognize risk and disease management earlier. A follow-up tracking and educational service will need to be created upon hospital discharge to further reduce potentially preventable, regular admissions and readmission.

### **Relationship to other Projects**

There are no RHP partners or services that receive any funding from USHHS. There is a community transformation project who we already collaborate with but the area of work is in the rural areas and we would concentrate on the urban areas, in addition the problems is so severe that we need both efforts working together to maximize services. This project improves community wellness by reducing risks, changing behavior, improving healthier food choices, and links and integrates mental health and disease self-management into primary care. This action, along with additional preventive primary care services proposed in Category I, will reduce hospitalization and reinforce prevention and wellness, as well as link primary care and medical and social services case management and mental health. Finally it links with the MHA and UTHSCSA rural patient navigator that we will partner with to ensure we reach more persons and avoid any potential of duplication.

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

CLHD will establish an enhanced working relationship with the MHA, hospitals, as well UTHSCSA, and their projects to assure we build a network of prevention and early intervention to reduce the risk of diabetes and its complications. This collaboration and coordination of chronic disease management services integrated into primary care are serving as a model to develop our expanded network of preventive care and disease management for the high risk vulnerable and indigent population.

### **Plan for Learning Collaborative**

As stated above a best practice model is being developed for disease management to use in the entire community. It will also link the partners even further in particular, to collaborate and maximize services and resources for disease self-management. The UTHSCSA/CLHD/MHA collaborative and partnership will grow and serve as a basis for an enhanced network of preventive care to improve the health of those most vulnerable in our communities. The hospitals are both equally integral to the formation of the new health care network. Finally this action will further reduce unnecessary and preventable hospitalization, and it will build a network of continuum of care through case management further reducing admissions and re-admissions.

We also plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 20, Webb County. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system. The RHP 20 Anchor will sponsor two learning collaborative per year

### **Project Valuation**

Valuation is based on clinical care needs, costs for hiring clinicians, care costs for high risk populations, consideration for community benefits (improving healthier outcomes, providing disease managed and making healthier choices), accessing better mental health services, as well reducing hospitalizations and hospital care costs. The final factor considered is the lack of local funding for these services.

<b>Unique Identifier:</b> 137917402.2.1	<b>RHP PP REFERENCE</b> NUMBER 2.2.2	<b>PROJECT COMPONENT</b> 2.2.2	<b>PROJECT TITLE: EXPAND CHRONIC CARE MANAGEMENT MODELS</b>	
Performing Provider Name: City of Laredo Health Department			TPI - 137917402	
<b>Related Category 3</b> <b>Outcome Measure(s):</b>	137917402.3.1	IT-1.11	Diabetes Care: BP control (<140/80mmHg)	
<b>Year 2</b> <b>(10/1/2012 – 9/30/2013)</b>		<b>Year 3</b> <b>(10/1/2013 – 9/30/2014)</b>		<b>Year 4</b> <b>(10/1/2014 – 9/30/2015)</b>
<b>Milestone 1 [P-1]:</b> Expand the Chronic Care Model to primary care clinics		<b>Milestone 1 [I-17]</b> Apply the Chronic Care Model to targeted chronic diseases, which are prevalent locally		<b>Milestone 1 [I-17]</b> Apply the Chronic Care Model to targeted chronic diseases, which are prevalent locally
<b>Metric 1 [P-1.1]:</b> Increased number of persons enrolled in disease self-management (DSM)		<b>Metric 1 [I-17.1]:</b> 25 additional patients receive care under the Chronic Care Model for a chronic disease or for MCC		<b>Metric 1 [I-17.1]:</b> 40 additional patients receive care under the Chronic Care Model for a chronic disease or for MCC
Baseline/Goal: 500 / increase DSM services to (25) new patients		a. Name the chronic disease or MCC included (Hypertension)		a. Name the chronic disease or MCC included (Hypertension)
Data Source: Health Department		b. Data Source: Primary Care Clinic registry/encounters		b. Data Source: Primary Care Clinic registry/encounters
Milestone 1 Estimated Incentive Payment: \$125,000		Baseline/Goal: increase DSM services to (25) new patients		Baseline/Goal: increase DSM services to (40) new patients
		Data Source: Health Department		Data Source: Health Department
		Milestone 1 Estimated Incentive Payment: \$125,000		Milestone 1 Estimated Incentive Payment: \$125,000
Year 2 Estimated Milestone Bundle Amount: <b>\$125,000</b>		Year 3 Estimated Milestone Bundle Amount: <b>\$125,000</b>		Year 4 Estimated Milestone Bundle Amount: <b>\$125,000</b>
				Year 5 Estimated Milestone Bundle Amount: <b>\$125,000</b>
<b>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD</b> (add milestone bundle amounts over DYs 2-5): <b>\$500,000</b>				

## **Title of Outcome Measure (Improvement Target)**

**Title:** IT-1.11 Diabetes Care: BP control (<140/80mmHg)

**Performing Provide/TPI:** City of Laredo Health Department/137917402

**Unique RHP ID#:**137917402.2.1

## **Outcome Measure Description**

OD-1 Primary Care and Chronic Disease Management (CAT II)

IT-1.11 Diabetes Care: BP control (<140/80mmHg)

Enhance diabetic disease self-management; promote healthier foods, physical activity, psychosocial support and early screening through increased disease self-management and education to 25 at risk and uninsured patients in DY2 and DY3, 40 in DY3 and 50 in DY4. The integrated disease management approach into primary care with mental health support will assist high risk and vulnerable person better control their disease and reduce urgent and preventable hospitalizations. In particular through the evidenced based Healthy Living/Viviendo Mejor model (using the Texas A&M extension service and the CDC curriculum) we can better control diabetes, reduce risk and target a reduction in blood pressure control and improve health and kidney outcomes. Our target is to reduce BP below 140/80.

### **Process Milestones:**

- DY2  
Process Milestone 1 [P-1]:  
Project Planning - Develop improved access preventive care plan with tracking and verification of blood pressure control.  
Data Source: Project Planning document  
Process Milestone 1 Estimated Incentive Payment: \$18,850

### **Outcome Improvement Targets for Each Year:**

- DY3  
[P-1.2]: Milestone: Primary Care and Chronic Disease Management  
IT-1.11 Diabetes care: BP control (<140/80mm Hg) 234 – NQF 0061  
Metric: Number of persons enrolled in DSM reducing BP to less than 140/80
  - a. Numerator: 5
  - b. Denominator: 500
  - c. Data Source: Documentation of practice management (i.e. surveys and encounters)
  - d. Rationale: Expanded care with DSM will improve access to early detection and care; improve disease management which will reduce BP in persons at risk to normal
- DY4:  
[P-1.2]: Milestone: Primary Care and Chronic Disease Management  
IT-1.11 Diabetes care: BP control (<140/80mm Hg) 234 – NQF 0061  
Metric: Number of persons enrolled in DSM reducing BP to less than 140/80
  - a. Numerator: 5
  - b. Denominator: 500

- c. Data Source: Documentation of practice management (i.e. surveys and encounters)
- d. Rationale: Expanded care with DSM will improve access to early detection and care; improve disease management which will reduce BP in persons at risk to normal
- DY5:
  - [P-1.2]: Milestone: Primary Care and Chronic Disease Management
  - IT-1.11 Diabetes care: BP control (<140/80mm Hg) 234 – NQF 0061
  - Metric: Number of persons enrolled in DSM reducing BP to less than 140/80
  - a. Numerator: 5
  - b. Denominator: 500
  - c. Data Source: Documentation of practice management (i.e. surveys and encounters)
  - d. Rationale: Expanded care with DSM will improve access to early detection and care, improve disease management which will reduce BP in persons at risk to normal

### **Rationale**

Because of the over 35% indigent population, 40% uninsured and being a health professions shortage area; access to care is imperative. Extending preventive care clinical care capacity, and including disease self-management as a standalone and as well integrating disease self-management, health education, case management and mental health into preventive primary care services will help transform region 20 into a healthier one. Using disease self-management for high risk and vulnerable populations will reduce risk, hospitalization for complications and admissions for preventable diseases, as well readmission for hospitalized patients. Specifically, it will address control of BP of diabetics. The integration of community disease self-management can reduce chronic disease risks, improve healthier choices, and reduce chronic and acute disease complications and co-morbidity. This prevents persons from using and going to the hospital for preventable chronic and acute disease complications, co-morbidities, and thus reduces hospitalizations, hospital and health care costs. This will reduce unnecessary hospitalization and non-emergency visits so persons can recognize risk and disease management earlier. A follow-up tracking and educational service will need to be created upon hospital discharge to further reduce potentially preventable, regular admissions and readmission.

### **Outcome Measure Valuation**

Is based on clinical care needs, costs for hiring clinicians, care costs for high risk populations, consideration for community benefits (improving healthier outcomes and making healthier choices) as well reducing hospitalizations and hospital care costs. Final factor considered is the lack of local funding for these services.

<i>Unique Cat 3 ID:137917402.3.1</i>	<i>Ref Number from RHP PP:IT-1.11</i>	<i>PROJECT TITLE: EXPAND CHRONIC CARE MANAGEMENT MODELS</i>	
<i>Performing Provider Name: City of Laredo Health Department</i>		<i>TPI - 137917402</i>	
<b>Related Category 1 or 2 Projects::</b>	<i>Unique Category 1 Identifier –137917402.2.1</i>		
<b>Starting Point/Baseline:</b>	500		
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>
<b>Process Milestone 1 [P-1]:</b> Project Planning - Develop improved access preventive care plan with tracking and verification of blood pressure control.  Data Source: Project Planning document  Process Milestone 1 Estimated Incentive Payment: \$16,567	<b>Outcome Improvement Target 1</b> BP control to <140/80mmHg IT-1.11 Diabetes care: BP control (<140/80mm Hg)234 – NQF 0061  a. Numerator: 5 b. Denominator: 500 Data Source: Health Department Documentation of practice management  Outcome Improvement Target 1 Estimated Incentive Payment: \$75,400	<b>Outcome Improvement Target 1</b> BP control to <140/80mmHg) IT-1.11 Diabetes care: BP control (<140/80mm Hg)234 – NQF 0061  a. Numerator: 5 b. Denominator: 500 c. Data Source: Health Department Documentation of practice management  Outcome Improvement Target 1 Estimated Incentive Payment: \$75,400	<b>Outcome Improvement Target 1</b> BP control to <140/80mmHg) IT-1.11 Diabetes care: BP control (<140/80mm Hg)234 – NQF 0061  a. Numerator: 5 b. Denominator: 500 c. Data Source: Health Department Documentation of practice management  Outcome Improvement Target 1 Estimated Incentive Payment: \$156,000
Year 2 Estimated Outcome Amount: (add incentive payments amounts from each milestone/outcome improvement target):\$16,567	Year 3 Estimated Outcome Amount: \$75,400	Year 4 Estimated Outcome Amount: \$75,400	Year 5 Estimated Outcome Amount: \$156,000
<b>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5): \$323,376</b>			

## **Project Summary:**

Unique Project Identifier: 132812205.2.1

Provider Name/TPI: Driscoll Children's Hospital/ 132812205

Provider Description: Driscoll Children's Hospital is a 189-bed tertiary care regional referral center offering complex and comprehensive medical and surgical care for children. Located in Corpus Christi, the hospital's medical staff is comprised of pediatric specialists in more than 32 medical and 13 surgical specialties serving a thirty-one county, 30,000 square mile area in South Texas.

Intervention(s): Early detection of congenital heart defects—conditions that are present at birth—allows for more careful planning of future care. A fetal echocardiogram program is an integral part in the diagnosis and treatment of congenital heart defects. If a heart defect is suspected by the Maternal-Fetal Medicine (MFM) specialist, the patient is referred to Pediatric Cardiologist where they can perform a more detailed image of the baby's heart.

Need for the project (include data as appropriate): A fetal echocardiogram program is necessary in the South Texas region due to the high prevalence of pre gestational diabetes and gestational diabetes. There is a 5-25% risk of a congenital heart defect in this population of patients. Congenital heart defects are among the most common birth defects, occurring in approximately 1 out of every 125 live births. Moreover, congenital heart defects results in the most costly hospital admissions for birth defects in the United States.

Target population (number of patients the project will serve and how many Medicaid/Indigent will benefit from the project): MFM specialists provide services for Medicaid women with high-risk pregnancies that include: mothers with diseases such as hypertension or diabetes, babies with possible genetic conditions or mothers expecting multiple babies.

Category 1 or 2 expected patient benefits: By the end of Year 5, the project will accomplish the following goals:

- DY 3 - Establish a new MFM clinic location and hire providers and staff to operate the clinic
- Increase the number of patient encounters in MFM echocardiogram program by 5 percent in DY3 for an additional 5 encounters; an increase of 7% in DY 4 for an additional 7 encounters; and an increase of 10 percent in DY 5 for an additional 10 encounters.

Expand MFM clinics and outreach program facility hours by 5 percent in DY 3 for an additional 10 hours; 7% in DY 4 for an additional 14 hours; and 10% in DY 5 for an additional 20 hours.

Category 3 outcomes expected patient benefits: IT-8.9 Our goal is to increase the number of detected related fetal anomalies in high-risk pregnant patients.

### Collaboration:

This project will be performed in collaboration with Laredo Medical Center. The collaborating provider entered into the collaboration agreement freely and with the intention of benefiting RHP 20 through local healthcare delivery transformation. Laredo Medical Center will be responsible for supporting the performing provider in efforts to fully implement a robust and transformative project. As the local community provider, the collaborators will assist Driscoll by participating in the planning, design, and

execution of the MFM program. This will include but is not limited to participating in the multidisciplinary Disease Prevention Task Force and the region-wide learning collaborative. These efforts will provide Driscoll with invaluable information regarding project impact and “lessons learned”, opportunities to adjust project target patient populations, identifying special considerations needed for safety-net populations, and reviewing challenges. This project advances RHP 20 goals and community needs assessment by expanding access to early detection program for fetal anomalies in patients with high-risk pregnancies. A fetal echocardiogram program is necessary in the South Texas region due to the high prevalence of pre gestational diabetes and gestational diabetes. There is a 5-25% risk of a congenital heart defect in this population of patients. Driscoll appreciates the willingness of a local provider to collaborate on such a project and we acknowledge that this collaboration is necessary to achieve the project goals and ensure a complete and successful transformation in RHP 20.

## **Identifying Project and Provider Information**

**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.)

**Unique RHP ID#:** 132812205.2.1

**Performing Provider/TPI:** Driscoll Children's Hospital/132812205

## **Project Description**

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

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

There is no overlap of this project with RHP 4 (132812205.2.1) or RHP 5(132812205.2.1) projects because staffing and services will be targeted to the specific counties aligned with each different RHP.

The Driscoll Service Area for this project is RHP 20 which includes Webb, Maverick, Jim Hogg, and Zapata counties, of which three counties are along the Texas/Mexico border. These four counties encompasses approximately 6,500 square miles. Ninety-five percent of the population is Hispanic or Latino origin and the total population is approximately 330,000. RHP 20 has a disproportionate number of children under the age of 5. The statewide average of children under age 5 is 7.6% and Zapata County is 11% and Jim Hogg County is 8.5%.

MFH specialists provide services for women with high-risk pregnancies that include: mothers with diseases such as hypertension or diabetes, babies with possible genetic conditions or mothers expecting multiple babies. All of these expectant mothers can benefit from the care of a

maternal-fetal medicine specialist. MFMs receive two to three years of additional training after an OB/GYN residency that focuses on high-risk pregnancies, ultrasound techniques and fetal anomalies.

A fetal echocardiogram program is necessary in the South Texas region due to the high prevalence of pre gestational diabetes and gestational diabetes. There is a 5-25percent risk of a congenital heart defect in this population of patients. Congenital heart defects are among the most common birth defects, occurring in approximately 1 out of every 125 live births. Moreover, congenital heart defects results in the most costly hospital admissions for birth defects in the United States. A fetal echocardiogram program is an integral part in the diagnosis and treatment of congenital heart defects. If a heart defect is suspected by the MFM specialist, the patient is referred to Pediatric Cardiologist where they can perform a more detailed image of the baby's heart.

This team approach in prenatal diagnosis allows for better pregnancy counseling and improved neonatal outcomes. Driscoll Health System will coordinate this initiative with local Maternal-Fetal Medicine specialists, Pediatric Cardiologists, managed care organizations, and community collaborators. Driscoll Health System will form a Disease Prevention Task Force and will hold quality improvement meetings twice a year to review. The task force will be multidisciplinary in composition and will assess progress on Maternal Fetal Medicine project milestones and metrics. The task force meeting will serve as a structure for activity such as, but not limited to: identifying project impacts and “lessons learned”, reviewing opportunities to adjust project target patient population, identifying any special considerations needed for safety-net populations, and reviewing challenges identified to date. Information identified in these meetings will be used to make improvements, adjustments, etc. to the Disease Prevention Project.

**Goal:** Since it was established, the MFM outreach program has proven highly successful in the early detection of fetal anomalies in patients with high risk pregnancies. Early detection potentially reduces medical costs by turning an unexpected emergent situation into an expected controlled situation. This strategy reduces critical care costs such as prolonged hospitalizations and co-morbidities. Both of these programs will help reduce in NICU inpatient days and pre-term births as well as improve early detection of fetal anomalies which is key to improving overall health care delivery and health outcomes in the region. The challenges with this project are the patient compliance of provider care instructions and the availability of timely access to care.

**Region 20 Goals:** This project advances RHP 20 goals and community needs assessment by expanding access to early detention program for fetal anomalies in patients with high-risk pregnancies. Preterm infants are at increased risk of disability and early death compared with infants born later in pregnancy. The preterm birth rate for Texas, however, is 13.3 percent, slightly above the national rate. The preterm birth rates are higher in the Driscoll Service Area compared with Texas as a whole and nationwide as the table below illustrates.

%Preterm (<37 weeks gestation) - Texas 2012

Metropolitan Statistical Area	percent Preterm	State Average	Difference
Brownsville- Harlingen	15.4	13.2	2.2
Corpus Christi	14.9	13.2	1.7
Laredo	13.8	13.2	0.6
Victoria	14.0	13.2	0.8

**Challenges/Issues:** The challenges with this project are the patient compliance of provider care instructions and the availability of timely access to care.

**Five-Year Expected Outcome for Provider and Patients:** By the end of Year 5, the project will accomplish the following goals:

- Establish a new MFM clinic location and hire providers and staff to operate the clinic
- Increase the number of patient encounters in MFM echocardiogram program above the baseline of 0 by 5% in DY 3 for an additional 5 encounters; by 7% in DY 4 for an additional 7 encounters; and by 10% in DY 5 for an additional 10 encounters.
- Expand MFM clinics and outreach program facility hours above the baseline of 0 by 5% in DY 3 for 10 additional operating hours; by 7% in DY 4 for 14 additional operating hours and by 10% in DY 5 for 20 additional operating hours.
- Increase the number of detected related fetal anomalies in high-risk pregnant patients

**Starting Point/Baseline**

The MFM clinics and outreach program facilities in Driscoll’s service area for baseline measurement will be 0 of operation in DY2. The MFM echocardiogram program in Driscoll’s service area for baseline measurement will be 0 completed procedures in DY2.

**Rationale**

Low-income pregnant women are at higher risk for pre-term births for a variety of known as well as unknown reasons. Expectant mothers and their unborn babies who are at high risk for certain health problems such as heart disease, high blood pressure, diabetes or other endocrine disorders, kidney or gastrointestinal disease, infectious diseases and maternal immune disorders should seek maternal-fetal medicine specialists. Healthy women whose pregnancy is at high risk for complications includes abnormal maternal serum screening, twins, triplets or more, advanced maternal age, recurrent pregnancy loss and more. Every year, Driscoll’s Transport Team transfers more than 840 neonatal and pediatric patients to or from Driscoll’s Children’s Hospital to receive the highest standard of care in the region. Maternal-fetal medicine specialists offer a wide range of care including a variety of therapies and programs that make sure that any high-risk baby in South Texas will have the best chances of living a healthy, normal life. This initiative will improve access to Maternal and Fetal Medicine care programs for Medicaid recipients. Driscoll Children’s Hospital does not receive any funding initiatives that may have related activities that are funded by the U.S. Department of Health and Human Services.

**Project Components:** Driscoll Children’s Hospital project plan (2.7 Implement Evidence-based Disease Prevention Programs) does not include any project components.

**Unique Community Need Identification Numbers the Project Addresses:** Consistent with RHP 20’s community need assessment, this project will utilize:

- CN 1: Capacity – Primary and Specialty Care (The demand for primary and specialty care services exceeds that of available medical physicians in these areas, and prevents adequate access to care and management or specialized treatment for prevalent health condition and preventative health conditions); and,
- CN 3: Chronic Disease and Disease Self-Management Initiatives (Many individuals in South Texas suffer from chronic diseases that are becoming more prevalent within the area).

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

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

**OD-8 Perinatal Outcome:**

IT-8.9 Early Detection of Fetal Anomalies

**Reasons/Rationale for Selecting the Outcome Measures:** The Maternal fetal echocardiogram program plays an essential and critical role in pediatric cardiac programs. Increased access to MFM clinics/outreach programs will provide the ability to establish early prenatal diagnosis which allows for optimal postnatal management and helps reduce the medical costs for mother and baby. With improvement in ultrasound equipment and access, the prenatal diagnosis of congenital heart disease has substantially increased over the past two decades. The detection of significant congenital heart disease prenatally provides for better surgical and medical planning which in return improves outcomes. Fetal anomalies are defined as any conditions that are not normal anatomical structure or function. Early detection potentially reduces medical costs by turning an unexpected emergent situation into an expected controlled situation. This strategy reduces critical care costs such as prolonged hospitalizations and co-morbidities. Both of these programs will help reduce in NICU inpatient days and pre-term births as well as improve early detection of fetal anomalies which is key to improving overall health care delivery and health outcomes in the region.

Driscoll disagrees that IT.8.9 is not a standalone measure. We did not find any reference in the PFM that supported the HHSC suggested revision.

**Relationship to other Projects**

Implement Evidence-based Disease Promotion Programs project is related to and will support other regional projects including but not limited to Expanding Primary Care Capacity Projects 137917402.1.1 and 137917402.2.1, Expand Chronic Care Management Models (with Primary Care Integration). Related Category 4 outcome measures include Patient Satisfaction in RD-4 and potentially preventable admission in RD-1.

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

This project will support other projects in the region that aim to improve care for pregnant women with pre-gestational or gestational diabetes such as 137917402.2.1, City of Laredo.

### **Plan for Learning Collaborative**

We plan to participate in a region-wide learning collaborative(s) as offered by the Anchor entity for Region 20, Webb County. Our participation in this collaborative with other Performing Providers within the region that have similar projects will facilitate sharing of challenges and testing of new ideas and solutions to promote continuous improvement in our Region's healthcare system. The RHP 20 Anchor will sponsor two learning collaboratives per year

### **Project Valuation**

The quantitative value is based on a determination that the NICU is a high cost service. Decreasing the number of patients and the average length of stay (ALOS) for a NICU patient is a more efficient use of resources. Increasing the hours and use of a MFM clinic/outreach program and increasing the number of Maternal Fetal echocardiogram procedures will create significant savings and value. Driscoll intends to accomplish this by increasing the number of patient encounters in MFM echocardiogram program by 5 percent in DY3 for an additional 5 encounters; an increase of 7% in DY 4 for an additional 7 encounters; and an increase of 10 percent in DY 5 for an additional 10 encounters. Expanding MFM clinics and outreach program facility hours by 5 percent in DY 3 for an additional 10 hours; 7% in DY 4 for an additional 14 hours; and 10% in DY 5 for an additional 20 hours.

Driscoll provides MFM services to the community for multiple reasons, one of which is to help reduce ALOS for NICU patients. Since the beginning of the MFM program, ALOS for a NICU patient has decreased significantly, resulting in reductions of NICU payment dollars between FY2010 and FY2012.

The Maternal fetal echocardiogram program plays an essential and critical role in pediatric cardiac programs. With improvement in ultrasound equipment and access, the prenatal diagnosis of congenital heart disease has substantially increased over the past two decades. The detection of significant congenital heart disease prenatally provides for better surgical and medical planning which in return improves outcomes. Early detection potentially reduces medical costs by turning an unexpected emergent situation into an expected controlled situation. This strategy reduces critical care costs such as prolonged hospitalizations and co-morbidities. Pediatric Cardiologists working in collaboration with the Maternal Fetal Medicine program give Perinatologists adjunctive support in diagnosing congenital heart disease, aiding in management of arrhythmias and congestive heart failure from various causes. Additionally, it allows for detailed counseling using the expertise of a Pediatric Cardiologist.

Maternal fetal echocardiogram programs provide the ability to establish early prenatal diagnosis which allows for optimal postnatal management and helps reduce the medical costs for mother and baby. In addition, having an established prenatal diagnosis allows for plans to be set for delivery in facility with a level three neonatal service. Based on the change in NICU ALOS between Calendar 2010 and 2012 plus the Calendar 2012 NICU admissions, we estimate a total saving and DSRIP value to the state of \$4,000,000 (inclusive of Categories 3 and 4).

<b>Unique Identifier:</b> 132812205.2.1	<b>RHP PP Reference Number:</b> 2.7.1	<b>Project Components:</b> N/A	<b>Implement Evidence-based Disease Prevention Programs</b>	
Performing Provider Name: Driscoll Children's Hospital			TPI: 132812205	
<b>Related Category 3 Outcome Measure(s):</b>	132812205.3.1	IT -8.9	Increase the number of detected related fetal anomalies in high-risk pregnant patients in the Driscoll service area	
<b>Year 2</b> (10/1/2012 – 9/30/2013)	<b>Year 3</b> (10/1/2013 – 9/30/2014)	<b>Year 4</b> (10/1/2014 – 9/30/2015)	<b>Year 5</b> (10/1/2015 – 9/30/2016)	
<p><b>Milestone 1</b> [P-X.1]: Appoint an interdisciplinary Task Force to provide oversight for expanding, increasing, and enhancing Driscoll's Maternal Fetal Medicine (MFM) Program.</p> <p><u>Metric 1</u> [P-X.1.1]: Documentation of Task Force establishment Baseline/Goal: 1 Task Force appointed Data Source: Hospital/health plan record</p> <p>Milestone 1: Estimated Incentive Payment (<i>maximum amount</i>): \$212,500</p> <p><b>Milestone 2</b> [P-1]: Develop plan/strategy to expand the Maternal Fetal Medicine Program in Driscoll serve area</p> <p><u>Metric 1</u> [P-1.1]: Document innovational strategy and plan Baseline/Goal: Plan finalized Data Source: N/A</p> <p>Milestone 2: Estimated Incentive Payment (<i>maximum amount</i>): \$212,500</p>	<p><b>Milestone 5</b> [P-X.4]: Task Force leads quality improvement initiative for MFM program</p> <p><u>Metric 1</u> [P-X.4.1]: Documentation of Quality Improvement meetings held twice per year</p> <p>Baseline/Goal: 2 QI meetings held</p> <p><u>Metric 2</u> [P-X.4.2] Documentation of Task Force report, findings and/or action plan to further improve the MFM Baseline/Goal: Finalize Task Force report Data Source: Hospital/health plan record</p> <p>Milestone 5 Estimated Incentive Payment (<i>maximum amount</i>): \$266,666</p> <p><b>Milestone 6</b> [I-7]: Increase access to MFM program</p> <p><u>Metric 1</u> [I-7.2]: Increase number of MFM echocardiogram program procedures by 5 patients over DY2 baseline of 0 Baseline: 0</p>	<p><b>Milestone 8</b> [P-X.4]: Task Force leads quality improvement initiative for MFM program</p> <p><u>Metric 1</u> [P-X.4.1]: Documentation of Quality Improvement meetings held twice per year</p> <p>Baseline/Goal: 2 QI meetings held</p> <p><u>Metric 2</u> [P-X.4.2]: Documentation of Task Force report, findings and/or action plan to further improve the MFM Baseline/Goal: Finalize Task Force report Data Source: Hospital/health plan record</p> <p>Milestone 8: Estimated Incentive Payment (<i>maximum amount</i>): \$250,000</p> <p><b>Milestone 9</b> [I-7]: Increase access to MFM program</p> <p><u>Metric 1</u> [I-7.2]: Increase number of MFM echocardiogram program procedures by 7 patients over DY 2 baseline of 0 Baseline/Goal: 0</p>	<p><b>Milestone 11</b> [P-X.4]: Task Force leads quality improvement initiative for MFM program</p> <p><u>Metric 1</u> [P-X.4.1]: Documentation of Quality Improvement meetings held twice per year</p> <p>Baseline/Goal: 2 QI meetings held</p> <p><u>Metric 2</u> [P-X.4.2:] Documentation of Task Force report, findings and/or action plan to further improve the MFM Baseline/Goal: Finalize Task Force report Data Source: Hospital/health plan record</p> <p>Milestone 11: Estimated Incentive Payment (<i>maximum amount</i>): \$190,000</p> <p><b>Milestone 12</b> [I-7]: Increase access to MFM program</p> <p><u>Metric 1</u> [I-7.2]: Increase of number of MFM echocardiogram procedures by 10 patients above the DY2 baseline of 0 Baseline/Goal: 0</p>	

<b>Unique Identifier:</b> 132812205.2.1	<b>RHP PP Reference Number:</b> 2.7.1	<b>Project Components:</b> N/A	<b>Implement Evidence-based Disease Prevention Programs</b>	
Performing Provider Name: Driscoll Children's Hospital			TPI: 132812205	
<b>Related Category 3 Outcome Measure(s):</b>	132812205.3.1	IT -8.9	Increase the number of detected related fetal anomalies in high-risk pregnant patients in the Driscoll service area	
<b>Year 2</b> (10/1/2012 – 9/30/2013)	<b>Year 3</b> (10/1/2013 – 9/30/2014)	<b>Year 4</b> (10/1/2014 – 9/30/2015)	<b>Year 5</b> (10/1/2015 – 9/30/2016)	
<p><b>Milestone 3</b> [P-X.2]: Develop a plan to hire MFM providers and staff for the new clinic location</p> <p><u>Metric 1</u> [P-X.2.1]: HR documentation Baseline/Goal: Finalize HR plan for staffing Data Source: N/A</p> <p>Milestone 3 Estimated Incentive Payment (<i>maximum amount</i>): \$212,500</p> <p><b>Milestone 4</b> [P-X.3]: Develop a plan to secure a new clinic location/site for patient access</p> <p><u>Metric 1</u> [P-X.3.1]: Property Contracts/documentation of property agreement Baseline/Goal: Finalize clinic site Data Source: N/A</p> <p>Milestone 4 Estimated Incentive Payment (<i>maximum amount</i>): \$212,500</p>	<p>Data Source: Hospital/health plan record</p> <p>Milestone 6: Estimated Incentive Payment (<i>maximum amount</i>): \$266,666</p> <p><b>Milestone 7</b> [P-X.5]: Increase hours of accessibility of MFM clinics/outreach program</p> <p><u>Metric 1</u> [P-X.5.1]: Increase MFM clinics/outreach program hours by 10 hours over DY2 baseline of 0. Baseline: 0 Data Source: Hospital/health plan record</p> <p>Milestone 7: Estimated Incentive Payment (<i>maximum amount</i>): \$266,667</p>	<p>Data Source: Hospital/health plan record</p> <p>Milestone 9: Estimated Incentive Payment (<i>maximum amount</i>): \$250,000</p> <p><b>Milestone 10</b> [P-X.5]: Increase hours of accessibility of MFM clinics/outreach program</p> <p><u>Metric 1</u> [P-X.5.1]: Increase MFM clinics/outreach program hours by 14 hours over DY 2 baseline of 0 Baseline: 0 Data Source: Hospital/health plan record</p> <p>Milestone 10 Estimated Incentive Payment (<i>maximum amount</i>): \$250,000</p>	<p>Data Source: Hospital/health plan record</p> <p>Milestone 12: Estimated Incentive Payment (<i>maximum amount</i>): \$190,000</p> <p><b>Milestone 13</b> [P-X.5]: Increase hours of accessibility of MFM clinics/outreach program</p> <p><u>Metric 13</u> [P-X.5.1]: Increase of MFM clinics/outreach program hours by 20 hours above DY 2 baseline of 0 Baseline: 0 Data Source: Hospital/health plan record</p> <p>Milestone 13: Estimated Incentive Payment (<i>maximum amount</i>): \$190,000</p>	
<b>Year 2 Estimated Milestone Bundle Amount: \$850,000</b>	<b>Year 3 Estimated Milestone Bundle Amount: \$800,000</b>	<b>Year 4 Estimated Milestone Bundle Amount: \$750,000</b>	<b>Year 5 Estimated Milestone Bundle Amount: \$570,000</b>	
<b>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5): \$2,970,000</b>				

## **Title of Outcome Measure (Improvement Target)**

**Title:** 2.7 Implement Evidence-based Disease Prevention Programs  
**Performing Provider/TPI:** Driscoll Children's Hospital/132812205  
**Unique RHP ID#:** 132812205.3.1

## **Outcome Measure Description**

IT-8.9 Other Outcome Improvement Target will be to increase the number of early detected related fetal anomalies in high-risk pregnant patients in the Driscoll service area by XX percent. Driscoll disagrees that IT.8.9 is not a standalone measure. We did not find any reference in the PFM that supported the HHSC suggested revision.

### **Process Milestones:**

- DY2  
P-1- Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans
- DY3  
P-2- Establish baseline for the number of early detected related fetal anomalies in high-risk pregnant patients

### **Outcome Improvement Target(s) for each year:**

- DY4  
IT-8.9 Improvement Target: Increase the number of early detected related fetal anomalies in high-risk pregnant patients in the Driscoll service area by XX%.
- DY5  
IT-8.9- Improvement Target: Increase the number of early detected related fetal anomalies in high-risk pregnant patients in the Driscoll service area by XX%.

## **Rationale**

The early detection of significant congenital heart disease prenatally provides for better surgical and medical planning which in return improves outcomes. This potentially reduces medical costs by turning an unexpected emergent situation into an expected controlled situation. This strategy reduces critical care costs such as prolonged hospitalizations and co-morbidities. Both of these programs will help reduce in NICU inpatient days and pre-term births as well as improve early detection of fetal anomalies which is key to improving overall health care delivery and health outcomes in the region.

## **Outcome Measure Valuation**

The Maternal fetal echocardiogram program plays an essential and critical role in pediatric cardiac programs. With improvement in ultrasound equipment and access, the prenatal diagnosis of congenital heart disease has substantially increased over the past two decades. The detection of significant congenital heart disease prenatally provides for better surgical and medical planning which in return improves outcomes. Early detection potentially reduces medical costs by turning an unexpected emergent situation into an expected controlled situation. This strategy reduces critical care costs such as prolonged hospitalizations and co-morbidities.

<i>Unique Cat 3 ID: 132812205.3.1</i>	<i>Ref Number from RHP PP: 3.IT-8.9</i>	<i>Early Detection of Maternal Fetal Anomalies</i>	
<i>Performing Provider Name: Driscoll Children's Hospital</i>		<i>TPI: 132812205</i>	
<b>Related Category 1 or 2 Projects::</b>	<i>Unique Category 2 Identifier – 13281205.2.1</i>		
<b>Starting Point/Baseline:</b>	<i>To be determined in DY3</i>		
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>
<b>Process Milestone 1 [P-1]:</b> Project Planning – engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans  Baseline/Goal: Finalize project plans  Data Source: Documentation of meeting minutes.  Process Milestone 1 Estimated Incentive Payment ( <i>maximum amount</i> ): \$100,000	<b>Process Milestone 2: [P-2]:</b> Establish baseline for the number of early detected related fetal anomalies in high-risk pregnant patients.  Baseline/Goal: TBD  Data Source: Hospital Records  Process Milestone 2: Estimated Incentive Payment \$100,000	<b>Outcome Improvement Target 1 [IT-8.9]:</b> Increase the number of early detected related fetal anomalies in high-risk pregnant patients in the Driscoll service area by XX% from prior demonstration year.  Baseline/Goal: TBD  Data Source: Hospital Records  Outcome Improvement Target 1 Estimated Incentive Payment: \$150,000	<b>Outcome Improvement Target 2 [IT-8.9]:</b> Increase the number of early detected related fetal anomalies in high-risk pregnant patients in the Driscoll service area by XX% from baseline year. Baseline/Goal: TBD  Data Source: Hospital Records  Outcome Improvement Target 2 Estimated Incentive Payment: \$330,000
<b>Year 2 Estimated Outcome Amount:: \$100,000</b>	<b>Year 3 Estimated Outcome Amount: \$100,000</b>	<b>Year 4 Estimated Outcome Amount: \$150,000</b>	<b>Year 5 Estimated Outcome Amount: \$330,000</b>
<b>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (<i>add outcome amounts over DYs 2-5</i>): \$680,000</b>			

## **Project Summary:**

Unique Project Identifier: 162033801.2.2

Provider Name/TPI: Laredo Medical Center / TPI 162033801

Provider Description: Laredo Medical Center is a 326-bed, acute care hospital that offers a range of comprehensive health services including inpatient, outpatient, medical, surgical, diagnostic and emergency care. Located in Webb County, the hospital serves both Webb and Zapata county residents. Laredo Medical Center's population service area is 277,492, of which 194,616 are in the primary service area. Laredo Medical Center operates the Zapata Family Medical Clinic in Zapata. Zapata is included in our hospital's secondary service area and includes a primary population of 13,150 which is projected to grow by 6.6% within the next five years.

Intervention(s): This project will annually survey Zapata Family Medical Clinic patients. We will incorporate patient experience into employee roles, and display these results to drive improvement. Based on survey data, we will conduct planning for performance improvement activities to address identified issues and engage patients.

Need for the project (include data as appropriate): There is currently little infrastructure in place to measure patient satisfaction and the patient experience. Once such tools are in place, we will be able to generate data to drive improvement of the patient experience. This is particularly important in Zapata, where significant population growth is expected, and especially in this clinic, which serves a significant proportion of the Zapata and surrounding communities' residents as a 24/7 clinic.

Target population (number of patients the project will serve and how many Medicaid/Indigent will benefit from the project): Last year, Zapata Family Medical Clinic had 9,886 patient visits, of which the payor mix is 32% Medicaid, 23% Medicare, 18% Blue Cross, 13% Uninsured, 8% Networks, 4% Zapata County Indigent and 2% all other patients. By measuring and improving the patient experience, we expect that all patients visiting the clinic will be positively impacted by this transformation work, including the 49% classified as Medicaid, Uninsured and Indigent.

Category 1 or 2 expected patient benefits: The project seeks to develop new methods of inquiry into patient satisfaction to achieve greater quality and consistency of data in order to improve patient experience for all clinic patients (9,886 visits/year).

Category 3 outcomes expected patient benefits: IT-6.1, percent improvement over baseline of patient satisfaction scores. Our goal is to achieve a 10% improvement over baseline by DY 5.

**Project Option:** 2.4.1 Implement processes to measure and improve patient experience  
**Unique RHP ID#:** 162033801.2.2  
**Performing Provider/TPI:** Laredo Medical Center/162033801

### **Project Description**

**Brief Description:** Laredo Medical Center serves a patient population that is 96% Hispanic or Latinos, young and low-income.<sup>49</sup> Laredo Medical Center will work to improve the patient experience and the patient's satisfaction with the care provided by the Zapata Family Medical Clinic, which serves Zapata County and is operated by Laredo Medical Center.<sup>50</sup> This project proposes to annually survey patients. We will incorporate patient experience into employee roles, and display survey results to drive improvement. Based on survey data, we will implement planning for conducting performance improvement activities to address identified issues, as well as engage patients.

The Zapata Family Medical Clinic has annual patient visits of 9,886, of which the payor mix is 32% Medicaid, 23% Medicare, 18% Blue Cross, 13% Uninsured, 8% Networks, 4% Zapata County Indigent and 2% all other patients. The clinic is included in Laredo Medical Center's secondary service area and the community of Zapata includes a primary population of 13,150 persons with a projected growth of 6.6% in the next five years. Recent data concludes that 46.7% of children under the age of 18 in Zapata County live in poverty.<sup>51</sup>

The clinic serves an essential community role in providing 24/7 services. The clinic provides preventive and primary care, urgent and some emergency care, 24-hour radiology coverage, laboratory testing (urine, pregnancy, flu, strep, etc.), PACS radiology system enabling telemedicine with Laredo Medical Center, ultrasounds, bone density testing, and patient case management and education services.

**Goal:** Laredo Medical Center's overall aim is to create an environment in the Zapata Family Medical Clinic in which families are able to access person-centered primary care efficiently, have long-standing relationships with the clinic and their providers, and work with their providers to stay healthy and out of the hospital. The goal of the project is to improve the patient experience and the patient's satisfaction with the care provided by the Zapata Family Medical Clinic by the use of focused patient surveys which includes all payors, importantly, the Medicaid, Uninsured and Indigent population that makes up approximately 49% of the patient visits. The format of the survey will be modeled after the CG-CAHPS tool. We intend to

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<sup>49</sup> The median age of Laredo Medical Center's primary service group is 27 years, with a median household income of \$31,303. The median age of the secondary services group is 30 years, with a median household income of \$47,442. The payor mix is Medicare 37%, Medicaid 36%, Networks 14%, Uninsured 9%, and all other at 4%.

<sup>50</sup> The Zapata Family Medical Clinic is a critical access point for indigent care in the community through six on-site physicians who rotate to provide primary care and urgent care services 24 hours a day, seven days a week. The clinic has almost 11,000 square feet including 12 exam rooms, four doctor's offices, two waiting areas, a conference room, an x-ray facility, a laboratory facility for routine diagnostics, capacity for minor emergency or urgent care treatment such as stitches and other related services, and capacity to provide classroom educational/informational programs for county residents.

<sup>51</sup> U.S. Census Bureau: Small Area Health Insurance Estimates, <http://www.census.gov/did/www/sahie/>

increase the organization's capacity to improve patients' experience of care by implementing new tools to measure it, and sharing results with and engaging employees and patients.

**Region 20 Goals:** Region 20 identified improvement of primary care and specialty care capacity as one of its most important goals. By focusing on improving the patient experience, our patients will be better able to be engaged in and take shared responsibility with staff and providers for managing their health.

**Challenges/Issues:** The Zapata Family Medical Clinic serves a primarily low-income patient population and faces many challenges associated with delivering care in a rural community. Patients rely on the clinic's 24/7 access for ongoing primary care as well as urgent care and even minor emergent needs. However, services or tests that cannot be provided/processed at the clinic result in long wait times for patients. Laredo Medical Center is taking steps to make sure the clinic can continue to serve this vital community role by introducing equipment with quicker results, enabling faster decisions on treatment and whether patients can be treated at the clinic or should go to a hospital.<sup>52</sup> As a result, Laredo Medical Center believes it will improve the experience of care at the clinic; however, it is impaired by inadequate tools and data. Moreover, patient experience has neither been explicitly incorporated into employee's job priorities, nor into the clinic's organizational culture.<sup>53</sup>

**Five-Year Expected Outcome for Provider and Patients:** This project proposes to annually survey clinic patients. We will incorporate patient experience into 100% of employees' roles, display survey results annually and annually engage patients to drive improvement. Based on survey data, we will perform planning to conduct performance improvement activities to address identified issues. By DY5, we will have annually surveyed a statistically significant sample of patients in order to generate meaningful and informative patient experience data, and we will have internally and externally displayed survey results, so that patient experience will be improved and provide benefit to the entire clinic population.

### **Starting Point/Baseline**

This is a new initiative and there is currently no baseline data or infrastructure in place to measure the patient experience at Zapata Family Medical Clinic.

### **Rationale**

The project option was selected because of the critical need to improve access to primary care services, patient satisfaction, and the patient experience during a period of significant growth in the patient community.

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<sup>52</sup> Patients must travel 60 miles to Laredo, McAllen or Harlingen to access health care services. This often may result in significant risk to the patient.

<sup>53</sup> The Picker Institute, the Institute for Patient and Family Centered Care, as well as national leaders such as Dale Schaller, Bridget Duffy and Anthony DeGioia, contend that the organizational culture that creates positive patient experience must be driven from the very top of the organization, which is why an executive will be accountable for the project and patient experience will be incorporated into employees' job descriptions and/or workplans.

All of the required core components of project option 2.4.1 can be met:

- 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.

While Laredo Medical Center has long focused on the patient experience and patient satisfaction in the hospital setting, a comprehensive patient survey administered to the patients of Zapata Family Medical Clinic represents a new and aggressive initiative to significantly improve the quality of care for Zapata County.

The project will be evaluated based on the following 18 Category 2, Project 4 Milestones:

In DY2, we will:

1. Appoint an executive to be accountable for patient experience at the clinic [P-1]
2. Designate a survey vendor [P-X]
3. Translate the survey into Spanish [P-8]
4. Administer the survey to at least 1.8% of patients in order to provide a nationally recommended, statistically significant sample (estimated 175 patients/9,886 total visits)<sup>54</sup> [P-10]

In DY3, we will:

5. Administer the survey to at least 2.0% of patients (estimated 200 completed surveys/9,886 total visits) [P-10]
6. Assess the baseline patient experience survey data [P-7]
7. Incorporate patient experience into 100% of employees' roles [P-6]
8. Internally display survey results in order to drive improvement [I-18]
9. Conduct planning for implementing improvement work on identified areas based on survey results [P-11]
10. Engage patients in patient experience improvement work and externally share survey results [I-19]

In DY4, we will:

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<sup>54</sup> The National CAHPS Consortium recently issued recommended sample sizes for collecting data at the clinic level: 175 completed surveys for a clinic with 4-9 providers. These recommendations are expected to achieve between 0.7 and 0.8 site-level reliability for all composite measures. There will be more than 175 surveys fielded in order to generate 175 completed surveys because not every patient fully completes the survey. Typically, surveys are fielded until the full sample size is reached. This project's survey sampling methodology will be consistent with CAHPS' recommendations. See:

[http://www.prconline.com/custom/editor/2012%20Conference%20Page/Session%20Handouts/New-FINAL%20HANDOUTS\\_An%20Update%20on%20CG-CAHPS.pdf](http://www.prconline.com/custom/editor/2012%20Conference%20Page/Session%20Handouts/New-FINAL%20HANDOUTS_An%20Update%20on%20CG-CAHPS.pdf).

11. Administer the survey to at least 2.3% of patients (estimated 225 completed surveys/9,886 total visits) [P-10]
12. Perform a mid-course evaluation of the results of improvement projects / Make necessary adjustments and continue with implementation [P-13]
13. Internally display survey results [I-18]
14. Improve the survey by providing hard copies of the survey in the office to encourage greater response rates (the survey is traditionally conducted by phone) [P-8]
15. Engage patients in patient experience improvement work and externally share survey results [I-19]

In DY5, we will:

16. Administer the survey to at least 2.5% of patients (estimated 250 completed surveys/9,886 total visits) [P-10]
17. Internally display survey results [I-18]
18. Engage patients in patient experience improvement work and externally share survey results [I-19]

**Project Components:** This project will address the four required components in Project Option 1.1, as detailed in the RHP Planning Protocol.

**Unique Community Need Identification Numbers the Project Addresses:**

- CN 1: Capacity – Primary and Specialty Care – The demand for primary and specialty care services exceeds that of available medical physicians in these areas, and prevents adequate access to care and management or specialized treatment for prevalent health condition and preventative health conditions. We hope that the project, by improving patient care delivery and patient satisfaction will improve the quality of primary and specialty care.

**How the Project Represents a New Initiative or Significantly Enhances an Existing Delivery System Reform Initiative:** No related activities are currently funded by HHS; the project represents a completely new initiative at Laredo Medical Center as there is currently little infrastructure in place to measure patient satisfaction and the patient experience at Zapata Family Medical Clinic.

**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:** The primary goal of this project is to improve the patient experience, as measured by this outcome (a standalone measure).

**Relationship to other Projects**

Project 162033801.2.2 proposes to promote disease prevention – specifically related to obesity – which is a major health concern for Zapata residents. This project is consistent with this focus because by measuring and improving the patient experience and making primary care more

patient-centered and focused on prevention, Laredo Medical Center believes it can improve the patient experience at the clinic.

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

Several projects in the RHP focus on the expansion of primary care and preventive services. This project relates to other performing providers' projects by focusing on redesign to improve the patient experience with the belief that such improvements will also improve access and utilization of primary care and preventive services.

### **Plan for Learning Collaborative**

We plan to participate in a region-wide learning collaborative as offered by the Anchor entity for Region 20, Webb County. Our participation in this collaborative 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 represents significant and substantial value for the Zapata County Community as it improves the health care experience for the patient population and substantially increases the focus on patient satisfaction for this high need community. The significant improvements expected to be realized will be of substantial value to the community and the patients served.

Given that we believe a baseline amount is needed for infrastructure related to implementing the survey tool, and taking into account the factors that: (1) the entire patient population of the clinic would be impacted by this project (9,886 visits/year), (2) we expect a 10% improvement in the patient experience, (3) the clinic contributes to system cost savings by providing urgent care 24/7 and reducing reliance on the emergency room for after-hours primary and urgent care, (4) the clinic is an essential community benefit and provides needed health services, (5) the nature of the project is highly sustainable, and (6) it includes 18 milestones, we therefore value this project at \$5,780,392 (more details on these factors are described in the Project Valuation section of the related Category 3 outcome 162033801.3.1 below). We have applied the following percentages to this valuation for each DY: DY2- 27%, DY3- 28%, DY4- 25% and DY5- 20% to reflect that important foundational work is being accomplished throughout the waiver, but more so in the earlier years. Finally, within each year, we assigned equal values to each milestone.

<b>Unique Identifier:</b> 162033801.2.2	<b>RHP PP Reference Number:</b> 2.4.1	<b>Project Components:</b> 2.4.1 a-d	<b>Project Title: Redesign to Improve Patient Experience</b>		
Performing Provider Name: Laredo Medical Center			TPI: 162033801		
<b>Related Category 3 Outcome Measure(s):</b>	162033801.3.2	IT -6.1	Percent improvement over baseline of patient satisfaction scores		
<b>Year 2</b> (10/1/2012 – 9/30/2013)		<b>Year 3</b> (10/1/2013 – 9/30/2014)		<b>Year 4</b> (10/1/2014 – 9/30/2015)	
<p><b>Milestone 1: P - 1</b> Appoint an executive accountable for experience performance or create a percentage of time in existing executive position for experience performance.</p> <p><u>Metric 1: P-1.1</u> Documentation of an executive assigned responsibility experience performance.</p> <p>Baseline/Goal: Designate an executive whose charge will include patient experience at Zapata Family Medical Clinic.</p> <p>Data Source: Job description with percent of time allocated to patient experience performance.</p> <p>Milestone 1 Estimated Incentive Payment (maximum amount): \$393,166</p> <p><b>Milestone 2: P-X</b> Designate/hire personnel or teams to support and/or manage the project/intervention.</p> <p><u>Metric 1: P-X.1</u> Documentation of a selection of a survey vendor.</p>		<p><b>Milestone 5: P-10</b> Administer regular inquiry into patient experience in the new organization or organizational area using methodologies such as: Written surveys, Phone interviews; Focus groups; Care experience flow mapping; Real - time electronic methodology for capturing patients' feedback during the process of care; and/or another innovative method for obtaining patient experience information.</p> <p><u>Metric 1: P - 10.1</u> % of active patients who were included in an inquiry.</p> <p>Baseline/Goal: At least 2.0% of clinic patients are surveyed (estimated 200 completed surveys/9,886 total visits) to generate larger than a statistically significant sample size per National CAHPS Consortium recommendations so that data reflects clinic-wide patient satisfaction representative of all clinic services (see project narrative for list of services) and all clinic patients visiting the</p>		<p><b>Milestone 11: P - 10</b> Administer regular inquiry into patient experience in the new organization or organizational area using methodologies such as: Written surveys, Phone interviews; Focus groups; Care experience flow mapping; Real - time electronic methodology for capturing patients' feedback during the process of care; and/or another innovative method for obtaining patient experience information.</p> <p><u>Metric 1: P - 10.1</u> % of active patients who were included in an inquiry.</p> <p>Baseline/Goal: At least 2.3% of clinic patients are surveyed (estimated 225 completed surveys/9,886 total visits) to generate larger than a statistically significant sample size per National CAHPS Consortium recommendations so that data reflects clinic-wide patient satisfaction representative of all clinic services (see project narrative for list of services) and all clinic patients visiting the</p>	<p><b>Milestone 16: P - 10</b> Administer regular inquiry into patient experience in the new organization or organizational area using methodologies such as: Written surveys, Phone interviews; Focus groups; Care experience flow mapping; Real - time electronic methodology for capturing patients' feedback during the process of care; and/or another innovative method for obtaining patient experience information.</p> <p><u>Metric 1: P - 10.1</u> % of active patients who were included in an inquiry.</p> <p>Baseline/Goal: At least 2.5% of clinic patients are surveyed (estimated 250 completed surveys/9,886 total visits) to generate larger than a statistically significant sample size per National CAHPS Consortium recommendations so that data reflects clinic-wide patient satisfaction representative of all clinic services (see project narrative for list of services) and all clinic patients visiting the</p>

<b>Unique Identifier:</b> 162033801.2.2	<b>RHP PP Reference Number:</b> 2.4.1	<b>Project Components:</b> 2.4.1 a-d	<b>Project Title: Redesign to Improve Patient Experience</b>	
Performing Provider Name: Laredo Medical Center			TPI: 162033801	
<b>Related Category 3 Outcome Measure(s):</b>	162033801.3.2	IT -6.1	Percent improvement over baseline of patient satisfaction scores	
<b>Year 2</b> <b>(10/1/2012 – 9/30/2013)</b>	<b>Year 3</b> <b>(10/1/2013 – 9/30/2014)</b>	<b>Year 4</b> <b>(10/1/2014 – 9/30/2015)</b>	<b>Year 5</b> <b>(10/1/2015 – 9/30/2016)</b>	
<p>Baseline/Goal: Designate a survey vendor.</p> <p>Data Source: Executed contract with survey vendor.</p> <p>Milestone 2 Estimated Incentive Payment (maximum amount): \$393,166</p> <p><b>Milestone 3: P-8</b> Develop new methods of inquiry into patient and/or employee satisfaction, or improve the existing ones, to achieve greater quality and consistency of data.</p> <p><u>Metric 1: P-8.1</u> This will vary from Performing Provider to Performing Provider, based on the gaps identified in the assessment (previous bullet) and the assignment of improvement priorities by organization’s leaders. Examples include: Develop a new patient experience survey tool or revise and improve the current ones; Translate and/or simplify written surveys to make them more user - friendly to LEP and low - literacy populations; Implement phone surveys and/or</p>	<p>clinic, estimated to be 9,886 visits/year.<sup>54</sup></p> <p>Data Source: Patient experience survey vendor reports.</p> <p>Milestone 5 Estimated Incentive Payment (maximum amount): \$267,318</p> <p><b>Milestone 6: P-7</b> Assess the organizational baseline for measuring patient/family and/or employee experience and utilizing results in quality improvement.</p> <p><u>Metric 1 P-7.1:</u> Submission of an assessment that includes answering questions such as: What are as of the organization have regular measures (e.g., inpatient vs. clinics vs. EDs); What methods are used to obtain experience data (e.g., mailed surveys vs. phone); What are the scores/findings for the organization as a whole; What are the scores/findings by service line, location, and patient demographics?; What are the response rates by service line, location, and patient demographics?; and/or How are data</p>	<p>clinic, estimated to be 9,886 visits/year.<sup>54</sup></p> <p>Data Source: Patient experience survey vendor reports.</p> <p>Milestone 11 Estimated Incentive Payment (maximum amount): \$294,665</p> <p><b>Milestone 12: P-13</b> Perform a mid - course evaluation of the results of improvement projects / Make necessary adjustments and continue with implementation.</p> <p><u>Metric 1: P - 13.1</u> Submission of evaluation results.</p> <p>Baseline/Goal: At least one evaluation performed.</p> <p>Data Source: Evaluation write - up.</p> <p>Milestone 12 Estimated Incentive Payment (maximum amount): \$294,665</p> <p><b>Milestone 13: I - 18</b> Develop regular organizational display(s) of patient</p>	<p>clinic, estimated to be 9,886 visits/year.<sup>54</sup></p> <p>Data Source: Patient experience survey vendor reports.</p> <p>Milestone 16 Estimated Incentive Payment (maximum amount): \$376,832</p> <p><b>Milestone 17: I - 18</b> Develop regular organizational display(s) of patient and/or employee experience data (e.g., via a dashboard on the internal Web) and provide updates to employees on the efforts the organization is undertaking to improve the experience of its patients and their families.</p> <p><u>Metric 1: I - 18.1</u> Number of organization - wide displays (can be physical or virtual) about the organization’s performance in the area of patient/family experience per year; and at least one example of internal CEO communication on the experience improvement work.</p> <p>Baseline/Goal: At least one</p>	

<b>Unique Identifier:</b> 162033801.2.2	<b>RHP PP Reference Number:</b> 2.4.1	<b>Project Components:</b> 2.4.1 a-d	<b>Project Title: Redesign to Improve Patient Experience</b>	
Performing Provider Name: Laredo Medical Center			TPI: 162033801	
<b>Related Category 3 Outcome Measure(s):</b>	162033801.3.2	IT -6.1	Percent improvement over baseline of patient satisfaction scores	
<b>Year 2</b> <b>(10/1/2012 – 9/30/2013)</b>	<b>Year 3</b> <b>(10/1/2013 – 9/30/2014)</b>	<b>Year 4</b> <b>(10/1/2014 – 9/30/2015)</b>	<b>Year 5</b> <b>(10/1/2015 – 9/30/2016)</b>	
<p>focus groups as alternative methodologies to written surveys; Conduct care experience flow mapping; implement a survey of employee experience; Roll out a pilot of real - time electronic methodology for capturing patients’ feedback during the process of care; and/or implement another innovative method for obtaining patient and/or employee experience information</p> <p>Baseline/Goal: Translate the survey into Spanish.</p> <p>Data Source: Submission of Spanish-translated survey.</p> <p>Milestone 3 Estimated Incentive Payment (maximum amount): \$393,166</p> <p><b>Milestone 4: P - 10</b> Administer regular inquiry into patient experience in the new organization or organizational area using methodologies such as: Written surveys, Phone interviews; Focus groups; Care experience flow mapping; Real - time electronic methodology for capturing patients’</p>	<p>stored, analyzed, fed back to the “sharp end” and used in quality improvement?</p> <p>Baseline/Goal: Conduct the assessment based on use of the survey tool.</p> <p>Data Source: Patient experience survey tool assessment.</p> <p>Milestone 6 Estimated Incentive Payment (maximum amount): \$267,318</p> <p><b>Milestone 7: P-6</b> Include specific patient and/or employee experience objectives into employee job descriptions and work plans. Hold employees accountable for meeting them.</p> <p><u>Metric 1: P-6.1</u> % employees who have specific patient and/or employee experience objectives in their job description and/or work plan.</p> <p>Baseline/Goal: 100% of clinic employees.</p>	<p>and/or employee experience data (e.g., via a dashboard on the internal Web) and provide updates to employees on the efforts the organization is undertaking to improve the experience of its patients and their families</p> <p><u>Metric 1: I - 18.1</u> Number of organization - wide displays (can be physical or virtual) about the organization’s performance in the area of patient/family experience per year; and at least one example of internal CEO communication on the experience improvement work.</p> <p>Baseline/Goal: At least one display visible to all employees and at least one CEO communication.</p> <p>Data Source: Copy of internal display and CEO communication.</p> <p>Milestone 13 Estimated Incentive Payment (maximum amount): \$294,665</p> <p><b>Milestone 14: P-8</b> Develop new</p>	<p>display visible to all employees and at least one CEO communication.</p> <p>Data Source: Copy of internal display and CEO communication.</p> <p>Milestone 17 Estimated Incentive Payment (maximum amount): \$376,832</p> <p><b>Milestone 18: I-19</b> Make patient and/or employee 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 its patients and their families.</p> <p><u>Metric 1: I - 19.1</u> Number of external communications aimed at the general public’ understanding of the organization’s results and improvement efforts in the area of patient and/or employee experience.</p> <p>Baseline/Goal: At least one meeting per year open to all clinic</p>	

<b>Unique Identifier:</b> 162033801.2.2	<b>RHP PP Reference Number:</b> 2.4.1	<b>Project Components:</b> 2.4.1 a-d	<b>Project Title: Redesign to Improve Patient Experience</b>	
Performing Provider Name: Laredo Medical Center			TPI: 162033801	
<b>Related Category 3 Outcome Measure(s):</b>	162033801.3.2	IT -6.1	Percent improvement over baseline of patient satisfaction scores	
<b>Year 2 (10/1/2012 – 9/30/2013)</b>		<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>
<p>feedback during the process of care; and/or another innovative method for obtaining patient experience information.</p> <p><u>Metric 1: P - 10.1</u> % of active patients who were included in an inquiry.</p> <p>Baseline/Goal: At least 1.8% of clinic patients are surveyed (estimated 175 completed surveys/9,886 total visits) to generate a statistically significant sample size per National CAHPS Consortium recommendations so that data reflects clinic-wide patient satisfaction representative of all clinic services (see project narrative for list of services) and all clinic patients visiting the clinic, estimated to be 9,886 visits/year.<sup>54</sup></p> <p>Data Source: Patient experience survey vendor reports.</p> <p>Milestone 4 Estimated Incentive Payment (maximum amount): \$393,165</p>		<p>Data Source: Job descriptions and/or workplans.</p> <p>Milestone 7 Estimated Incentive Payment (maximum amount): \$267,318</p> <p><b>Milestone 8: I-18</b> Develop regular organizational display(s) of patient and/or employee experience data (e.g., via a dashboard on the internal Web) and provide updates to employees on the efforts the organization is undertaking to improve the experience of its patients and their families.</p> <p><u>Metric 1: I-18.1</u> Number of organization - wide displays (can be physical or virtual) about the organization's performance in the area of patient/family experience per year; and at least one example of internal CEO communication on the experience improvement work.</p> <p>Baseline/Goal: At least one display visible to all employees and at least one CEO communication.</p>	<p>methods of inquiry into patient and/or employee satisfaction, or improve the existing ones, to achieve greater quality and consistency of data.</p> <p><u>Metric 1: P-8.1</u> This will vary from Performing Provider to Performing Provider, based on the gaps identified in the assessment (previous bullet) and the assignment of improvement priorities by organization's leaders. Examples include: Develop a new patient experience survey tool or revise and improve the current ones; Translate and/or simplify written surveys to make them more user - friendly to LEP and low - literacy populations; Implement phone surveys and/or focus groups as alternative methodologies to written surveys; Conduct care experience flow mapping; implement a survey of employee experience; Roll out a pilot of real - time electronic methodology for capturing patients' feedback during the process of care; and/or implement another innovative method for obtaining patient and/or employee experience information.</p>	<p>patients visiting the clinic (estimated at 9,886 visits/year) to become engaged in responding to survey results.</p> <p>Data Source: Submission of external communications.</p> <p>Milestone 18 Estimated Incentive Payment (maximum amount): \$376,833</p>

<b>Unique Identifier:</b> 162033801.2.2	<b>RHP PP Reference Number:</b> 2.4.1	<b>Project Components:</b> 2.4.1 a-d	<b>Project Title: Redesign to Improve Patient Experience</b>	
Performing Provider Name: Laredo Medical Center			TPI: 162033801	
<b>Related Category 3 Outcome Measure(s):</b>	162033801.3.2	IT -6.1	Percent improvement over baseline of patient satisfaction scores	
<b>Year 2 (10/1/2012 – 9/30/2013)                      Year 3 (10/1/2013 – 9/30/2014)                      Year 4 (10/1/2014 – 9/30/2015)                      Year 5 (10/1/2015 – 9/30/2016)</b>				
	<p>Data Source: Copy of internal display and CEO communication.</p> <p>Milestone 8 Estimated Incentive Payment (maximum amount): \$267,318</p> <p><b>Milestone 9: P - 11</b> Orchestrate improvement work on identified experience targets (targets could include, for example, better understanding of HCAHPS results or results of other measures; improved caregiver communication; better discharge planning; improved cleanliness, noise levels and/or dining experience; better ambulatory experience; improved employee experience, etc.). Workgroups should be formed under the steering committee to work on experience targets. Detailed implementation plans should be created for each workgroup.</p> <p><u>Metric 1: P - 11.1</u> Submission of implementation plan.</p> <p>Baseline/Goal: Improvement implementation plan, including</p>	<p>Baseline/Goal: Provide hard copies of the survey in English and Spanish in the clinic office (survey traditionally administered by phone).</p> <p>Data Source: Copy of survey hard copies.</p> <p>Milestone 14 Estimated Incentive Payment (maximum amount): \$294,665</p> <p><b>Milestone 15: I-19</b> Make patient and/or employee 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 its patients and their families.</p> <p><u>Metric 1: I - 19.1</u> Number of external communications aimed at the general public' understanding of the organization's results and improvement efforts in the area of patient and/or employee experience.</p>		

<b>Unique Identifier:</b> 162033801.2.2	<b>RHP PP Reference Number:</b> 2.4.1	<b>Project Components:</b> 2.4.1 a-d	<b>Project Title: Redesign to Improve Patient Experience</b>	
Performing Provider Name: Laredo Medical Center			TPI: 162033801	
<b>Related Category 3 Outcome Measure(s):</b>	162033801.3.2	IT -6.1	Percent improvement over baseline of patient satisfaction scores	
<b>Year 2</b> <b>(10/1/2012 – 9/30/2013)</b>	<b>Year 3</b> <b>(10/1/2013 – 9/30/2014)</b>	<b>Year 4</b> <b>(10/1/2014 – 9/30/2015)</b>	<b>Year 5</b> <b>(10/1/2015 – 9/30/2016)</b>	
	<p>workplan writeup, workgroups formed, and focus for improvement work.</p> <p>Data Source: Implementation plan.</p> <p>Milestone 9 Estimated Incentive Payment (maximum amount): \$267,318</p> <p><b>Milestone 10: I-19</b> Make patient and/or employee 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 its patients and their families.</p> <p><u>Metric 1: I - 19.1</u> Number of external communications aimed at the general public’ understanding of the organization’s results and improvement efforts in the area of patient and/or employee experience.</p> <p>Baseline/Goal: At least one meeting per year open to all clinic patients visiting the clinic</p>	<p>Baseline/Goal: At least one meeting per year open to all clinic patients visiting the clinic (estimated at 9,886 visits/year) to become engaged in responding to survey results.</p> <p>Data Source: Submission of external communications.</p> <p>Milestone 15 Estimated Incentive Payment (maximum amount): \$294,664</p>		

<b>Unique Identifier:</b> 162033801.2.2	<b>RHP PP Reference Number:</b> 2.4.1	<b>Project Components:</b> 2.4.1 a-d	<b>Project Title: Redesign to Improve Patient Experience</b>	
Performing Provider Name: Laredo Medical Center			TPI: 162033801	
<b>Related Category 3 Outcome Measure(s):</b>	162033801.3.2	IT -6.1	Percent improvement over baseline of patient satisfaction scores	
<b>Year 2 (10/1/2012 – 9/30/2013)</b>				
<b>Year 3 (10/1/2013 – 9/30/2014)</b>				
<b>Year 4 (10/1/2014 – 9/30/2015)</b>				
<b>Year 5 (10/1/2015 – 9/30/2016)</b>				
	(estimated at 9,886 visits/year) to become engaged in responding to survey results.  Data Source: Submission of external communications.  Milestone 10 Estimated Incentive Payment (maximum amount): \$267,318			
<b>Year 2 Estimated Milestone Bundle Amount: \$1,572,663</b>	<b>Year 3 Estimated Milestone Bundle Amount: \$1,603,908</b>	<b>Year 4 Estimated Milestone Bundle Amount: \$1,473,324</b>	<b>Year 5 Estimated Milestone Bundle Amount: \$1,130,497</b>	
<b>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add milestone bundle amounts over Years 2-5): \$5,780,392</b>				

**Title of Outcome Measure (Improvement Target)**

**Title:** 6.1 Percent improvement over baseline of patient satisfaction scores

**Performing Provider/TPI:** Laredo Medical Center/162033801

**Unique RHP ID#:** 162033801.3.2

**Outcome Measure Description**

We decided to focus on the standalone measure of IT-6.1(1)- establishing if patients are getting timely care, appointments, and information. The outcome measure shows percent improvement over baseline of patient satisfaction scores.

Our goal is to improve the number of patients indicating they have received timely care, appointments and information, as scored in our survey, by 10% by DY 5.

**Process Milestones:**

<b>Year/Milestone</b>	<b>Quantifiable Patient Impact:</b> Redesigning care for a better patient experience impacts all patients who visit the clinic, estimated at 9,886 visits/year.
DY2: Develop a patient experience implementation/expansion plan to annually use the new patient experience survey tool in Zapata Family Medical Clinic	This plan will describe how patient experience can be measured and improved for all clinic patients.
DY3: Establish baseline rate for the domain	The baseline rate will be established from data collection, analysis and results of the sample of completed patient experience surveys. The sample is statistically significant and therefore its data will represent the entire clinic population (estimated at 9,886 visits/year) with between 0.7 and 0.8 site-level reliability for all composite measures. The sample will be generated to be inclusive of all services provided by the clinic, which, as a 24/7 service provider, includes preventive and primary care, urgent and some emergency care, 24-hour radiology coverage, laboratory testing (urine, pregnancy, flu, strep, etc.), PACS radiology system enabling telemedicine with Laredo Medical Center, ultrasounds, bone density testing, and patient case management and education services.

**Outcome Improvement Targets for Each Year:**

<b>Year/Milestone</b>	<b>Quantifiable Patient Impact:</b> Redesigning care for a better patient experience impacts all patients who visit the clinic, estimated at 9,886 visits/year.
DY3: 2.5% improvement over baseline of patient	The scores will demonstrate that all patients visiting the clinic in this DY (estimated at 9,886 visits/year) have a better experience by 10% over the baseline. Without having yet established a baseline, we are selecting an

satisfaction scores	outcome improvement target for the duration of the demonstration that we believe will be a stretch and will make a significant impact on the patients served by the clinic.
DY4: 5.0% improvement over baseline of patient satisfaction scores	
DY5: 10% improvement over baseline of patient satisfaction scores	

Clinic patients are receiving the following services: 24/7 access to care, preventive and primary care, urgent and some emergency care, 24-hour radiology coverage, laboratory testing (urine, pregnancy, flu, strep, etc.), PACS radiology system enabling telemedicine with Laredo Medical Center, ultrasounds, bone density testing, and patient case management and education services.

**Rationale**

Selection of IT-6.1, percent improvement over baseline of patient satisfaction scores -- with a specific focus on ensuring patients are getting timely care, appointments, and information -- is most consistent with our selection of Category 2 project 2.4.1, Redesign to Improve Patient Experience.

The process milestone to develop a patient experience implementation plan to annually use the new survey tool in Zapata Family Medical Center is an important first step in planning our work in future years. The other process milestone to establish the baseline rate is necessary to understand the starting point of patient satisfaction scores.

The outcome improvement targets were selected because it is a key goal of the organization to improve the patient experience. Improvement over baseline of patient satisfaction scores by addressing timely care, appointments, and information will help make sure patients are getting primary care when they need it, in a satisfactory way. Our target is a 10% improvement over baseline in this patient experience domain. Not only will these reductions increase patient satisfaction, we believe they will permit more and better access to primary and preventative care.

**Outcome Measure Valuation**

This project represents significant and substantial value for the Zapata County Community as it improves the health care experience for the patient population and substantially increases the focus on patient satisfaction for this high-need community.

- *Expected Outcome:* 10% improvement in patient satisfaction, which is significant.
- *Population Impacted by Project:* This project will improve the patient experience for the entire clinic population (9,886 visits/year). The clinic annually provides care to a significant portion of the Zapata population of 13,150 persons, which are largely rural, Hispanic and low-income (49% Medicaid, Uninsured and Indigent). This population is expected to increase by 6.6% during the demonstration time period.
- *Services Provided by Clinic:* The clinic serves an essential community role in providing 24/7 services, preventive and primary care, urgent and some emergency care, 24-hour radiology coverage, laboratory testing (urine, pregnancy, flu, strep, etc.), PACS radiology system enabling telemedicine with Laredo Medical Center, ultrasounds, bone density testing, and patient case management and education services. Providing 24/7 access requires physician coverage, administrative costs and staff credentialing.

- *Cost Avoidance:* Having a 24/7-clinic that provides after-hour care relieves the community of the need to travel 50-60 miles to an emergency room, which avoids more costly care and saves patients the time and wait for care that may be needed immediately. Thus, receiving satisfactory and timely care at the clinic can avoid costs and improve patient outcomes.
- *Community Benefit:* Zapata County qualifies as a Medically Underserved Area/Population (MUA) because it has a shortage of personal health services, making it increasingly difficult for individuals to access various services including, but not limited to, primary care and emergency services. Because of this, it is important that MUAs seek innovative ways to help expand access to health care in the community. Zapata County is also a designated Health Professional Shortage Area for primary care.<sup>55</sup> The lack of medical providers and facilities has long been an issue in Zapata County. For years groups of concerned citizens and organizations have been trying to secure medical personal to come to Zapata, but it has been difficult to find medical personnel to live in the small rural town along the border and provide medical care for the residents. At this time, Zapata has more providers than it has ever had in its history due to Laredo Medical Center's operation of Zapata Family Medical Clinic: Residents can now have primary care which for years was not obtainable in Zapata.
- *Addressing Priority Community Need:* Providing 24/7 access to health care is critical for these families. The nearest medical inpatient and outpatient clinic is 50 miles either to the North (Laredo) or South (Rio Grande City). Many of the residents lack transportation and funding for travel to the medical providers, so instead they ignore their medical needs until they become imperative. Then it is often too late for medical intervention to treat the medical problem. There have been too many persons with poor prognoses and delayed care due to the limited access of medical care. Providing satisfactory and timely access to care in the community addresses this priority community need.
- *Sustainability of Project:* We believe the work of putting in place the survey tool, annually administering it and using its results to drive improvement will help establish significant cultural change at the clinic that emphasizes patient experience. As a result, the continued ability to assess and improve patient experience will become ingrained institutionally and therefore be highly sustainable.
- *Project Workload:* We are undertaking organization-wide cultural and operational changes. As such, this project represents significant workload to the organization, which underscores the value of this project to patients, providers, the system and the entire community.

Respectively, we are valuing milestones as the following, placing greatest weight on the achievement of the outcome we are seeking through this demonstration:

- **Process Milestones:**
  - DY2: Develop a patient experience implementation/expansion plan - \$100,931
  - DY3: Establish the baseline rate for the domain - \$77,995
- **Outcome Improvement Targets for Each Year:**
  - DY3: 2.5% improvement over baseline of patient satisfaction scores - \$77,995
  - DY4: 5.0% improvement over baseline of patient satisfaction scores - \$187,732
  - DY5: 10.0% improvement over baseline of patient satisfaction scores - \$448,924

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<sup>55</sup> U.S. Department of Health and Human Services, Find Shortage Areas: MUA/P by State & County, <http://muafind.hrsa.gov/index.aspx>; and Find Shortage Areas: HPSA by State & County, <http://hpsafind.hrsa.gov/HPSASearch.aspx>.

<i>Unique Cat 3 ID: 162033801.3.2</i>	<i>Ref Number from RHP PP: IT-6.1</i>	<i>Percent improvement over baseline of patient satisfaction scores</i>	
<i>Performing Provider Name: Laredo Medical Center</i>			<i>TPI - 162033801</i>
<b>Related Category 1 or 2 Projects:</b>	162033801.2.2		
<b>Starting Point/Baseline:</b>	To be determined DY 3		
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>
<p><b>Process Milestone 1 [P-1]:</b> Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans.</p> <p>Data Source: Submission of a patient experience implementation/expansion plan to annually use the new patient experience survey tool in Zapata Family Medical Clinic to improve patient experience for all patients visiting the clinic, estimated at 9,886 visits/year.</p> <p>Process Milestone 1 Estimated Incentive Payment (<i>maximum amount</i>): \$100,931</p>	<p><b>Process Milestone 2 [P-2]:</b> Establish baseline rates.</p> <p>Data Source: Patient Survey satisfaction scores for timely care, appointments, and information domain from survey administered in DY2; baseline rates generated from statistically significant sample representative of all clinic visits (estimated at 9,886 visits/year).</p> <p>Process Milestone 2 Estimated Incentive Payment: \$77,995</p> <p><b>Outcome Improvement Target 1 [IT-6.1]:</b> Percent improvement over baseline of patient satisfaction scores for domain (1) patients are getting timely care, appointments, and information (Standalone measure).</p> <p>Improvement Target: 2.5% improvement in targeted patient satisfaction domain.</p> <p>Data Source: Patient Survey results of a sample which statistically represents all patients visiting the clinic (estimated 9,886 visits/year).</p> <p>Outcome Improvement Target 1</p>	<p><b>Outcome Improvement Target 2 [IT-6.1]:</b> Percent improvement over baseline of patient satisfaction scores for domain (1) patients are getting timely care, appointments, and information (Standalone measure).</p> <p>Improvement Target: 5.0% improvement over baseline in targeted patient satisfaction domain.</p> <p>Data Source: Patient Survey results of a sample which statistically represents all patients visiting the clinic (estimated 9,886 visits/year).</p> <p>Outcome Improvement Target 2 Estimated Incentive Payment: \$187,732</p>	<p><b>Outcome Improvement Target 3 [IT-6.1]:</b> Percent improvement over baseline of patient satisfaction scores for domain (1) patients are getting timely care, appointments, and information (Standalone measure).</p> <p>Improvement Target: 10.0% improvement over baseline in targeted patient satisfaction domain.</p> <p>Data Source: Patient Survey results of a sample which statistically represents all patients visiting the clinic (estimated 9,886 visits/year).</p> <p>Outcome Improvement Target 3 Estimated Incentive Payment: \$448,924</p>

<i>Unique Cat 3 ID: 162033801.3.2</i>	<i>Ref Number from RHP PP: IT-6.1</i>	<i>Percent improvement over baseline of patient satisfaction scores</i>	
<i>Performing Provider Name: Laredo Medical Center</i>			<i>TPI - 162033801</i>
<b>Related Category 1 or 2 Projects:</b>	162033801.2.2		
<b>Starting Point/Baseline:</b>	To be determined DY 3		
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>
	Estimated Incentive Payment: \$77,995		
<b>Year 2 Estimated Outcome Amount: \$100,931</b>	<b>Year 3 Estimated Outcome Amount: \$155,990</b>	<b>Year 4 Estimated Outcome Amount: \$187,732</b>	<b>Year 5 Estimated Outcome Amount: \$448,924</b>
<b>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5): \$893,577</b>			

## **Project Summary:**

Unique Project Identifier: 162033801.2.3

Provider Name/TPI: Laredo Medical Center / TPI 162033801

Provider Description: Laredo Medical Center is a 326-bed, acute care hospital that offers a range of comprehensive health services including inpatient, outpatient, medical, surgical, diagnostic and emergency care. Located in Webb County, the hospital serves both Webb and Zapata county residents. Laredo Medical Center's population service area is 277,492, of which 194,616 are in the primary service area. Laredo Medical Center operates the Zapata Family Medical Clinic in Zapata. Zapata is included in our hospital's secondary service area and includes a primary population of 13,150 which is projected to grow by 6.6% within the next five years.

Intervention(s): This project will implement innovative evidence-based strategies to reduce and prevent obesity in children and adolescents through quarterly patient education sessions for Zapata residents.

Need for the project (include data as appropriate): There is an obesity crisis in the area: 27% of adults in Zapata County report a BMI  $\geq$  30.<sup>56</sup>

Target population (number of patients the project will serve and how many Medicaid/Indigent will benefit from the project): Last year, the Zapata Family Medical Clinic had 9,886 patient visits, of which the payor mix is 32% Medicaid, 23% Medicare, 18% Blue Cross, 13% Uninsured, 8% Networks, 4% Zapata County Indigent and 2% all other patients. Zapata residents will be invited to attend obesity reduction and prevention sessions, with the goal of providing education to at least 40 people in DY3, 80 people in DY4 and 120 people in DY5.

Category 1 or 2 expected patient benefits: The project seeks to provide quarterly patient education sessions on obesity reduction and prevention. Specifically, attendees will learn about nutrition and self-management. In conjunction with Project 162033801.2.1 to redesign the patient experience, we expect that clinic patients will be better able to access satisfactory preventative and primary care at the Zapata Family Medical Clinic as a result. Additionally, we hope that the knowledge and tools being imparted on attendees will help make their and their families' lifestyles healthier. While we will market this service offering broadly to the Zapata Family Medical Clinic patient population, because it is a new service, we expect that a small number would attend initially and increase over time, estimated at 40-180 patients/year.

Category 3 outcomes expected patient benefits: IT-6.1, percent improvement over baseline of patient satisfaction scores. Our goal is to achieve a 10.0% improvement over baseline of patient satisfaction scores by DY 5. We believe this new offering will be a factor in influencing patient satisfaction scores by the clinic population (9,886 visits/year).

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<sup>56</sup> County Health Rankings & Roadmaps, <http://www.countyhealthrankings.org/node/2910/11/archived-data/2010>.

## **Identifying Project and Provider Information**

**Project Option:** 2.7.5 Implement innovative evidence-based strategies to reduce and prevent obesity in children and adolescents.

**Unique RHP ID#:** 162033801.2.3

**Performing Provider/TPI:** Laredo Medical Center/162033801

## **Project Description**

**Brief Description:** Laredo Medical Center will provide hospital staff to present quarterly education on obesity reduction and prevention in Zapata, Texas.<sup>50</sup> These sessions will provide culturally-appropriate nutrition counseling and disease self-management education so that attendees leave empowered with the knowledge and tools to make their and their families' lifestyles healthier.

Laredo Medical Center serves a patient population that is 96% Hispanic or Latinos, young and low-income.<sup>49</sup> Laredo Medical Center is located in Webb County, but serves both Webb County and Zapata County residents. The primary and secondary population service area is 277,492, of which 194,616 are in the primary service area. Hispanic or Latinos make up 96% of the population. The median age of the primary service group is 27 years, with a median household income of \$31,303. The median age of the secondary services group is 30 years, with a median household income of \$47,442. The patient population is further broken down as follows: Medicare 37%, Medicaid 36%, Networks 14%, Uninsured 9%, and all other at 4%.

Patients will be targeted from the Zapata Family Medical Clinic to attend the educational sessions on obesity reduction and prevention. This clinic has annual patient visits of 9,886, of which the payor mix is 32% Medicaid, 23% Medicare, 18% Blue Cross, 13% Uninsured, 8% Networks, 4% Zapata County Indigent and 2% all other patients. The clinic is included in Laredo Medical Center's secondary service area and the community of Zapata includes a primary population of 13,150 persons with a projected growth of 6.6% in the next five years. The clinic serves an essential community role in providing 24/7 services. The clinic provides preventive and primary care, urgent and some emergency care, 24-hour radiology coverage, laboratory testing (urine, pregnancy, flu, strep, etc.), PACS radiology system enabling telemedicine with Laredo Medical Center, ultrasounds, bone density testing, and patient case management and education services.

The Zapata population faces significant health issues associated with obesity: 27% of adults in Zapata County report a BMI  $\geq 30$ .<sup>56</sup> Obesity contributes to a host of other health issues that are chronic and sometimes fatal, particularly diabetes. Issues relating to diabetes are a major focus of concern for Zapata County and the entire Texas/Mexico Border. According to the Centers for Disease Control and Prevention, "the results of the analysis indicated that the age- and sex-adjusted rate of diabetes-related lower extremity amputation (LEA) in the general population along the border was nearly double the rate of nonborder counties."<sup>57</sup> The Office of Minority Health has found that rates of obesity and diabetes are high among Hispanics, which is consistent

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<sup>57</sup> See <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5546a3.htm>.

with the crisis facing the largely Hispanic Zapata community.<sup>58</sup> The population is also low-income, another contributing factor as a result of a lack of access to nutritional foods. Recent data concludes that 46.7% of children under the age of 18 in Zapata County live in poverty.<sup>51</sup> In 2007, Zapata fast food expenditures per capita were \$784.26, up from \$541 just five years before.<sup>59</sup> While the Zapata Family Medical Clinic provides preventative, primary and urgent care services to the families of Zapata, a concerted effort to reduce and prevent obesity has not yet been put in place.

The educational sessions would not only focus on providing information on culturally-appropriate nutrition, but also on self-management. All patients with chronic illness make decisions and engage in behaviors that affect their health (self-management). Disease control and outcomes depend to a significant degree on the effectiveness of self-management. Disease management emphasizes prevention of disease-related exacerbations and complications using evidence-based guidelines and patient empowerment tools. It can help manage and improve the health status of a defined patient population over the entire course of a disease.<sup>60</sup> By concentrating on the causes of chronic disease, the community moves from a focus on sickness and disease to one based on wellness and prevention.

Successfully engaging the individual in disease self-management and wellness activities empowers person-centered recovery and improved health outcomes. This project would aim to provide effective self-management support that acknowledges the patients' central role in their care, one that fosters a sense of responsibility for their own health.

Evidence from controlled clinical trials suggests that:<sup>61</sup> (1) programs teaching self-management skills are more effective than information-only patient education in improving clinical outcomes; (2) in some circumstances, self-management education improves outcomes and can reduce costs for arthritis and probably for adult asthma patients<sup>62</sup>; and (3) in initial studies, a self-management education program bringing together patients with a variety of chronic conditions may improve outcomes and reduce costs.<sup>63</sup>

**Goal:** Laredo Medical Center's overall aim is to create an environment in Zapata Family Medical Clinic in which families are able to access person-centered primary care efficiently, have long-standing relationships with the clinic and their providers, and work with their providers to stay healthy and out of the hospital. The goal of the project specifically is to implement a program to reduce and prevent obesity among Zapata residents, which is a serious problem in the community. We intend to provide education to residents on nutrition and self-

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<sup>58</sup> See <http://minorityhealth.hhs.gov/templates/content.aspx?ID=6459>.

<sup>59</sup> See <http://county-food.findthedata.org/1/2773/Zapata>.

<sup>60</sup> See <http://www.qualitymeasures.ahrq.gov/popups/printView.aspx?id=23918>.

<sup>61</sup> Thorpe, K, The Affordable Care Act lays the groundwork for a national diabetes prevention and treatment strategy. Health Aff January 2012 vol. 31 no. 1 61-66.

<sup>62</sup> A Witmer, S D Seifer, L Finocchio, J Leslie, and E H O'Neil. Community health workers: integral members of the health care work force. American Journal of Public Health August 1995: Vol. 85, No. 8\_Pt\_1, pp. 1055-1058. doi: 10.2105/AJPH.85.8\_Pt\_1.1055

<sup>63</sup> Bodenheimer T, Lorig K, Holman H, Grumbach K. Patient Self-management of Chronic Disease in Primary Care. JAMA. 2002; 288(19):2469-2475.

management in a culturally concurrent manner so that the families of Zapata are equipped with the knowledge and tools that can help them sustainably achieve healthier lifestyles.

**Region 20 Goals:** Region 20 identified improvement of primary care and specialty care capacity as one of its most important goals. By focusing on obesity reduction and prevention, our patients will be better able to be engaged in, communicate with, and take shared responsibility with staff and providers for managing their health.

**Challenges/Issues:** The Zapata population faces significant health issues associated with obesity: 27% of adults in Zapata County report a BMI  $\geq 30$ .<sup>64</sup> Obesity contributes to a host of other health issues that are chronic and sometimes fatal, particularly diabetes. The current prevention and treatment system is an unconnected, silo-based approach, which reduces the effectiveness and increases the cost of health care.<sup>64</sup> While the Zapata Family Medical Clinic provides preventative, primary and urgent care services to the families of Zapata, a concerted effort to reduce and prevent obesity has not yet been put in place.

**Five-Year Expected Outcome for Provider and Patients:** This project proposes to provide obesity reduction and prevention educational sessions on a quarterly basis, with the goal to have at least 40 attendees in DY3, 80 in DY4 and 120 in DY5.

### **Starting Point/Baseline**

This is a new initiative and there is currently no applicable baseline data.

### **Rationale**

The project option was selected because obesity is a major health issue for the Border community of Zapata. Equipping residents with the tools to reduce and prevent obesity will not only benefit attendees to the session, but also their children as well.

The project will be evaluated based on the following nine Category 2, Project 7 Milestones:

In DY2, we will develop a strategy and plan to implement innovative evidence-based strategies to reduce and prevent obesity in children and adolescents [P-1].

In DY3, we will:

- Conduct quarterly patient education sessions on obesity reduction and prevention [P-2].
- Have at least 40 patients attend patient education sessions during the DY [I-5].

In DY4, we will:

- Conduct quarterly patient education sessions on obesity reduction and prevention [P-2].
- Have at least 80 patients attend patient education sessions during the DY [I-5].
- Perform at least one Plan-Do-Study-Act (PDSA) workshop related to the educational program in order to conduct quality improvement [P-X].

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<sup>64</sup> See <http://www.qualitymeasures.ahrq.gov/popups/printView.aspx?id=23918>.

In DY5, we will:

- Conduct quarterly patient education sessions on obesity reduction and prevention [P-2].
- Have at least 120 patients attend patient education sessions during the DY [I-5].
- Perform at least one PDSA workshop related to the educational program in order to conduct quality improvement [P-X].

**Unique Community Need Identification Numbers the Project Addresses:**

- CN 1: Capacity – Primary and Specialty Care – The demand for primary and specialty care services exceeds that of available medical physicians in these areas, and prevents adequate access to care and management or specialized treatment for prevalent health condition and preventative health conditions. This project will help increase primary care capacity by promoting prevention and equipping patients with the tools and information to change their lifestyles as well as better communicate with the clinic staff and providers on related health issues and solutions.

**How the Project Represents a New Initiative or Significantly Enhances an Existing Delivery System Reform Initiative:** No related activities are currently funded by HHS at Laredo Medical Center. The project represents a completely new initiative for Laredo Medical Center.

**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:** The primary goal of this project is to provide Zapata residents with the knowledge and tools to fight obesity, and we believe the service will help improve patient experience, as measured by this outcome (a standalone measure).

**Relationship to other Projects**

Laredo Medical Center is also working to redesign the patient experience at Zapata Family Medical Clinic (see Project 162033801.2.1) by implementing annual patient survey tools and ingrain patient experience into the culture of the clinic over the duration of the demonstration.

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

Several projects in the RHP focus on the expansion of primary care and preventive services. This project is consistent with this focus because this project will allow more patients to access preventive care services.

## **Plan for Learning Collaborative**

We plan to participate in a region-wide learning collaborative as offered by the Anchor entity for Region 20, Webb County. Our participation in this collaborative 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 represents value for the Zapata County Community as it increases prevention for this high-need community:

- *Expected Outcome:* The Category 3 expected outcome is a 10.0% improvement in patient satisfaction during the waiver demonstration period.
- *Population Impacted by Project:* Our goals are to provide prevention education to at least 40 people in DY3, 80 people in DY4 and 120 people in DY5 (space is limited for the location of the sessions and as this is a new service offering, we expect that it will take some work and time to build up attendance). Attendees will likely represent a subset of the patient population of the Zapata Family Medical Clinic, which annually provides nearly 10,000 patient visits to a significant portion of the Zapata population of 13,150 persons. This population is largely rural, Hispanic and low-income (49% Medicaid, Uninsured and Indigent). The county population is expected to increase by 6.6% during the demonstration time period.
- *Services Provided:* This project is providing educational sessions on obesity reduction and prevention with culturally-appropriate nutrition counseling and self-management education.
- *Cost Avoidance:* Initial studies have shown that self-management education may improve outcomes and reduce costs.<sup>62-64</sup>
- *Community Benefit:* The population faces an obesity crisis, which contributes to a host of other health conditions. This project seeks to help reduce and prevent obesity. Zapata County qualifies as a Medically Underserved Area/Population (MUA) because it has a shortage of personal health services, making it increasingly difficult for individuals to access various services including, but not limited to, primary care and emergency services. Because of this, it is important that MUAs seek innovative ways to help expand access to health care in the community. Zapata County is also a designated Health Professional Shortage Area for primary care.<sup>55</sup>
- *Addressing Priority Community Need:* Obesity is a crisis in this community; this project will be providing patients with the knowledge and tools to become healthier.
- *Project Workload:* With nine milestones, this project represents a moderate workload to the organization.

Taking into account the factors that: (1) a subset of the population would be targeted, (2) we expect a 10.0% improvement in the patient experience, (3) the prevention education may contribute system cost savings, (4) the service confronts a community crisis, and (5) the project includes nine milestones, we therefore value this project at \$1,235,460. Based on this project valuation, we have designated the following percentages to each DY: DY2- 12%, DY3- 22%, DY4- 33% and DY5- 34% to reflect the ramp up in implementing the project. Finally, within each year, we assigned equal values to each milestone.

<b>Unique Identifier:</b> 162033801.2.3	<b>RHP PP Reference Number:</b> 2.7.5	<b>Project Components:</b> 2.7.5 [N/A]	<b>Project Title:</b> <i>Implement innovative evidence-based strategies to reduce and prevent obesity in children and adolescents.</i>	
Performing Provider Name: Laredo Medical Center			TPI: 162033801	
<b>Related Category 3 Outcome Measure(s):</b>	162033801.3.3	IT-6.1	Percent improvement over baseline of patient satisfaction scores	
<b>Year 2</b> (10/1/2012 – 9/30/2013)	<b>Year 3</b> (10/1/2013 – 9/30/2014)	<b>Year 4</b> (10/1/2014 – 9/30/2015)	<b>Year 5</b> (10/1/2015 – 9/30/2016)	
<p><b>Milestone 1: P-1</b> Development of innovative evidence-based project for targeted population.</p> <p><u>Metric 1: P-1.1</u> Document innovational strategy and plan.</p> <p>Baseline/Goal: Develop a strategy and plan to implement innovative evidence-based strategies to reduce and prevent obesity in children and adolescents.</p> <p>Data Source: Submission of plan.</p> <p>Milestone 1 Estimated Incentive Payment (maximum amount): \$143,166</p>	<p><b>Milestone 2: P-2</b> Implement evidence-based innovational project for targeted population.</p> <p><u>Metric 1: P-2.1</u> Document implementation strategy and testing outcomes.</p> <p>Baseline/Goal: Conduct quarterly patient education sessions on obesity reduction and prevention.</p> <p>Data Source: Patient class notices, schedules and curriculum.</p> <p>Milestone 2 Estimated Incentive Payment (maximum amount): \$133,985</p> <p><b>Milestone 3: I-5</b> Identify X number or percent of patients in defined population receiving innovative intervention consistent with evidence-based model.</p> <p><u>Metric 1: I-5.1</u> TBD by Performing Provider based on milestone described above.</p> <p>Baseline/Goal: At least 40 patients attend patient education sessions</p>	<p><b>Milestone 4: P-2</b> Implement evidence-based innovational project for targeted population.</p> <p><u>Metric 1: P-2.1</u> Document implementation strategy and testing outcomes.</p> <p>Baseline/Goal: Conduct quarterly patient education sessions on obesity reduction and prevention.</p> <p>Data Source: Patient class notices, schedules and curriculum.</p> <p>Milestone 4 Estimated Incentive Payment (maximum amount): \$134,665</p> <p><b>Milestone 5: I-5</b> Identify X number or percent of patients in defined population receiving innovative intervention consistent with evidence-based model.</p> <p><u>Metric 1: I-5.1</u> TBD by Performing Provider based on milestone described above.</p> <p>Baseline/Goal: At least 80 patients attend patient education sessions</p>	<p><b>Milestone 7: P-2</b> Implement evidence-based innovational project for targeted population.</p> <p><u>Metric 1: P-2.1</u> Document implementation strategy and testing outcomes.</p> <p>Baseline/Goal: Conduct quarterly patient education sessions on obesity reduction and prevention.</p> <p>Data Source: Patient class notices, schedules and curriculum.</p> <p>Milestone 7 Estimated Incentive Payment (maximum amount): \$140,110</p> <p><b>Milestone 8: I-5</b> Identify X number or percent of patients in defined population receiving innovative intervention consistent with evidence-based model.</p> <p><u>Metric 1: I-5.1</u> TBD by Performing Provider based on milestone described above.</p> <p>Baseline/Goal: At least 120 patients attend patient education</p>	

<b>Unique Identifier:</b> 162033801.2.3	<b>RHP PP Reference Number:</b> 2.7.5	<b>Project Components:</b> 2.7.5 [N/A]	<b>Project Title:</b> <i>Implement innovative evidence-based strategies to reduce and prevent obesity in children and adolescents.</i>	
<i>Performing Provider Name: Laredo Medical Center</i>			<i>TPI: 162033801</i>	
<b>Related Category 3 Outcome Measure(s):</b>	162033801.3.3	IT-6.1	<i>Percent improvement over baseline of patient satisfaction scores</i>	
<b>Year 2</b> <b>(10/1/2012 – 9/30/2013)</b>	<b>Year 3</b> <b>(10/1/2013 – 9/30/2014)</b>	<b>Year 4</b> <b>(10/1/2014 – 9/30/2015)</b>	<b>Year 5</b> <b>(10/1/2015 – 9/30/2016)</b>	
	during the DY.  Data Source: Patient class sign-in sheets.  Milestone 3 Estimated Incentive Payment (maximum amount): \$133,984	during the DY.  Data Source: Patient class sign-in sheets.  Milestone 5 Estimated Incentive Payment (maximum amount): \$134,665  <b>Milestone 6: P-X</b> Assess efficacy of processes in place and recommend process improvements to implement, if any.  <u>Metric 1: P-X.1</u> Perform at least one Plan-Do-Study-Act (PDSA) workshop related to the educational program in order to conduct quality improvement.  Baseline/Goal: Perform at least one PDSA workshop related to the educational program in order to conduct quality improvement.  Data Source: PDSA workshop notes.  Milestone 6 Estimated Incentive Payment (maximum amount): \$134,664	during the DY.  Data Source: Patient class sign-in sheets.  Milestone 8 Estimated Incentive Payment (maximum amount): \$140,110  <b>Milestone 9: P-X</b> Assess efficacy of processes in place and recommend process improvements to implement, if any.  <u>Metric 1: P-X.1</u> Perform at least one Plan-Do-Study-Act (PDSA) workshop related to the educational program in order to conduct quality improvement.  Baseline/Goal: Perform at least one PDSA workshop related to the educational program in order to conduct quality improvement.  Data Source: PDSA workshop notes.  Milestone 9 Estimated Incentive Payment (maximum amount): \$140,111	sessions during the DY.  Data Source: Patient class sign-in sheets.

<b>Unique Identifier:</b> 162033801.2.3	<b>RHP PP Reference Number:</b> 2.7.5	<b>Project Components:</b> 2.7.5 [N/A]	<b>Project Title:</b> <i>Implement innovative evidence-based strategies to reduce and prevent obesity in children and adolescents.</i>	
<i>Performing Provider Name: Laredo Medical Center</i>			<i>TPI: 162033801</i>	
<b>Related Category 3 Outcome Measure(s):</b>	162033801.3.3	IT-6.1	<i>Percent improvement over baseline of patient satisfaction scores</i>	
<b>Year 2</b> (10/1/2012 – 9/30/2013)	<b>Year 3</b> (10/1/2013 – 9/30/2014)	<b>Year 4</b> (10/1/2014 – 9/30/2015)	<b>Year 5</b> (10/1/2015 – 9/30/2016)	
<b>Year 2 Estimated Milestone Bundle Amount: \$143,166</b>	<b>Year 3 Estimated Milestone Bundle Amount: \$267,969</b>	<b>Year 4 Estimated Milestone Bundle Amount: \$403,994</b>	<b>Year 5 Estimated Milestone Bundle Amount: \$420,331</b>	
<b>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD</b> ( <i>add milestone bundle amounts over Years 2-5</i> ): <b>\$1,235,460</b>				

**Title of Outcome Measure (Improvement Target)**

**Title:** 6.1 Percent improvement over baseline of patient satisfaction scores

**Performing Provider/TPI:** Laredo Medical Center/162033801

**Unique RHP ID#:** 162033801.3.3

**Outcome Measure Description**

We decided to focus on the standalone measure of IT-6.1(1) – establishing if patients are getting timely care, appointments, and information – because we believe that educational sessions on obesity reduction and prevention with a focus on self-management is a service offering increasing access to timely, prevention and chronic care management information. The outcome measure shows percent improvement over baseline of patient satisfaction scores.

Our goal is to improve the number of patients indicating effective communication with their provider, as scored in our survey, by 10.0% by DY 5.

**Process Milestones:**

<b>Year/Milestone</b>	<b>Quantifiable Patient Impact:</b> Improved patient experience impacts all patients who visit the clinic, estimated at 9,886 visits/year.
DY2: Develop a plan to provide obesity reduction and prevention educational sessions	This plan will describe the implementation of the obesity reduction and prevention program, which is expected to be used by 40-120 patients per year.
DY3: Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities	Improved data collection and intervention activities related to improving the patient experience impacts the broader clinic population across the service offerings. The clinic, which, as a 24/7 service provider, includes preventive and primary care, urgent and some emergency care, 24-hour radiology coverage, laboratory testing (urine, pregnancy, flu, strep, etc.), PACS radiology system enabling telemedicine with Laredo Medical Center, ultrasounds, bone density testing, and patient case management and education services.

**Outcome Improvement Targets for Each Year:**

<b>Year/Milestone</b>	<b>Quantifiable Patient Impact:</b> Improved patient experience impacts all patients who visit the clinic, estimated at 9,886 visits/year.
DY3: 2.5% improvement over baseline of patient satisfaction scores	The scores will demonstrate that all patients visiting the clinic in this DY (estimated at 9,886 visits/year) have more access to timely information over the baseline. Without having yet established a baseline, we are selecting an outcome improvement target for the duration of the demonstration that we believe will be a stretch and will make a significant impact on the patients served by the clinic, and in particular to the large number of patients battling obesity.
DY4: 5.0% improvement over baseline of patient satisfaction scores	
DY5: 10.0%	

improvement over baseline of patient satisfaction scores	preventive and primary care, urgent and some emergency care, 24-hour radiology coverage, laboratory testing (urine, pregnancy, flu, strep, etc.), PACS radiology system enabling telemedicine with Laredo Medical Center, ultrasounds, bone density testing, and patient case management and education services. The program to reduce and prevent obesity among Zapata residents would be a new offering at the clinic.
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**Rationale**

Selection of IT-6.1, percent improvement over baseline of patient satisfaction scores -- establishing if patients are getting timely care, appointments, and information -- is most consistent with our selection of Category 2, Project 2.7.5, Implement innovative evidence-based strategies to reduce and prevent obesity in children and adolescents, because we believe providing education, particularly on self-management, is an important service offering that increases patient access to timely information- in addition to their clinic visits. Moreover, having the ability to refer a patient to this program will give the provider another vehicle to effectively work with patients on goal-setting and implementing healthier lifestyles.

The process milestone to develop a plan to provide obesity reduction and prevention is an important first step in planning our work in future years. The other process milestone to conduct a PDSA cycle will help us make internal improvements in order to better collect data on patient satisfaction.

The outcome improvement targets were selected because it is a key goal of the organization to improve the patient experience as well as reduce and prevent obesity. Improvement over baseline of patient satisfaction scores by addressing timely access to information and care will help make sure patients are getting preventative, primary and chronic care when they need it, in a satisfactory way. Our target is a 10.0% improvement over baseline because it would indicate organizational change.

**Outcome Measure Valuation**

This project represents value for the Zapata County Community as it provides obesity reduction and prevention for interested patients and substantially increases the organizational focus on addressing the obesity crisis. The significant improvements expected to be realized in patient satisfaction will be of substantial value to the community and the patients served:

- *Expected Outcome:* The Category 3 expected outcome is a 10.0% improvement in patient satisfaction during the waiver demonstration period.
- *Population Impacted by Project:* This outcome will be indicative of the entire clinic population (9,886 visits/year). The clinic annually provides care to a significant portion of the Zapata population of 13,150 persons, which are largely rural, Hispanic and low-income (49% Medicaid, Uninsured and Indigent), and which is expected to increase by 6.6%.
- *Services Provided by Clinic:* The clinic serves an essential community role in providing 24/7 services. The clinic provides preventive and primary care, urgent and some emergency care, 24-hour radiology coverage, laboratory testing (urine, pregnancy, flu, strep, etc.), PACS radiology system enabling telemedicine with Laredo Medical Center, ultrasounds, bone

density testing, and patient case management and education services. The program to reduce and prevent obesity among Zapata residents would be a new offering.

- *Cost Avoidance:* Having a 24/7-clinic that provides after-hour care relieves the community of the need to travel 50-60 miles to an emergency room, which avoids more costly care and worse patient health outcomes. Thus, receiving satisfactory and prevention-focused care at the clinic can avoid costs and improve patient outcomes. Moreover, initial studies have shown that self-management education may improve outcomes and reduce costs.<sup>62-64</sup>
- *Addressing Priority Community Need:* The population faces an obesity crisis, which contributes to a host of other health conditions.

Respectively, we are valuing milestones as the following, placing greatest weight on the achievement of the outcome we are seeking through this demonstration:

**Process Milestones:**

- DY2: Develop a plan to provide obesity reduction and prevention educational sessions - \$100,931
- DY3: Conduct a PDSA cycle - \$38,997

**Outcome Improvement Targets for Each Year:**

- DY3: 2.5% improvement over baseline of patient satisfaction scores - \$38,998
- DY4: 5.0% improvement over baseline of patient satisfaction scores - \$187,732
- DY5: 10.0% improvement over baseline of patient satisfaction scores - \$448,923

<i>Unique Cat 3 ID: 162033801.3.3</i>	<i>Ref Number from RHP PP: IT-6.1</i>	<i>Percent improvement over baseline of patient satisfaction scores</i>	
<i>Performing Provider Name: Laredo Medical Center</i>			<i>TPI - 162033801</i>
<b>Related Category 1 or 2 Projects:</b>	162033801.2.3		
<b>Starting Point/Baseline:</b>	To be determined DY 3		
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>
<p><b>Process Milestone 1 [P-1]:</b> Project planning - engage stakeholders, identify current capacity and needed resources, determine timelines and document implementation plans.</p> <p>Data Source: Submission of a plan to provide obesity reduction and prevention educational sessions.</p> <p>Process Milestone 1 Estimated Incentive Payment (<i>maximum amount</i>): \$100,931</p>	<p><b>Process Milestone 2 [P-4]:</b> Conduct Plan Do Study Act (PDSA) cycles to improve data collection and intervention activities.</p> <p>Data Source: PDSA cycle activity notes.</p> <p>Process Milestone 2 Estimated Incentive Payment: \$38,997</p> <p><b>Outcome Improvement Target 1 [IT-6.1]:</b> Percent improvement over baseline of patient satisfaction scores for domain (1) patients are getting timely care, appointments, and information (Standalone measure).</p> <p>Improvement Target: 2.5% improvement in targeted patient satisfaction domain.</p> <p>Data Source: Patient Survey results of a sample which statistically represents all patients visiting the clinic (estimated 9,886 visits/year).</p> <p>Outcome Improvement Target 1 Estimated Incentive Payment: \$38,998</p>	<p><b>Outcome Improvement Target 2 [IT-6.1]:</b> Percent improvement over baseline of patient satisfaction scores for domain (1) patients are getting timely care, appointments, and information (Standalone measure).</p> <p>Improvement Target: 5.0% improvement over baseline in targeted patient satisfaction domain.</p> <p>Data Source: Patient Survey results of a sample which statistically represents all patients visiting the clinic (estimated 9,886 visits/year).</p> <p>Outcome Improvement Target 2 Estimated Incentive Payment: \$187,732</p>	<p><b>Outcome Improvement Target 3 [IT-6.1]:</b> Percent improvement over baseline of patient satisfaction scores for domain (1) patients are getting timely care, appointments, and information (Standalone measure).</p> <p>Improvement Target: 10.0% improvement over baseline in targeted patient satisfaction domain.</p> <p>Data Source: Patient Survey results of a sample which statistically represents all patients visiting the clinic (estimated 9,886 visits/year).</p> <p>Outcome Improvement Target 3 Estimated Incentive Payment: \$448,923</p>

<i>Unique Cat 3 ID: 162033801.3.3</i>	<i>Ref Number from RHP PP: IT-6.1</i>	<i>Percent improvement over baseline of patient satisfaction scores</i>	
<i>Performing Provider Name: Laredo Medical Center</i>			<i>TPI - 162033801</i>
<b>Related Category 1 or 2 Projects:</b>	<i>162033801.2.3</i>		
<b>Starting Point/Baseline:</b>	<i>To be determined DY 3</i>		
<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>
<b>Year 2 Estimated Outcome Amount: \$100,931</b>	<b>Year 3 Estimated Outcome Amount: \$77,995</b>	<b>Year 4 Estimated Outcome Amount: \$187,732</b>	<b>Year 5 Estimated Outcome Amount: \$448,923</b>
<b>TOTAL ESTIMATED INCENTIVE PAYMENTS FOR 4-YEAR PERIOD (add outcome amounts over DYs 2-5): \$815,581</b>			

## ***D. Category 4: Population-Focused Improvements***

**Performing Provider Name: Laredo Medical Center**

**TPI: 162033801**

### **Narrative Description:**

Laredo Medical Center will report on all five required domains:

Domain 1: Potentially Preventable Admissions (8 measures)

Domain 2: Potentially Preventable Readmissions – 30 days (7 measures)

Domain 3: Potentially Preventable Complications (64 measures)

Domain 4: Patient-Centered Healthcare (2 measures)

Domain 5: Emergency Department (1 measure)

Laredo Medical Center will provide a report on what changes were made in order to measure and report the required domains in DY3. The results of these metrics will actually be monitored and reported for DY4 and DY5. The domains are related to the goals of the DSRIP project being proposed by LMC.

### **Domain 1: Potentially Preventable Admissions**

This Category 2 project, 2.4.1, will implement focused patient surveys with respect to the patients seen at the Zapata Family Medical Clinic. Such improvement will require a redesign of primary care to meet the needs of patients. Focus will be on timely, patient-centered, continuous, and coordinated care and increased access to care. By improving patient satisfaction and the patient experience, as well as decreasing wait-time for scheduled and unscheduled appointments, Laredo Medical Center believes it will improve the utilization of primary care physicians and preventive care services at the Zapata Family Medical Clinic. Increasing access to primary care physicians and physician extenders, and increasing utilization of preventive care services, has the ability to reduce potentially preventable admissions.

### **Domain 2: Potentially Preventable Readmissions - 30 days**

This project has the ability to reduce the number of potentially preventable readmissions. By improving patient satisfaction and the patient experience, as well as decreasing wait-time for scheduled and unscheduled appointments, Laredo Medical Center believes it will improve the utilization of primary care physicians and preventive care services at the Zapata Family Medical Clinic. By improving access to preventive services, emergency room physicians, and others, can focus on delivering the best care to the patient population. Because the population of Zapata will have increased access to preventive and follow-up care, and improved access and use of primary care physicians and physician extenders, Laredo Medical Center expects to see improvements in the level of hospital readmissions.

### **Domain 3: Potentially Preventable Complications**

This project has the ability to reduce the number of potentially preventable complications. This project will measure 64 potentially preventable complications, which are adverse complications acquired in the inpatient setting (such as hospital-acquired conditions). Laredo Medical Center Category 2-3 projects will not play a role in a reduction of potentially preventable complications

#### Domain 4: Patient-Centered Healthcare

This project has the ability to: (1) improve patient satisfaction in the inpatient setting by using HCAHPS (themes include: Your care from doctors; Your care from nurses; The hospital environment; When you left the hospital); as well as (2) improve medication management in the inpatient setting, as measured by Medication Reconciliation Metric (medication reconciliation levels in discharged inpatient population derived from NQF 0646). Laredo Medical Center Category 2-3 projects will not play a role in this project.

#### Domain 5: Emergency Department

The project should help to reduce admit decision time to ED departure time for admitted patients, as measured by 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. Laredo Medical Center Category 2-3 projects will not play a role in this project.

#### Domain Valuation

The domains total 9% of the cumulative Category 4 total, with 5% in DY 2, and 10% in DYs 3-5.

<b>Category 4: Population-Focused Measures</b> <b>Laredo Medical Center</b> <b>162033801</b>				
	<b>Year 2</b> <b>(10/1/2012 –</b> <b>9/30/2013)</b>	<b>Year 3 (10/1/2013</b> <b>– 9/30/2014)</b>	<b>Year 4</b> <b>(10/1/2014 –</b> <b>9/30/2015)</b>	<b>Year 5</b> <b>(10/1/2015</b> <b>–</b> <b>9/30/2016)</b>
<b>Capability to Report</b> <b>Category 4</b>	<b>Milestone:</b> Submission to HHSC of status report that describes the system changes the clinic is putting in place to prepare to successfully report Category 4 measures in DY 3-5.			
Estimated Maximum Incentive Amount	\$100,931	\$46,796		
<b>Domain 1: Potentially Preventable Admissions (PPAs)</b>				
Planned Reporting Period: 1 or 2		2	2	2
Domain 1 - Estimated Maximum Incentive Amount		\$46,796	\$50,061	\$54,415
<b>Domain 2: Potentially Preventable Readmissions (30-day readmission rates)</b>				
Planned Reporting Period: 1 or 2		2	2	2
Domain 2 - Estimated Maximum Incentive Amount		\$46,796	\$50,061	\$54,415
<b>Domain 3: Potentially Preventable Complications (PPCs)</b>				
Includes a list of 64 measures identified in the RHP Planning Protocol.				
Planned Reporting Period: 1 or 2			2	2
Domain 3 - Estimated Maximum Incentive Amount			\$50,061	\$54,415
<b>Domain 4: Patient Centered Healthcare</b>				
<b>Patient Satisfaction – HCAHPS</b>				
Measurement period for report		Calendar Year 2013	Calendar Year 2013	Calendar Year 2013
Planned Reporting Period: 1 or 2		2	2	2
<b>Medication Management</b>				
Measurement period for report		Calendar Year 2013	Calendar Year 2013	Calendar Year 2013
Planned Reporting Period: 1 or 2		2	2	2

Domain 4 - Estimated Maximum Incentive Amount		\$46,796	\$50,061	\$54,415
<b>Domain 5: Emergency Department</b>				
Measurement period for report		Calendar Year 2013	Calendar Year 2013	Calendar Year 2013
Planned Reporting Period: 1 or 2		2	2	2
Domain 5 - Estimated Maximum Incentive Amount		\$46,796	\$50,061	\$54,415
<b>OPTIONAL Domain 6: Children and Adult Core Measures</b>				
<i>Initial Core Set of Health Care Quality Measures for Children in Medicaid and CHIP (24 measures)</i>				
Measurement period for report				
Planned Reporting Period: 1 or 2				
<i>Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults (26 measures)</i>				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Domain 6 - Estimated Maximum Incentive Amount				
<b>Grand Total Payments Across Category 4</b>				
	\$100,931	\$233,980	\$250,305	\$272,075

**Category 4: Population-Focused Improvements –  
Driscoll Children’s Hospital [TPI: 132812205]**

**Domain 1: Potentially Preventable Admissions (8 measures)**

**Domain Description:**

Because Driscoll Children’s Hospital is a pediatric facility, reporting RD 1.3 Behavioral Health and Substance Abuse Admission Rate and RD 1.6 Pediatric Asthma are the only Domain 1 reporting measures that will apply to the population we serve. While we cannot claim an exemption from reporting due to the conditions identified in the Program Funding and Mechanics Protocol paragraph 11f, as a practical matter we will not have a population sufficiently large to report on other measures within Domain 1 because all other measures (RD 1.1, 1.2, 1.4, 1.5, 1.7 and 1.8) apply to populations age 18 and above. However, we will provide the reporting data as required.

Although we do not expect any direct project impact in domain 1, Driscoll is dedicated to serving the population through our local specialty centers. By continuing to provide services throughout the region, children are more likely to be able to obtain appointments when symptoms first develop and before the condition progresses to the point that hospitalization is required. Appointment availability will improve our ability to see patients on a more regular basis in order to monitor medication adherence and to detect changes or recognize symptoms that might lead to hospitalization if left undetected.

**Domain Valuation and Rationale:**

The valuation of this reporting domain is based on the size of the population we serve, the scope of our overall plan and the impact on our community, the extent to which future costs can be reduced or avoided by the project implementation, and estimated availability of funding. By preventing hospital admissions through improved outpatient care, we will not only save money but will also improve the patient’s outcome and quality of life and reduce the potential for complications associated with hospitalization. These factors also contribute to patient satisfaction and free-up hospital services and allow staff to focus on more critical patients.

**Domain 2: Potentially Preventable Readmissions – 30 days (7 measures)**

**Domain Description:**

Because Driscoll Children’s Hospital is a pediatric facility, reporting RD 2.6 Pediatric Asthma is the only Domain 2 reporting measures that will apply to the population we serve. While we cannot claim an exemption from reporting due to the conditions identified in the Program Funding and Mechanics Protocol paragraph 11f, as a practical

matter we will not have a population sufficiently large to report on other measures within Domain 2 because all other measures (RD 2.1, 2.2, 2.3, 2.4, 2.5, and 2.7) apply to populations age 18 and above. However, we will provide the reporting data as required.

Although we do not expect any direct project impact in domain 1, Driscoll is dedicated to serving the population through our local specialty centers. By continuing to provide services throughout the region, children are more likely to be able to obtain appointments when symptoms first develop and before the condition progresses to the point that hospital readmission is required. Appointment availability will improve our ability to see patients on a more regular basis in order to monitor medication adherence and to detect changes or recognize symptoms that might lead to a readmission if left undetected.

#### **Domain Valuation and Rationale:**

The valuation of this reporting domain is based on the size of the population we serve, the scope of our overall plan and the impact on our community, the extent to which future costs can be reduced or avoided by the project implementation, and estimated availability of funding. By preventing hospital readmissions through improved outpatient care, we will not only save money but will also improve the patient's outcome and quality of life and reduce the potential for complications associated with hospitalization. These factors also contribute to patient satisfaction and free-up hospital services and allow staff to focus on more critical patients.

#### **Domain 3: Potentially Preventable Complications (64 measures)**

##### **Domain Description:**

Although many of the measures included in domain 3 are specific to adult care, Driscoll Children's Hospital is prepared to report on all measures found applicable by the state PPC data. While we cannot claim an exemption from reporting due to the conditions identified in the Program Funding and Mechanics Protocol paragraph 11f, as a practical matter we will not have a population sufficiently large to report on many of the measures included in domain 3. However, we will provide the reporting data as required.

We do not anticipate any project impact at this time. However, Driscoll is prepared to report on all non-exempted measurements in an effort to understand the causes of PPCs and make changes to reduce complications within our organization.

### **Domain Valuation and Rationale:**

The valuation of this reporting domain is based on the size of the population we serve, the scope of our overall plan and the impact on our community, the extent to which future costs can be reduced or avoided by tracking and reporting the measures, and estimated availability of funding. By tracking and reporting PPCs, Driscoll will be required to evaluate its own performance, and will drive organizational change to reduce the potential for complications associated with hospitalization. This will not only reduce cost but will also improve the patient's outcome and quality of life. Avoiding PPCs also contribute to patient satisfaction and free-up hospital services and allow staff to focus on more critical patients.

### **Domain 4: Patient-Centered Healthcare (2 measures)**

#### **Domain Description**

Because Driscoll Children's Hospital is a pediatric facility, reporting RD 4.2 Medication Management is the only Domain 4 reporting measures that will apply to the population we serve. While we cannot claim an exemption from reporting due to the conditions identified in the Program Funding and Mechanics Protocol paragraph 11f, RD 4.1 patient satisfaction is not applicable to the pediatric population due to HCAHPS requirements. However, we will provide the reporting data as required.

Although Driscoll is exempted from the patient satisfaction measure we are dedicated to improving patient satisfaction whenever possible and recognize the value of tracking and reporting such measures. Research has shown that patient satisfaction has a high correlation to patient compliance of care, specifically in regards to patients following through on taking medication and following care instructions given by providers. Increasing patient satisfaction and medication management would help to increase patient compliance which in time would result in better continuum of care for the patient.

### **Domain Valuation and Rationale:**

The valuation of this reporting domain is based on the size of the population we serve, the scope of our overall plan and the impact on our community, the extent to which future costs can be reduced or avoided by tracking and reporting the measures, and estimated availability of funding. The valuation is based on a determination that Providing pediatric specialty services to patients is a high cost to organizations since these services includes but is not limited to transportation of providers and patients, access to facilities, access to a range of specialists and more.

### **Domain 5: Emergency Department (1 measure)**

**Domain Description:**

Driscoll Children's Hospital will measure the admit decision time to ED departure time for admitted patients. Driscoll supports a commitment to streamlining the patient transfer process and positively impacting the overall health and well-being of the children we serve. Although none of our projects directly impact the domain 5 measure, Driscoll is committed to improving the patient transfer process.

**Domain Valuation and Rationale:**

The valuation of this reporting domain is based on the size of the population we serve, the scope of our overall plan and the impact on our community, the extent to which future costs can be reduced or avoided by streamlining the patient transfer process, and estimated availability of funding. Emergency room use is a high cost service line. The ED is the first contact that many patients have with our hospital. Driscoll Children Hospital ED cares for varying levels of acuity. It is imperative that the throughput is as efficient and effective as possible in order to treat these patients and improve patient flow throughout the system. Reducing the decision time to make the first call from arrival in transferring ED until call initiated the ED creates significant savings and value.

**Optional Domain 6: Children and Adult Core Measures (8 measures)**

Driscoll Children's Hospital will not be reporting on optional domain 6.

<b>Category 4: Population-Focused Measures Driscoll Children's Hospital – TPI: 132812205</b>				
	<b>Year 2 (10/1/2012 – 9/30/2013)</b>	<b>Year 3 (10/1/2013 – 9/30/2014)</b>	<b>Year 4 (10/1/2014 – 9/30/2015)</b>	<b>Year 5 (10/1/2015 – 9/30/2016)</b>
<b>Capability to Report Category 4</b>	<b>Milestone:</b> Status report submitted to HHSC confirming system capability to report Domains 1, 2, 4, 5, and 6.	<b>Milestone:</b> Status report submitted to HHSC confirming system capability to report Domains 3.		
Estimated Maximum Incentive Amount	\$50,000	\$20,000		
<b>Domain 1: Potentially Preventable Admissions (PPAs)</b>				
Planned Reporting Period: 1 or 2				
Domain 1 - Estimated Maximum Incentive Amount		\$20,000	\$20,000	\$20,000
<b>Domain 2: Potentially Preventable Readmissions (30-day readmission rates)</b>				
Planned Reporting Period: 1 or 2				
Domain 2 - Estimated Maximum Incentive Amount		\$20,000	\$20,000	\$20,000
<b>Domain 3: Potentially Preventable Complications (PPCs)</b> Includes a list of 64 measures identified in the RHP Planning Protocol.				
Planned Reporting Period: 1 or 2				
Domain 3 - Estimated Maximum Incentive Amount			\$20,000	\$20,000
<b>Domain 4: Patient Centered Healthcare</b>				
<b><i>Patient Satisfaction - HCAHPS</i></b>				
Measurement period for report		12 months prior to due date	12 months prior to due date	12 months prior to due date
Planned Reporting Period: 1 or 2		2	2	2
<b><i>Medication Management</i></b>				
Measurement period for report		12 months prior to due date	12 months prior to due date	12 months prior to due date
Planned Reporting Period: 1 or 2		2	2	2
Domain 4 - Estimated Maximum Incentive		\$20,000	\$20,000	\$20,000

Amount				
<b>Domain 5: Emergency Department</b>				
Measurement period for report		12 months prior to due date	12 months prior to due date	12 months prior to due date
Planned Reporting Period: 1 or 2		2	2	2
Domain 5 - Estimated Maximum Incentive Amount		\$20,000	\$20,000	\$20,000
<b>OPTIONAL Domain 6: Children and Adult Core Measures</b>				
<i>Initial Core Set of Health Care Quality Measures for Children in Medicaid and CHIP (24 measures)</i>				
Measurement period for report				
Planned Reporting Period: 1 or 2				
<i>Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults (26 measures)</i>				
Measurement period for report				
Planned Reporting Period: 1 or 2				
Domain 6 - Estimated Maximum Incentive Amount		\$	\$	\$
<b>Grand Total Payments Across Category 4</b>				
	\$50,000	\$100,000	\$100,000	\$100,000

## Section VI. RHP Participation Certifications

*Each RHP participant that will be providing State match or receiving pool payments must sign the following certification.*

By my signature below, I certify the following facts:

- I am legally authorized to sign this document on behalf of my organization;
- I have read and understand this document;
- The statements on this form regarding my organization are true, correct, and complete to the best of my knowledge and belief.

Signature	Name	Organization

## **Section VII. Addendums**

- *Private hospital certifications – refer to Companion Document for additional details.*
- *List of DSRIP projects that were considered but not selected for inclusion in the RHP Plan*
- *Signed agreements of small hospitals participating in a collaboration in Pass 1 as allowed in the PFM Protocol, paragraph 25.c.iii.*
- *Signed agreements of Tier 3 and 4 Performing Providers that combined their Pass 1 allocations as allowed in the PFM Protocol, paragraph 25.c.iv.*
- *Signed agreements of Performing Providers that combined their Pass 2 allocations as allowed in the PFM Protocol, paragraph 25.d.iii.*
- *Optional: additional community assessment information*
- *Optional: supporting evidence of stakeholder participation (e.g. meeting lists, minutes, letters of support)*
- *Optional: additional valuation information*